



Chapter One

Mind-Body Interventions

Linda U. Krebs, RN,
PhD, AOCN

Introduction

Mind-body medicine, which also is referred to as behavioral medicine, unites biomedical, behavioral, and psychosocial strategies for the promotion of health and the understanding of illness. Segen (1998) defined it as “an evolving field of health care based on the belief that a complex interplay of external and internal factors influence the mind, and therefore a person’s response and recuperation from disease” (p. 243). Mind-body medicine is viewed as a holistic, healing philosophy predicated on the interconnection between the mind and body, the innate healing capacity of the body, and the potential for an individual to exercise some personal control over the healing process (Lewith, Kenyon, & Lewis, 1996). Basic principles of mind-body medicine include the beliefs that (a) each individual is unique; thus, the cause of disease and the strategies for cure and healing are unique and (b) chronic stress and lack of balance in one’s life contribute to disease and illness (Burton Goldberg Group, 1993).

Although only recently gaining attention in Western medicine, mind-body interventions have been recognized for thousands of years by traditional medical systems. These interventions are based on the recognition that the mind and body are wholly integrated, each with the ability to influence the other. As described in the Workshop on Alternative Medicine (1994) report, “Mind-body relations are always mutual and bidirectional—the body affects the mind and is affected by it” (p. 4). A variety of interventions, including the use of relaxation techniques and creative art therapies, have been used to actively involve patients in their own treatment, thereby enhancing the body’s inherent healing mechanisms and leading to altered expressions and experiences of illness for patients.

Controversy exists over whether mind-body interventions prolong survival or merely enhance quality of life and the sense of feeling healed (Cannistra, 1998). Anecdotal reports and individual case studies abound. Greer, Morris, and Pettingale (1979) noted that women with breast cancer who had a “fighting spirit” lived longer than those who felt helpless or hopeless. Recent literature has indicated that depression, stress, a lack of sense of control over life, a negative outlook, and a lack of social support correlate with poorer prognosis, while a sense of control, a positive outlook, and adequate social support are correlated with improved survival (Pelton & Overholser, 1994). What appears to be most important, however, is that patients place great value on feeling “healed” (defined as an enhanced sense of well-being, balance and harmony, and wholeness) even when cure is not attained and disease remains (Workshop on Alternative Medicine, 1994). For some, the use of mind-body interventions promotes this feeling.

Relaxation Techniques

Relaxation techniques include a variety of methods, such as biofeedback training, breath therapy, hypnotherapy, imagery and visualization, meditation, progressive muscle relaxation, and yoga, to reduce physical and mental stress. While the techniques vary in methodology, all require an environment that is free of distractions and that the participants attain a comfortable position and wear clothing that is nonrestrictive to movement and relaxation. The participant must be able to limit his or her focus to a single image, object, or phrase and must be able to attain a passive attitude of “letting go,” thus allowing thoughts, fears, and concerns to be overcome (Segen, 1998).

Biofeedback Training

Biofeedback training is a component of autogenic training that was developed to allow an individual to gain voluntary control over processes within the body that previously were thought to be involuntary. Described in the early 1960s by Neal Miller, biofeedback training uses electronic equipment to assess and monitor a patient’s ability to gain control over a symptom or function (Lewith, Kenyon, & Lewis, 1996). Once control is mastered, the patient is able to recognize early symptoms and take appropriate measures to minimize or alleviate them. A therapist (biofeedback trainer or practitioner) facilitates the process until the patient is able to achieve the desired results on his or her own.

In the initial phase of biofeedback training, an electronic device (i.e., an electrocardiogram, a temperature gauge, a blood pressure cuff, or a galvanic skin response indicator) is attached to an area of the body to “feed” responses to symptoms “back” to the patient. The measurement device continuously records and displays the response with a light or sound. With increased response, the light will brighten or the sound will become louder. Through a process of trial and error, and with the assistance of a biofeedback therapist, the patient will develop a method by which to individually alter the light or sound. With practice, the patient will be able to devise a method to totally extinguish the light or tone. Once this process is learned, the patient is then able to self-regulate behavior without the use of electronic equipment. Mastering the process typically takes 10–15 half-hour weekly sessions (Lewith et al., 1996). Recent technique updates have included the use of interactive software packages that allow the patient to learn to control images on a computer-based video display terminal (Woodham & Peters, 1997).

Biofeedback training has been used to decrease muscle tension and spasm, treat sleep disorders, control urinary and fecal incontinence, relieve chronic pain, and manage esophageal motility abnormalities. In patients with cancer, biofeedback training has been used alone or in conjunction with other therapies

to prevent anticipatory nausea and vomiting, achieve pain relief, and decrease anxiety and stress related to disease and treatment (Kastner & Burroughs, 1993; Workshop on Alternative Medicine, 1994).

Special Considerations

No specific contraindications have been identified, and biofeedback appears to be safe for all patients. Patients are requested not to alter the doses of any medications without specific recommendations from their healthcare providers. Electrode sites should be monitored for local irritation (*Nurse's Handbook*, 1999). Success in using biofeedback is contingent upon patient motivation, the use of a competent therapist for biofeedback training, and a reasonable expectation that the use of biofeedback can alleviate the symptom or result in enhanced function (Segen, 1998).

Breath Therapy

Breath therapy, or breath regulation, consists of a number of techniques designed to increase energy that can be used to promote healing and self-care. Breathing techniques most commonly are combined with various methods of relaxation to enhance one's ability to cope with stress. Proper breathing is necessary for relaxation, to decrease tension, and to enhance calmness (Shealy, 1996). Strategies include the use of slow inhalation and exhalation to promote relaxation and forced respirations (also known as evocative breath therapy), which often is practiced with music and used to promote emotional release. Holotropic breathwork, or holotropic breathing, "combines breathing, evocative music, and a specific form of bodywork" (Kastner & Burroughs, 1993, p. 114). It combines the spiritual, physical, and psychological dimensions and is used to promote a sense of "wholeness."

When under stress, an individual may experience short, shallow breathing that can cause increased blood levels of carbon monoxide, leading to symptoms such as panic attacks, feeling faint, increased perspiration, muscle tension, and heart palpitations (Shealy, 1996; Woodham & Peters, 1997). Breath regulation therapies are intended to diminish or eliminate these symptoms. According to Shealy and Woodham and Peters, proper breathing techniques incorporate diaphragmatic, or abdominal, breathing.

Diaphragmatic breathing, which uses long, deep breaths that expand the rib cage, allows the respiratory system to function more efficiently because the lungs are entirely filled and emptied with each complete breath. This is particularly important because diaphragmatic breathing is associated with decreased stress, a sensation of calmness and well-being, and a state of relaxation and increased awareness of one's surroundings (Burton Goldberg Group, 1993; Woodham & Peters, 1997). A practitioner may be used to assist in mastery of proper breathing techniques.

Breath therapy has been used to decrease anxiety, pain, and stress (Ryder, 1997; Segen, 1998) and has been suggested to enhance immune function (Segen). Jahnke (1996) noted that proper breathing promotes homeostasis (balance) in the autonomic nervous system and may play a role in the movement of lymphatic fluid throughout the body.

Special Considerations

Breath therapy is contraindicated for patients who are experiencing shortness of breath.

Hypnotherapy

The beginnings of hypnotherapy can be traced to ancient Greeks and Egyptians, who used healing trances, and to aboriginal cultures in Africa and in North, Central, and South America, in which medicine men and women, shamans, and witch doctors created hypnotic states through drumming and dancing (Woodham & Peters, 1997). Franz Anton Mesmer, an 18th century Austrian physician, is believed to be the “founding father of hypnotherapy,” although his peers considered him to be a charlatan (Kastner & Burroughs, 1993). Mesmer called his form of hypnotherapy “animal magnetism.” James Baird, a Scottish surgeon, first used the term “hypnosis” in the 1840s; however, Milton H. Erickson is considered to be the “father of modern hypnotherapy” (Woodham & Peters). Sigmund Freud was an early proponent of hypnotherapy but later abandoned this method for his own forms of analysis (Burton Goldberg Group, 1993). Hypnotherapy has been considered a valid form of medical therapy since the early 1950s and is now widely used throughout the world (Shealy, 1996). A variety of forms have been postulated; the most common include (a) deep relaxation, in which stress is eased through relaxation, (b) suggestion therapy, which promotes positive thoughts and ideas, and (c) analytic therapy, which examines problems and their causes (Shealy).

Hypnotherapy has been described as a state of “heightened awareness” in which suggestions, as posed by the therapist or through autosuggestion (i.e., self-hypnosis), are more likely to be followed (Burton Goldberg Group, 1993). Through hypnotherapy, the body becomes relaxed and one’s attention is focused on an image, an object, or other ideas as suggested by the therapist or oneself. The goal is to access the unconscious mind, which is believed to be less critical and more likely to accept suggestion. The use of imagery is central to hypnotherapy and may include mental images, sensory input, or words or thoughts. Shealy (1996) defined the hypnotic state as a “naturally occurring state of equilibrium somewhere between waking and sleeping” (p. 113).

For hypnotherapy to be beneficial, three conditions need to be present: (a) an affinity must exist between the patient and the hypnotherapist, (b) the environment must be suitable (comfortable and noise-free), and (c) the patient must be willing to be hypnotized. Individuals who attain the somnambulistic (deep) state of hypnotherapy are most likely to experience some benefit. The hypnotherapist serves as a facilitator, and self-hypnosis techniques can be taught for self-care (Burton Goldberg Group, 1993).

Approximately 90% of the population can be hypnotized; however, only 20%–30% can attain the somnambulistic state (Woodham & Peters, 1997). One cannot be hypnotized against one's will, and an individual will not follow suggestions unless he or she desires to do so (Woodham & Peters).

Hypnotherapy has been used successfully to alleviate stress; to decrease anxiety, depression, fear, and sensations of panic; and to treat headaches, migraines, addictions, bed-wetting, and sleep disorders (Arner, 1990; Segen, 1998). It has been noted to decrease blood pressure and respiratory rate and promote relaxation and a sense of well-being (Burton Goldberg Group, 1993). Hypnotherapy also has been used to manage addictions, enhance concentration, and manage stress-related illnesses (Shealy, 1996). In patients with cancer, hypnotherapy has been noted to diminish side effects related to cancer treatment and to control or decrease cancer pain (Segen; Spiegel & Moore, 1997). Gordon (1996) noted a decrease in nausea and vomiting, a 50% decrease in levels of pain, and an overall decrease in anxiety in patients with chemotherapy-related nausea and vomiting or cancer-related pain. Self-hypnosis has been used to ease pain and decrease chemotherapy-induced nausea and vomiting (Workshop on Alternative Medicine, 1994).

Special Considerations

Contraindications for the use of hypnotherapy include epilepsy, depression, organic psychiatric conditions, antisocial personality disorders, and severe psychosis (Burton Goldberg Group, 1993; Woodham & Peters, 1997). It is essential that a qualified therapist be used (see “Implications” section on page 23 for further details).

Imagery and Visualization

Techniques incorporating imagery and visualization (also referred to as guided imagery, creative imagery, or visualization therapy) use images or symbols to focus the mind on bodily functions. Gordon (1996) described imagery as a process that uses “the conscious mind to create mental images in order to evoke physiologic changes, promote natural healing processes, and provide insight and self-awareness” (p. 92). The goal is to create physiologic changes or to accomplish a par-

ticular goal (e.g., pain relief) through communicating positive thoughts about the desired outcome to the body (Kastner & Burroughs, 1993; Segen, 1998). Imagery is a common component of most mind-body therapies. The exact mechanism of action is unclear.

Florence Nightingale is suggested to have described imagery/visualization and its effects on health early in her career (Hoffart & Keene, 1998), while O. Carl Simonton pioneered imagery in the United States in the early 1970s (Gordon, 1996). Originally, this therapy incorporated aggressive images that consisted of waging war on, killing off, or eating up the symptom or problem. More recently, however, these aggressive images have been replaced by idyllic scenes and images of serenity and calm (Gordon, 1996).

Most techniques using imagery can be placed into one of three categories: (a) evaluation or diagnostic imagery, (b) mental rehearsal, and (c) therapeutic interventions. Therapeutic interventions are, by far, the most common (Workshop on Alternative Medicine, 1994). Phalen (1998) and Woodham and Peters (1997) described two forms of imagery: active and receptive. In active imagery, a particular image is selected by the patient and used to alter a situation or control a symptom. In receptive imagery, images that may provide information about the reasons for a particular symptom or problem are allowed to surface.

Imagery and visualization have been used to decrease stress, stage fright, tension, pain, headaches, and heart rate. Additionally, they have been noted to ameliorate symptoms related to premenstrual syndrome (PMS) and to assist patients in managing urinary incontinence (Burton Goldberg Group, 1993; Kastner & Burroughs, 1996). Guided imagery and visualization may stimulate the immune system (Segen, 1998). Patients with cancer have used imagery and visualization for relaxation and minimization or relief of treatment- and disease-related symptoms, for emotional release, to gain an understanding about the meaning of the cancer experience, and for pain relief (Rancour, 1994; Ryder, 1997). Troesch, Rodehaver, Delaney, and Yates (1993) randomized 40 patients who were receiving chemotherapy with cisplatin to two groups: conventional antiemetic therapy with or without the addition of guided imagery. Although they found no statistical differences in the occurrence of nausea, vomiting, and retching between the groups, patients using guided imagery reported feeling more in control and had a more positive view of the chemotherapy experience. In addition, the experimental group developed the most distressing symptoms at 48 hours, compared to within 12 hours for the control group. In another study, the combination of guided imagery and relaxation increased the ability to manage pain associated with oral mucositis in patients who were undergoing bone marrow transplant as compared to controls or those receiving support from a therapist (Syrjala, Donaldson, Davis, Kippes, & Carr, 1995).

Special Considerations

Few contraindications exist for the use of guided imagery except for patients who are known to be psychotic (*Nurse's Handbook*, 1999). However, in some instances, the image can trigger a physical response, such as an asthma attack when imaging a field of flowers. In addition, some patients may identify so completely with the image that the inability to accomplish the goal or solve the problem may be seen as failure (Cleaveland, 1997). Although imagery can be used as a self-help technique, because of the potential to evoke troubling or disturbing images, initial practice should begin under the guidance of a skilled therapist who has been educated in the art and science of imagery. It may be possible to enhance the effects of imagery by the addition of a smell, which may evoke the desired image for the patient (*Nurse's Handbook*).

Meditation

Meditation has been practiced for thousands of years and is a component of all cultures and every major religion (Kastner & Burroughs, 1993; Woodham & Peters, 1997). Meditation is viewed as a therapeutic method through which an individual is able to block out nonessential thoughts, raise the mind to a higher level, and, thus, transcend everyday concerns (Segen, 1998). Through meditation, one is believed to be able to come into contact with one's inner energy and emotions, calm the mind, relax the body, and concentrate on the moment (Gordon, 1996; Pelton & Overholser, 1994; Phalen, 1998). Meditation can involve breath awareness, repetitive movement, or the use of a mantra, a religious icon, or a physical object to achieve deep relaxation (Woodham & Peters).

Gordon (1996) described two basic approaches to meditation: concentrative meditation and mindfulness meditation. In concentrative meditation, one focuses attention on a sound, an image, or one's breathing, while in mindfulness meditation, the mind is allowed to remain open to whatever flows through. Kastner and Burroughs (1993) and Segen (1998) further categorized meditation techniques based on whether they involve the mind or the body or incorporate techniques for letting go or maintaining control. These include (a) control of the body through activities such as yoga, (b) control of the mind through visualizing an image, focusing on an object, or repeating a word or syllable, (c) letting go of the body through intentional release of muscle tension, and (d) letting go of the mind through leaving the mind open to new thoughts and ideas. As noted by Pelton and Overholser (1994), the meditation technique used is unique to the individual.

Transcendental meditation is the most widely known form of meditation in the United States. It is based on Hindu philosophy and was introduced to the United States in the 1950s by Maharishi Mahesh Yogi (Shealy, 1996). In transcendental meditation, a repeated mantra (sound or tone) is used to achieve deep relaxation

and enhance mental clarity. Reported benefits include increased longevity and quality of life and decreased anxiety (Phelan, 1998; Shealy; Workshop on Alternative Medicine, 1994).

Meditation has been shown to be of benefit in decreasing blood pressure and lowering respiratory and heart rates (Gordon, 1996; Segen, 1998). It also has been noted to decrease insomnia, anger, aggression, and nervousness; relieve muscular aches and pains; and increase concentration and mental clarity (Phelan, 1998). In patients with cancer, meditation has been shown to have a calming effect with a resultant alleviation or decrease in pain, anxiety, and depression and decreased chemotherapy-related nausea (Murphy, Morris, & Lange, 1997; Ryder, 1997). Ainslie Meares, a psychiatrist in Melbourne, Australia, has suggested that meditation may increase blood flow, and thus oxygen and white blood cells, to the tumor (Pelton & Overholser, 1994).

Special Considerations

Individuals with epilepsy or schizophrenia should avoid practicing meditation because of reports of grand mal seizures in the former and acute psychotic events in the latter when meditation techniques were used (Gordon, 1996; *Nurse's Handbook*, 1999). In addition, the special considerations related to breathing, imagery, relaxation, and exercise should be reviewed if these methods are incorporated into the meditation process.

Relaxation Therapy/Progressive Muscle Relaxation

Shealy (1996) defined relaxation therapy as a method that “allows the mind-body complex to get on with its own healing work, restoring internal harmony, and creating afresh conditions for release of mental and physical tension” (p. 116). Breathing techniques are the foundation of relaxation, and most relaxation strategies begin by having participants focus on their patterns of breathing. Relaxation can be used in almost any setting, is easy to learn, and allows the patient to achieve maximal benefit in a minimal amount of time (Gordon, 1996; Woodham & Peters, 1997). Hildebrand and Annala (1998) noted that relaxation is a simple, effective method for patients with cancer to manage symptoms associated with cancer and its treatments. As with many of the mind-body therapies, the benefits of relaxation have been known for thousands of years.

Most forms of relaxation include controlled breathing techniques combined with muscle relaxation, usually in the form of systematic tensing and relaxing of muscle groups. Pioneered by Edmund Jacobson in the 1930s, progressive muscle relaxation incorporates breathing to allow the participant to consciously relax skeletal muscles by initially tensing and then relaxing, or letting go of the tension, in the specific muscle group (Woodham & Peters, 1997). The process begins by

tensing the feet and progressively moves up the body. Upon completion, all muscles, potentially even smooth, internal muscles, are relaxed; one feels as if the “idle” of the body’s “engine” has been returned to normal (Bricklin, 1990; Gordon, 1996; Woodham & Peters).

Relaxation therapy has been used to decrease stress, anxiety, depression, blood pressure, and symptoms of PMS. In individuals with cancer, it may decrease pain, nausea, vomiting, and the stress and anxiety associated with diagnosis and treatment (Hiltebrand & Annala, 1998; Shealy, 1996; Woodham & Peters, 1997). Baider, Uziely, and De-Nour (1994) studied the impact of six sessions of progressive muscle relaxation and guided imagery on individuals with cancer. Of the 86 patients who completed the entire course, all experienced a decrease in symptoms and their impact on quality of life. Sloman, Brown, Aldana, and Chee (1994) and Sloman (1995) reported improved cancer pain relief in patients receiving relaxation training, with or without guided imagery. Additionally, Burish and Jenkins (1992) and Arakawa (1997) conducted studies that demonstrated significant decreases in nausea and anxiety in patients who received relaxation treatment. Finally, Wallace (1997) conducted a meta-analysis of published studies concerning relaxation and guided imagery interventions for cancer pain and found decreased distress and pain and increased physiologic functioning and visual concentration in patients who received these interventions.

Special Considerations

While assisting patients to relax does no harm and may be of benefit in reducing stress and alleviating feelings of helplessness (Kastner & Burroughs, 1993), contraindications do exist. Relaxation therapy is contraindicated in individuals who experience shortness of breath or who have experienced increased stress or anxiety when attempting to focus on breathing. Techniques that use progressive muscle relaxation with intermittent tensing and relaxing of muscles are contraindicated in individuals with bone metastases or compromised functional status. Therapy must be individualized to the unique needs and requirements of the patient (Hiltebrand & Annala, 1998; Shealy, 1996).

Yoga

Yoga is believed to have originated in India more than 5,000 years ago. Often called “the work,” “the way,” or “the path,” yoga is based on ancient Indian Vedic teachings (Kastner & Burroughs, 1993) and traditionally was practiced by Hindu ascetics (yogis). Its name is derived from the Sanskrit *yuj*, which means “union,” and the word *yoga* itself means to combine, coordinate, or harmonize. Yoga as it is known today is thought to be the product of Patanjali, who wrote the *Yoga Sutras* following a period of meditation in the mountains of India in 200 B.C. (Woodham

& Peters, 1997). It was introduced into the West in the 19th century and is considered to be a “fully integrated system controlling all aspects of life” (Woodham & Peters, p. 108). Gardner (1990) stated that the goal of yoga is to attain good health, which includes a simple diet, outdoor exercise, a tranquil mind, and an awareness of one’s relationship with one’s creator. She defined a healthy person as one who experiences unity of body, mind, and spirit. Because healing is believed to begin with relaxation, yoga also begins with a period of relaxation.

In its purest form, yoga consists of eight stages (limbs), each increasingly spiritual, to the attainment of enlightenment, or *samadhi*. The first four limbs consist of postures (*asanas*) and breathing exercises (*prana*, meaning “life energy”) that are designed to purify and bring the body and mind into harmony. The second four consist of meditative practices that eventually lead to enlightenment. *Asanas* may be therapeutic or meditative and always are practiced with breath control exercises. They are designed to create bodily ease or comfort, to facilitate meditation, or as therapy for a specific physical symptom or disorder. *Samadhi* is attained only after dedicated and disciplined practice. When an individual has reached *samadhi*, he or she is believed to have gone beyond the normal states of consciousness (i.e., waking, dream, and sleep) to a fourth level (Lewith et al., 1996).

Many different types of yoga exist, ranging from yoga therapy used to maintain health or combat a specific medical problem to power yoga (*ashtanga*). In the Western world, the most common type is Hatha yoga, or health yoga. Hatha yoga is a technique for achieving better health through total care of the body and all of its functions. It is a combination of *asanas* and *pranayama* that, when practiced appropriately, leads to a calm mind, steady breathing, and a relaxed body. A minimum of one hour of practice per day is believed to be necessary to attain the suggested benefits. Regular daily practice enhances one’s energy, stamina, muscle tone, and concentration, resulting in a greater sense of control and an improved ability to manage stress (Woodham & Peters, 1997).

Yoga has been shown to have a physiologic effect on circulation and muscle tone. Suggested uses include symptomatic relief of back pain, arthritis, stress, fatigue, asthma, bronchitis, PMS, anxiety, muscle tension, and a variety of other conditions, including cancer. The *asanas* are thought to affect the endocrine glands and autonomic nervous system, stimulating digestion, the lymphatic system, and brain activity (Gardner, 1990; Kastner & Burroughs, 1993; Segen, 1998; Shealy, 1996; Woodham & Peters, 1997). Anecdotal reports of 29 individuals with cancer suggested that 90% had some positive benefit from practicing yoga (Burton Goldberg Group, 1993).

Special Considerations

When practiced appropriately, yoga has no known side effects. One should exercise caution when attempting new postures. Certain postures, particularly

headstands, should not be attempted during pregnancy or by patients with hypertension or heart disease. Individuals with diabetes, hernias, cancer metastatic to bone, or a history of eye, ear, or brain problems should consult with their health-care providers prior to beginning any yoga program (Shealy, 1996; Woodham & Peters, 1997).

Qigong

Qigong is an ancient Chinese form of exercise that, similar to yoga, incorporates breathing exercises, movement, and meditation. In conjunction with other components of Chinese traditional medicine, Qigong has been used to reduce stress and maintain health through balancing the body's energy along identified meridians that correspond to the body's emotions and organs (Phalen, 1998). The goal of Qigong is to influence the flow of *qi*, the vital life energy or animating force of the body. Abnormalities of *qi* are evidenced as stagnation, collapse, deficiency, and rebellion (Beinfeld & Korngold, 1995). The two primary branches (forms) of Qigong include soft (internal) Qigong, in which the *qi* is self-manipulated through various forms of exercise and breathing techniques, and hard (external) Qigong, in which the *qi* is extended to another (i.e., one uses his or her energy to heal another) (Beinfeld & Korngold; Segen, 1998). Additional branches include static Qigong, which involves minimal or no movement, and dynamic Qigong, which incorporates movement. Although multiple branches of Qigong exist, all include specific activities designed to regulate the body, the mind, and breathing. Additional forms may incorporate some form of automassage or extremity and torso movement that includes both gentle stretching and circular movements. These exercises may be done while sitting, standing, or lying down; body positioning is dependent upon the expected outcome of the individual exercise (Gordon, 1996; Kastner & Burroughs, 1993).

Qigong has been stated to be of benefit in managing gastrointestinal complaints, reducing stress and fatigue, improving circulation, improving resistance to disease, and decreasing blood pressure, pulse, respiratory rate, and oxygen consumption through providing emotional release and a sense of serenity. Some also have suggested that the practice of Qigong can bolster immune function and may prolong survival in individuals with cancer and HIV/AIDS (Burton Goldberg Group, 1993; Segen, 1998; Woodham & Peters, 1997).

Special Considerations

No known side effects or contraindications have been identified; however, individuals with bone tumors or metastases or those with severe bone marrow depression should contact their healthcare providers prior to attempting any aspect of Qigong.

Creative Arts Therapies

The creative arts therapies, consisting of art, dance, drama, music, sound, and other related forms of expression, have played an integral part in healing and self-expression. In many instances, emotions and reactions to illness may be expressed nonverbally earlier and with less difficulty than possible with verbal forms of expression. Creative arts therapies can foster healing, offer clarity to feelings and emotions, increase insight, and make concrete the vague, unexplainable feelings often related to illness and treatment (Hedlund, 1998; Kastner & Burroughs, 1993; Woodham & Peters, 1997).

Art Therapy

Art therapy is the use of drawing, painting, sculpture, or other creative forms for therapeutic benefit. It is designed to improve, maintain, or restore mental or physical well-being through nonverbal expression and communication. It provides a means through which patients can express unspoken concerns about their illnesses and reconcile emotional conflict. Art therapy's origins can be traced to the 1800s with the work of Rudolf Steiner, who proposed art as a method of healing (Woodham & Peters, 1997), but it was not defined as a profession until 1915, when Margaret Naumberg founded the Walden School, where she incorporated the use of art to meet her students' psychological needs (Kastner & Burroughs, 1993). Art therapy has been used with war veterans as a form of post-traumatic rehabilitation, is being investigated as a tool in patients with Alzheimer's disease to promote free expression, is widely used for personal development, and is used by patients with cancer to assist in adapting and coping with disease- and treatment-related sequelae (Segen, 1998; Woodham & Peters, 1997; Workshop on Alternative Medicine, 1994).

Art therapy can incorporate any art form, from painting to pottery to arts and crafts and model making. In many instances, the actual act of creating a product is therapeutic, whereas in other instances, the product tells a story or has symbolic meaning that may be analyzed and discussed to facilitate healing. Art may be used as a vehicle for expressing socially unacceptable emotions, such as jealousy or rage, or socially acceptable but sometimes personally unacceptable feelings, such as fear, grief, and confusion. As a method of self-help, art therapy can allow an individual to convey thoughts and feelings, relax, and release emotions. By drawing themselves, some patients with cancer find that they can more readily express their feelings about disease, treatment, and survival (Workshop on Alternative Medicine, 1994).

Art therapy is believed to be of benefit for managing stress, bereavement, mental and emotional illness, anorexia nervosa, low self-esteem, Alzheimer's

disease, and terminal illness. Many patients with cancer have used art therapy to describe their reactions to and feelings about diagnosis, treatment, and stages of survival and as a method of healing (Hedlund, 1998; Hildebrand & Annala, 1998; Kastner & Burroughs, 1993; Segen, 1998; Woodham & Peters, 1997). Patients with cancer who are experiencing pain have found that drawing portraits that depict themselves with and without pain has been helpful in understanding cancer pain and easing the pain experience (Pimentel, 1998).

Special Considerations

Art therapy has the potential to elicit unexpected responses triggered by the release of emotions; thus, it is recommended that a qualified and registered therapist be available to help the patient to deal with these emotions. No contraindications to the use of art therapy in individuals with cancer have been described, although a patient's physical status and medications must be taken into consideration when planning projects.

Dance Therapy

Dance therapy, or dance movement therapy, assists individuals to become aware of and express feelings and emotions with a goal of building self-esteem, regaining a sense of identity, and restoring or improving balance between mind and body. Marian Chase developed dance therapy in the United States in the 1940s as a method of expressing one's self through movement. In 1966, the American Dance Therapy Association was founded (Workshop on Alternative Medicine, 1994).

Dance therapy functions on the premise that, through the use of rhythm and movement, the conscious mind can be bypassed and contact can be made with the inner emotional world. Through dance, patients can learn to adapt to disabilities, cope with change, and express emotions and feelings. Dance therapy may be performed with or without a therapist. When a therapist is used, movement may either be choreographed or spontaneous, and music is not required. A typical "session" includes a warm-up and then finger and hand movements that eventually progress to involvement of the entire body. Props often are used but are not required. Simple steps, including walking, sliding, and swaying, are incorporated into the dance. Additionally, classical ballet movements may be incorporated to promote body flexibility, symmetrical movement, good posture, and balance (Kastner & Burroughs, 1993; Segen, 1998; Woodham & Peters, 1997).

Aerobic dance, created by Jackie Sorenson in 1970, and Jazzercise, created by Judie Sheppard Missett in 1969, are two of the many more specialized forms of dance therapy. Each of these forms is considered to be a complete physical-fitness

and body-conditioning program that incorporates dance movements with basic exercises. Tribal dancing, used for thousands of years by aborigines and other indigenous peoples, also can be used as dance therapy. It promotes mental and physical relaxation, provides exercise, and develops participant unity into a tightly woven social community (Kastner & Burroughs, 1993; Workshop on Alternative Medicine, 1994).

Dance therapy is believed to be of benefit for individuals with anorexia nervosa, bulimia, learning disabilities, stress, tension, anxiety, and depression. For women with breast cancer, dance therapy may be used to increase range of motion on the affected side, increase flexibility, decrease lymphedema, and increase self-esteem and self-confidence (Davis, 1998).

Special Considerations

Although no contraindications have been described for the use of dance therapy, individuals at risk for pathologic fractures or those experiencing peripheral neuropathies in the feet and lower extremities should be cautioned about falls and the potential for injury. The potential for cardiovascular compromise from strenuous activity should be evaluated prior to beginning dance therapy. A qualified, registered therapist is recommended. Dance therapy does have the potential to elicit unexpected responses triggered by the release of emotions (Burton Goldberg Group, 1993; Woodham and Peters, 1997).

Drama Therapy

Drama therapy is the deliberate use of the theater arts for therapeutic benefit. Ranging from theater productions to puppetry and mime, drama therapy is designed to release emotions, allow for free expression, promote symptom relief, and support personal growth through active participation. An important aspect of drama therapy is the use of improvisational techniques that allow for free expression and exploration of feelings and the playing-out of experiences and unsettling events. Drama therapy also can promote change through exploration and dramatization (i.e., role-play) of potential events and conflicts (Kastner & Burroughs, 1993).

Drama therapy may be of benefit in those who are experiencing emotional trauma, stressful life events, and depression and for those who are developmentally disabled, are elderly, or have cancer or HIV/AIDS.

Special Considerations

The potential exists for eliciting unexpected responses triggered by the release of emotions; thus, the availability of a qualified and registered therapist is recommended. No known contraindications have been described.

Music Therapy

For more than 2,000 years, music has been known to have therapeutic benefits (Bricklin, 1990; Woodham & Peters, 1997). Aristotle (ca. fourth century BC) believed that flute playing provided healing, and Pythagoras (ca. sixth century BC) believed that music, along with diet, was a primary means to promote health and harmony in mind and body (Bricklin; Kastner & Burroughs, 1993; Workshop on Alternative Medicine, 1994). In 400 BC, European Christians used chanting and intonation to treat illness. Music has been shown to decrease tension, facilitate the release of emotions, and provide an avenue for the exploration of thoughts and concerns (Shealy, 1996, Woodham & Peters).

Music therapy is the intentional use of music or sound (i.e., using an instrument [including the voice], writing music, or listening to music) to induce health and healing. It has been noted to be an effective nonverbal method of exploring and expressing feelings that have not previously or easily been put into words (Segen, 1998; Shealy, 1996; Woodham & Peters, 1997). Music may be stimulative, encouraging movement and participation (e.g., Gospel, Big Band, Dixieland), or sedative, promoting serenity and relaxation (e.g., classical compositions) (Segen).

The National Association for Music Therapy, Inc. was founded in 1950. Music therapists observe and assess patients, develop and initiate a plan of therapy, and evaluate therapeutic outcomes. They may work with individual patients or conduct music therapy group sessions. Group work often promotes the development of trust that may facilitate emotional expression. Therapy is individualized to the person or group and is based on personal or group preferences and surrounding environment (Workshop on Alternative Medicine, 1994). Cleaveland (1997) suggested that music therapy sessions allow a minimum of 20 minutes for listening or participating in a music-related activity in order to achieve optimum effects.

Sound therapy is a subset of music therapy that involves the use of sound waves to restore body harmony. It may incorporate chanting or toning, in which elongated vowel sounds are made and allowed to resonate throughout the body. These practices are believed to decrease stress and create harmony between mind and body, although no specific research findings to support this could be found. Recently, the use of a musical bed, with speakers that amplify musical vibrations transmitted through a mattress, has been suggested.

Music therapy has been used with individuals who are experiencing anxiety, depression, insomnia, low self-esteem, and communication disorders. In patients with Alzheimer's disease, specific types of music have evoked memories and facilitated recall (Burton Goldberg Group, 1993). In patients with cancer, music therapy has been shown to decrease the need for analgesics (Beck, 1991), promote emotional release, increase communication, decrease tension and feelings of helplessness, and increase verbal interactions (Lane, 1992; Ryder, 1997). Ezzone, Baker, Rosselet,

and Terepka (1998) randomized 39 patients who were undergoing high-dose chemotherapy for bone marrow transplant to receive either conventional antiemetic therapy or conventional therapy plus a music therapy intervention. The researchers noted that patients in the experimental group experienced a statistically significant decrease in nausea and vomiting as compared with patients in the control group. Emma O'Brien, BMUS, RMT, a music therapist from the Royal Melbourne Hospital in Melbourne, Australia, has used music therapy to assist patients in defining the cancer experience and in coping with disease and treatment. A CD, *Life Sounding the Soul*, using materials written by or for individual patients was produced and has been used in both therapeutic and educational settings. Patient ratings of their music therapy experiences have shown benefit (i.e., increased comfort and decreased side effects) in both the acute-care and palliative-care settings (E. O'Brien, personal communication, December 3, 1998).

Special Considerations

No contraindications to music therapy have been described. The potential to elicit unexpected responses triggered by releasing emotions exists; thus, the availability of a qualified and registered therapist is recommended. O'Brien (personal communication, December 3, 1998) reported that release of emotions is not uncommon and is felt to be therapeutic by most patients and care providers.

Poetry Therapy

Poetry therapy (also known as bibliotherapy), developed by Eli Grifer in the 1940s, is the planned use of poetry or other forms of literature to elicit or clarify emotions, release stress, resolve conflict, and promote personal growth. Poetry therapy may include individual, creative forms of expression or the discussion and analysis of another's work. Although often conducted in a group with a poetry therapist, reading or writing of poetry and other forms of literature on one's own may provide an avenue for the expression of emotions that one may find difficult to express verbally. Poetry used in group sessions is chosen for a specific effect or to elicit certain types of responses; metaphors and analogies may be used. The reading, writing, and analysis of all forms of literature was noted to be of benefit to prisoners of Nazi concentration camps, who used poetry and storytelling to preserve their sanity and sense of humanity (Kastner & Burroughs, 1993).

Poetry therapy may be of benefit for individuals with anorexia nervosa, bulimia, Alzheimer's disease, stress, depression, strokes, or emotional trauma. In the elderly, poetry therapy may evoke memories and foster communication with others. In patients with cancer, expression through poetry and other forms of writing has been shown to decrease stress, reduce trauma related to disease and treatment, clarify emotional responses, and promote healing. In some instances, the sharing

of writings with others has opened the doors of communication between families and friends, increasing quality of life (Heiney, 1995).

Special Considerations

No contraindications to poetry therapy have been described. However, side effects include the potential to elicit unexpected responses triggered by releasing emotions; thus, the availability of a qualified and registered therapist is recommended.

Other Therapies

Many other well-known mind-body therapies exist. Among these are myriad psychotherapy techniques and support groups. Additionally, horticultural therapy, pet therapy, and the use of prayer and spirituality, although in existence for many years, are gaining increased interest.

Horticultural Therapy

Horticultural therapy, as defined by Morgan (1989), “uses gardening, plants, floral materials, and vegetation to stimulate clients’ interest in their surroundings and to promote the development of leisure or vocational skills” (p. 15). Plants have been used therapeutically since colonial times, with the first description presented by Benjamin Rush in the 1770s (Smith, 1998). The first known greenhouse created for horticultural therapy was built in Pennsylvania in 1879 (Smith). Horticultural therapy includes projects ranging from designing, planting, and tending a garden, flower bed, or potted plant to making potpourri, painting pumpkins, or making grapevine wreaths (Morgan). As an adjunct therapy, horticultural therapy primarily has been used with individuals with chronic mental-health problems or with those who are socially isolated. Horticultural therapy has been used in children’s rehabilitation centers, with the elderly, and in intergenerational programs. Benefits include decreased aggression and anxiety, increased socialization, and an enhanced sense of well-being (Smith).

Although not described for use with individuals with cancer, the potential to be creative, to promote a futures orientation, and to relieve stress and anxiety suggests that horticultural therapy could be beneficial for this patient population.

Special Considerations

Contraindications to this therapy exist for those who are severely immunocompromised. Those who are at risk for or currently afflicted with lymphedema should use appropriate arm and hand care.

Pet Therapy

Pet therapy is the use of domesticated animals for therapeutic purposes. Dogs are the most commonly involved pets, although cats, horses, birds, fish, and other animals also have been used. For inpatient visits, animals are washed and groomed prior to visiting the patients. Some animals are specifically trained so that they can be taken to visit patients in nursing homes and mental institutions as well as to schools to visit children with specialized educational needs. These animals often act as ice breakers, assisting therapists to communicate with clients (Bricklin, 1990).

Pets provide love, warmth, and security, and individuals often respond better to them than other human beings (Bricklin, 1990). Exposure to pets helps many individuals to express emotions that they previously were unable to express and may open lines of communication. Having pets also has been shown to be therapeutic, providing both physical benefits (through such activities as walking a dog) and emotional benefits (through unconditional love and a sense of being needed) (Ryder, 1997).

Pet therapy has been shown to decrease social isolation, decrease stress and anxiety, provide a sense of comfort and support, and decrease heart and respiratory rates and blood pressure. For example, patients with cancer are thought to experience a calming sensation when exposed to aquariums, and the act of taking care of pets has been associated with decreasing one's sense of loneliness and isolation and providing a sense of control over part of one's life (Ryder, 1997).

Special Considerations

Side effects include the possibility of allergic reactions, bites, and scratches. No specific contraindications have been described except for those with known allergies. Those with severe bone marrow suppression probably should limit their exposure to animals. Animals should be examined thoroughly by a veterinarian and bathed and brushed prior to any patient visit.

Prayer

Prayer as a technique for healing has multiple components and varies widely from culture to culture. Prayer may be integral to a patient's life prior to an illness and, thus, continued through diagnosis, treatment, and follow-up, or it may become a component of an individual's self-help plan following diagnosis or the development of initial symptoms. Prayer for the sick includes asking a higher power to cure, promote healing, or relieve suffering of another individual. Many ill individuals, including patients with cancer, have visited healing shrines, such as Lourdes in the south of France, the Basilica of Our Lady of Guadeloupe in Mexico, and Compostele in Spain, in the hopes of finding a miraculous cure or some

form of healing (Segen, 1998). Montbriand (1993, 1994) noted that patients often recite sets of prayers, usually asking St. Jude, the patron saint of hopeless causes, to intercede on their behalf.

For many, prayer has a calming effect and is used to provide a sense of support and safety (Ryder, 1997). In a study by Nokes, Kendrew, and Longo (1995), prayer was noted to be the fourth most common complementary therapy used by individuals with HIV/AIDS. In the majority of cases, it was used daily. Prayer can alleviate stress, assist in adapting and coping with illness, decrease vital signs, and allow for release of emotions. It also has been said to decrease symptoms (including decreases in pain, nausea, vomiting, and anxiety), provide a sense of being healed, and even induce spontaneous remission or cure from cancer (Dossey, 1996; Krebs, 1997; Larsen & Milano, 1995; Marwick, 1995; Segen, 1998).

Spirituality and prayer play important roles in healing. Completing a patient-focused spiritual assessment allows the healthcare provider to assess an individual patient's identified meaning and purpose in life, inner strengths, and ability to connect with others in life-giving ways (Dossey, 1998). The report from the Workshop on Alternative Medicine (1994) identified numerous studies that used prayer, or "prayerfulness," either locally or from a distance, to promote healing. The participants could derive no firm conclusions from the findings; they recommended further investigations into this arena. Dossey and Dossey (1998) noted that more than 250 published studies show that religious practices, regardless of type, are beneficial for health and healing. In addition, Brown-Saltzman (1997) noted that prayers can be worthwhile approaches that nurses can use when caring for patients with cancer.

Special Considerations

No specific side effects or contraindications have been ascribed to prayer therapy, although an individual may feel guilty if he or she prays, leads a spiritual life, or is prayed for and healing or cure does not occur.

Psychotherapy

Psychotherapy is a "catch-all" term used to describe therapy for behavioral, psychiatric, emotional, and personality disorders through verbal and nonverbal methods of communication. The most well-known form of psychotherapy is classical psychotherapy, which is based on the Freudian school of psychoanalysis. In general, psychotherapy is less intense than psychoanalysis and is more interactive, with the therapist providing advice and encouragement (Segen, 1998).

Multiple forms of psychotherapy exist, including therapies that rely on verbal communication, those that focus on changing perceptions and habits, and those

that encourage patients to explore and take responsibility for their own actions. These include four major types: (a) the psychoanalytic therapies, which emanate from Freudian principles and attempt to understand current behaviors and ideas by understanding memories that lie in the unconscious mind, (b) counseling techniques, which focus on the management of a specific problem or life crisis, (c) behavioral therapies, which focus on altering negative behaviors and emotions, and (d) humanistic therapies, which assist participants to understand and take responsibility for their own thoughts and emotions (Shealy, 1996; Woodham & Peters, 1997; Workshop on Alternative Medicine, 1994). Within each major type, numerous specific therapies exist, each with its own defined set of principles and methods to promote emotional and physical well-being. Therapies may be undertaken individually or as part of a group.

Therapists involved in psychotherapy include psychoanalysts, psychologists, psychotherapists, counselors, social workers, nurses, and a variety of other specially accredited and credentialed individuals. Education and training can range from years of advanced education and clinical practice, including personal exposure to psychotherapeutic techniques, to a weekend or two of training. The role of the therapist includes evaluation of the problem, followed by the provision of individualized advice and encouragement that leads to resolution of the problem or adjustment to the situation. The therapist primarily functions as a sounding board, facilitating discussion that allows clients to solve their own problems (Segen, 1998; Woodham & Peters, 1997).

In addition to decreasing anxiety, increasing a sense of control, and enhancing the ability to cope with disease and treatment (Fawzy, Fawzy, Arndt, & Pasnau, 1995; Horrigan, 1995; Woodham & Peters, 1997; Workshop on Alternative Medicine, 1994), psychotherapeutic interventions also may increase the life expectancy of patients with cancer. Simonton, Matthews-Simonton, and Sparks (1980) noted that patients using psychotherapy in addition to conventional cancer treatment had double the survival time of those who did not participate in psychotherapy. Lawrence LeShan, as described in an interview with Horrigan, began psychotherapeutic interventions with patients with cancer in 1952. At that time, the medical paradigm for psychotherapy focused on what was wrong with the patient. LeShan noted that this type of therapy did not seem to be particularly beneficial to his patients. He subsequently changed his focus to evaluate what the patient was doing right and how the patient could move on with life despite the reality of the situation. In evaluating his patients following this change in approach, LeShan noted that while prior long-term survival was less than 5%, almost 50% were experiencing long-term remissions with his new method and that many patients seemed to respond better to all forms of therapy (Horrigan).

Special Considerations

No contraindications to psychotherapy have been identified for individuals with cancer. Of highest importance is receiving therapy from an appropriately educated therapist who is capable of providing the type of therapy that is most needed by the individual patient.

Support Groups

Support groups, or mutual aid groups, are designed to provide social support to individuals with a common concern. Their primary goals are to aid individuals in finding meaning, creating a sense of belonging through group participation, and decreasing physical and emotional discomfort (Cella & Yellen, 1993; Pelton & Overholser, 1994). As an integral component of our social fabric, support groups promote coping with illness through facilitating communication, emotional release, peer support, decreased feelings of social isolation, and the development of a sense of value for one's life experiences (Murphy et al., 1997; Pilisuk, Wentzel, Barry, & Tennant, 1997). Support groups have been shown to enhance physical and emotional adjustment to disease with a concomitant decrease in treatment- and disease-related side effects (Meyer & Mark, 1995). Groups offer peer support, advice and counsel, and emotional support in an atmosphere in which participants can draw strength from one other. Through group interaction, participants may become empowered to gain or maintain a positive attitude and may learn new coping skills. Additionally, the opportunity exists for gaining new friendships, developing a sense of community, sharing fears and concerns in a supportive environment, mourning the loss of a loved one or one's own pending death, managing family relationships, and celebrating survival (Pelton & Overholser; Phalen, 1998; Pilisuk et al.).

Three support programs of note are The Wellness Community, Bernie Siegel's Exceptional Cancer Patients (EcaP), and the assorted support programs of the American Cancer Society. The Wellness Community was founded by Harold Benjamin in 1982 and is designed to foster health and well-being through patients helping patients. It is designed to be complementary to Western medical practices and includes individual and group support structures, education on self-help techniques and diet and nutrition, and social events. EcaP "is based on the principles of *care-frontation*, a loving, safe, therapeutic confrontation that facilitates personal change and healing" (Phalen, 1998, p. 72). The aim of EcaP is to assist patients to become "exceptional" patients with cancer—those who become well against all predicted odds. EcaP founder Siegel has noted that some patients become unexpectedly well (Phalen). Controversy exists concerning the potential to "blame the victim" (i.e., place the guilt or blame for not being cured on the individual with cancer) as opposed to assisting the individual to assume responsibility for his or her ability

to heal (Phalen). The American Cancer Society's support programs are well-documented and include, but are not limited to, Reach to Recovery, I Can Cope™, and Look Good . . . Feel Better™ (Murphy et al., 1997).

In patients with cancer, the benefits of support groups have been shown not only through enhanced coping and vigor and decreased anxiety, tension, and confusion but also through enhanced survival and decreased death rates (Cella & Yellen, 1993; Murphy et al., 1997; Ryder, 1997). Spiegel and Moore (1997) reported a doubling in length of survival (36.6 months vs. 18.8 months) in women with metastatic breast cancer who participated in a year-long support group as compared to the control group. These women believed that they had gained so much from the group that they chose to continue to meet beyond the one-year experimental period. Additionally, in a study by Fawzy et al. (1993), patients with melanoma who participated in support groups had decreased recurrence rates (7 of 34 vs. 13 of 34) and decreased death rates (3 of 34 vs. 10 of 34) over the six-year study period.

Support groups have been noted to decrease anxiety, tension, feelings of confusion and helplessness/hopelessness, and fatigue and to impart a sense of vigor on participants (Richardson et al., 1997). They facilitate coping and communication and have been shown to enhance survival in patients with malignant melanoma and metastatic breast cancer.

The potential exists to create a release of emotions that cannot be adequately supported without the benefit of a qualified group leader. Although no contraindications for participation in support groups have been identified, those with emotional instability, schizophrenia, or any severe mental imbalance probably should not participate.

Implications

While there are few contraindications to the various therapies described under the category of mind-body medicine, numerous implications exist for nursing practice. Of extreme importance is ensuring that the patient receives the therapeutic intervention or education for self-help from a qualified therapist. While no rigid set of criteria exists to identify a "qualified" therapist (practitioner), there are some specific questions that can be asked and guidelines to follow to facilitate selection of a qualified therapist. These include:

1. Adequate education/training: All of the therapeutic interventions described in this section have national or international organizations that prescribe specific educational and/or training requirements. The therapist should meet these requirements. Additionally, the therapist should have received this education/training from a reputable institution.

2. Certification: If a specific certification is available for the intervention, the therapist preferably should hold that certification.
3. Membership in a professional organization: Because specific criteria are established for the professional organizations, membership may be an additional indicator of the therapist's qualifications.
4. Special qualifications: For specific therapies such as hypnosis or psychotherapy, the therapist should be licensed or otherwise appropriately educated and credentialed (e.g., MD, DDS, APN, LCSW).
5. Additional questions: The therapist also should describe the location and length of his or her training, length of practice, previous experience(s) with specific types of illness, previous success rates and problem/complication rates, and certification and compliance with the appropriate regulatory agency associated with that specific therapeutic intervention (Shealy, 1996; Woodham & Peters, 1997).

Many of these interventions will be undertaken by the patient as a form of self-help or may be suggested by a healthcare provider to assist in coping with disease or treatment. Numerous patients (and family members) keep journals, draw, paint, or use other forms of creative expression to describe their emotions related to diagnosis, treatment, and their sequelae. Additionally, patients may follow directions outlined in self-help books or audio- or videotapes or provided by members of the healthcare team to learn such practices as relaxation and guided imagery. This makes it imperative that the nurse be aware of any contraindications or potential complications and intervene appropriately. In addition to not forcing a patient to participate in an activity and recognizing that many of the mind-body medicine interventions have the potential to elicit strong emotions that may require specific and rapid medical interventions, the nurse should

1. Ensure that the patient is physically fit to undertake the desired activity through a thorough evaluation of the patient's medical/psychoemotional history and relevant physical examination. If any questions arise, the patient should be referred to the appropriate healthcare professional prior to undertaking the activity.
2. Educate the patient to continue with regularly prescribed medications and treatments.
3. Properly educate about and assess the patient for potential complications associated with a specific mind-body intervention and be prepared to intervene as needed.
4. Be able to identify additional resources that may be of benefit (e.g., support groups, qualified therapists).
5. Be aware of potential ethical issues (e.g., unqualified therapists, use of prayer or mental healing by others without the patient's knowledge).

6. Be aware of others in surrounding areas who may be affected (positively and negatively) by the therapeutic intervention and minimize intrusion.
7. Continue to provide routine care and other interventions as would be expected for that particular patient.

Summary

Mind-body interventions have been used for thousands of years by traditional medical systems and have become more widely used in Western medicine over the last several decades. Encompassing relaxation techniques, creative therapies, various forms of psychotherapy, and therapies using plants and animals, mind-body therapies generally are without contraindications for the typical patient. When practiced appropriately, with a qualified therapist or as self-care following adequate instruction, these therapies can help to alleviate symptoms and promote an increased sense of control, self-esteem, and quality of life.

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