O R I G I N A L P A P E R

A Multiparadigmatic Model for a Holistic Nursing

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Abstract

Based on a primary study (Santos, 2011) focusing the integration of non-conventional therapeutic modalities in the nursing care process, a secondary analysis of the findings was performed in order to answer the following questions: What conception guides nursing practice when using non-conventional therapeutic modalities? What is the place of holistic nursing in nursing's theoretical development? The analytical expansion, as a way of doing secondary analysis, led to organize the reflection in four dimensions: evidence of the utilization by nurses of non-conventional therapeutic modalities; holistic care is nursing's choice; a multi paradigmatic model for a holistic nursing; the place of holism in health and nursing paradigms. We believe this is a contribution for the clarification of nursing's identity and consider further research to be necessary.

Key-words: model, nursing model, nursing intervention, unconventional therapeutic modalities.

Introduction

Strengthening nursing as a scientific discipline implies a clear identification of its conceptual, content and method elements as well as the understanding of its natural evolution. The diversity and mobility of nursing's disciplinary frontiers have hindered this necessary process of clarification, though allowing at the same time for the emergency of new therapeutic modalities that slowly take place in the professional practice. The social acceptance and increased use of non-conventional therapeutic modalities by nurses, leads to the need to analyze further its conceptual implications. Findings of a primary study (Santos, 2011) confirm and enlarge Engebretson's model of holistic nursing (1997) leading to the present secondary analysis guided by the following questions:

What conception guides nursing practice when using non-conventional therapeutic modalities?

What is the place of holistic nursing in nursing's theoretical development?

Background

Paradigms, defined as perspectives of something (Taylor et al 2007) are used as approaches to comprehend and develop nursing knowledge and have evolved through time. The traditional scientific paradigm is generally considered a positivist approach to science, often called mechanistic. It has been argued that nursing science needs a holistic perspective in order to develop its knowledge (Rolfe, 1996).

The traditional scientific paradigm - in the form of hypothetico-deductionism and of inductionism – has been considered unsuitable for the construction of informal micro theory, whereas the nurse practitioner requires informal, personal theory constructed from practice (Rolfe, 1996; Charmaz, 2012). Rolfe (1996) argues for a hypothetico-abductivism as a useful reasoning for nursing and proposes "nursing praxis" as a model of including the processes of reflection-in-action and reflection-on-action.

Table 1 - Multiparadigmatic model of Engebretson (1997)

Positivist ◄——————————————► Metaphysical

Material ▲ ▼ Nonmaterial

Paradigms Modalities	Mechanical	Purification	Balance	Supranormal
Physical / manipulation	Biomedical Surgery	Colonics Cupping	Magnetic healing polarity	Drumming Dancing
Applied and ingestion substances	Pharmacology	Chelation	Humoral medicine	Flower remedies Hallucinogenic plants
Energy	Laser Radiation	Bioenergetics	Tai chi Chi gong Acupuncture Acupressure	Healing touch Laying on of hands
Psychological	Mind-body	Sel-help (confessional type)	Mindfulness	Imagery
Spiritual	Attendance at organized religious functions	Forgiveness Penance	Meditation Chakra balancing	Primal religious Experience prayer

Engebretson's multiparadigmatic model (1997) (Table 1), is called by its author a multiparadigm approach for nursing, in the sense that includes therapeutic modalities that span the spectrum from positivist to metaphysical approaches. The author's position seems to be in accordance with Rolfe in the sense of getting away from the traditional perspective reminding that nursing care corresponds to the human nature that calls for approaches that go from material to non-material therapeutic modalities. "Non-conventional", instead of "alternative" or "complementary", is used in the present article in accordance with the philosophy behind it and its use in some countries' (i.e. Portugal) legislation.

The increasing use of non conventional therapeutic modalities by a great variety of professionals, and the clear acceptance by the population in general, is due of its benefits for its well being (Wardel e Engebretson, 2001; Geller et al, 2004; Haselen, 2004; Smith, et al, 2006; Young et al, 2007).

We have witnessed that some nurses integrate non convectional therapeutic modalities in their daily care practice, based on a rationale and paradigm of practice quite different from the dominant health sciences paradigm of the western part of the world. These modalities include: techniques born in eastern medical and healing systems; traditional western techniques lost through time and technical developments, but with clear therapeutic potential, thus its increasing utilization; and also care modalities that are central in modern nursing, since Florence Nightingale (Watson, 1999/2002; Dorsey et al, 2005), such as those of an environmental nature.

Main characteristics of most of these modalities are: consider the person/client the center of care; consider relationship as therapeutic; consider patient autonomy more important than dependency; emphasize health and not disease (Luz, 2005).

These characteristics have a profound meaning in nursing and are considered some of its basic assumptions – both for the academic discipline and the profession, taking into account the person as a whole (Risjord, 2010; Santos, 2013).

Efficacy of these therapeutic modalities seems to have empiric evidence and to a certain degree scientific evidence (Santos, 2011). Because some weak points persist, there is a need for exploring further, in the area of disease prevention and treatment, balance and promotion of well-being.

Turning public all elements of practice and characterizing them, allows for a systematic evaluation of its therapeutic outcomes, to learn more about the underpinned knowledge, giving them a conceptual coherence, thus legitimating its use both from a professional and disciplinary perspectives.

Characterizing the primary study

The research question was *how do nurses integrate non-conventional therapeutic modalities in the care process?* The study's objectives were: to identify innovative practices (content); to understand its reasoning (conceptual elements) and modes of action (method); as well as strategies used to include them in their practice and outcomes evaluated by nurses and patients.

Method

The primary study was based on an inductive paradigm of science, using grounded theory, following Charmaz's (2006/2008) constructivist perspective. The first part of the study involved 15 nurses practicing in nine public hospitals in Portugal, who volunteered, on a basis of a snowball sample method, and responded to in-depth interviewing. The second part of the study was based on participant observation of a team of 10 nurses' practice and 17 patients, in a pain unit of a cancer hospital in Portugal. Theoretical sampling was used. The data was collected and analyzed by grounded theory's constant comparative method.

Results

The main findings of the primary study were: identification of new non-conventional therapeutic modalities, as well as the ways in which they are used by nurses and the expansion of Engebretson's multiparadigmatic model.

A great diversity of non-conventional therapeutic modalities was identified as being used regularly by hospital nurses. The modalities (Table 2) were classified according to the nature of the therapeutic principles they correspond to, adapted from the National Center for Complementary/Alternative Medicines, the North-American organization that monitors these therapeutic modalities' practice and research (Snyder & Lindquist, 2006): environmental, manipulative, mental-cognitive, energetic and relationship modalities.

It is worth mentioning that the participants perceived the therapeutic value of these modalities in a variety of settings, but they mention there are differences: from recognition of an intrinsic value of the different therapeutic modalities that they perform, to being considered a mediator to the utilization of specific therapeutic modalities, according to the possibilities allowed by the environment.

The primary study helped to systematize some outcome indicators of non-conventional therapeutic modalities (Table 4) from the nurses and researcher's perspective and also from the patients' perspective. There is a strong coherence among them, mainly in the indicators of well being where the nurse's observation overlapped the patient's verbalization, which validated previous findings, namely decreased preoperative anxiety (Bunyuns, et al, 2002) and relaxation and stress reduction (Wardel e Engebretson, 2001; Hanley et al, 2003).

The nurses emphasized two important reasons for using these modalities: enriching the content of the nursing discipline and enlarging the scope of their practice.

Non-conventional therapeutic modalities are seen as enlarging the discipline with knowledge that integrates easily the nursing core conceptual rationale and is a contribution to its development.

The nurses consistently state the coherence between these modalities and the philosophy of nursing as facilitating factor of their practice. The majority of the study participants calls for the holistic approach as the rationale and the legitimization to *act in a different way*, meaning that while not negating the biological dimension of the person and the "classic" nursing interventions, bringing in other instruments that correspond to their global vision of the person. As suggested by Hall (2005), great part of our knowledge to practice is larger than the cure of disease: it includes the person's emotional, physical, and spiritual health, in a way that might or might not include a disease.

Whatever helps the patients was felt as a challenge for the participants that try to respond to the patients' health needs efficiently. Non-conventional therapeutic modalities allow nurses to give a more global response to patients needs.

Table 2 – Therapeutic modalities encountered in the field of research

Classificatory group	Modalities
Environmental procedures	The use of music and aromas, the luminosity and temperature, the use of color.
Manipulative procedures	Massage (various types): massage therapy, reflexology, shiatsu and lymphatic drainage.
Mental-Cognitive methods	Hypnotherapy, pain distraction techniques (guided imagery), the use of humor; various relaxation techniques (guided by voice, yoga); prayer, guided reading.
Arrangements Energy	Reiki, "therapeutic touch", acupressure.
Arrangements Relationship	Intentional use of silence and conversation, tone of voice, the *warmth*.

Adapted from: NCCAM – National Center for Complementary/Alternative Medicines or Modalities, Snyder e Lindquist, 2006.

Table 3 – Multiparadigmatic expanded model (2012/13)

Positivist ⟷ Metaphysical

Material ↕ Nonmaterial

Paradigms / Modalities	Mechanical	Purification	Balance	Supranormal
Physical / manipulation	Biomedical Surgery	Colonics Cupping	Promotion of exercise exercício; ***Therapeutic massage***	Intuitive bodily work
Applied and ingestion substances	Pharmacology	Chelation	Nutritional counseling	Homeopathic medicines
Energy	Laser Radiation	Phototherapy	Acupressure; Acupuncture	Therapeutic touch; ***Reiki***
Psychological	Mind-body; ***Relaxation techniques***	Active listening; ***Tone of voice; Use of humor.***	Counseling; ***Intentional use of silence and conversation***	Guided visualization; ***Hypnotherapy***
Spiritual	Attendance at organized religious functions	Forgiveness; Purification rituals	Meditation	*Spiritual support;* ***Prayer***
Environmental	***Comfort temperature***	***Use of scents***	***Use of color and light***	***Use of music; Aesthetics of the environment***

Table 4 – Indicators for assessing therapeutic modalities studied

Physiological	Behavioral	Wellness
The perspective of the nurse / researcher		
Vital signs; skin color and lip mucosa; muscle tone; state of mind; body posture; alertness; *body architecture.*	Degree of agility, altered voice; bodily movements (quiet / restlessness); speak of the "turn"; keep silent.	Physiognomy of the labial commissures; gloss and eye closure; alertness; serenity; smile.
The perspective of the user / patient		
Normalization of biological functions: quality of appetite; sleep quality; bowel functioning; physical strength. Level of pain.	Decrease in intake of analgesia in SOS; ability to manage everyday life.	Management of pain and emotions (*umbrella effect*); relief; sense of feeling good; feeling at peace; release of tension and anxiety; feeling of lightness; energy level; courage; improving mood ; increased stress tolerance; will to live; trust; "out of themselves".

The study's findings led to suggest the expansion of Engebretson's multi paradigmatic model (1997) (Table1), adding to the original 13 therapeutic modalities in four categories and proposing a new category: "Environmental" that encompasses five therapeutic modalities (Table 3). The original author showed her appreciation in the following way: *"… I see (…) that you are focusing on nursing. So this is a wonderful addition to the literature regarding how the model is specifically relevant to nursing. I really like the inclusion of environmental actions. As your study was on nursing, yes add that line as I think nurses do this and often may be more conscious of the environment that other clinicians or even other healers. It is a very important issue in healing and for nursing (...)". (Joan Engebretson, July 24, 2011, by mail).*

The secondary study

Once the primary study was completed and published (Santos, 2013) new questions were raised that led to a secondary research approach, an "analytic expansion" described by Thorn (2013, p.397) as a *"study in which a researcher makes further use of a primary data set in order to ask new or emerging questions that derive from having conducted the original analysis but were not envisioned within the original scope of the primary aims (Heaton, 2004)."*

The questions that guided the present analysis were:

What conception guides nursing practice when using non-conventional therapeutic modalities?

What is the place of holistic nursing in nursing's theoretical development?

Based on discussions between the authors and further readings, the reflexion was organized in four dimensions: evidence of the utilization by nurses of non-conventional therapeutic modalities; holistic care is nursing's choice; a multi paradigmatic model for a holistic nursing; the place of holism in health and nursing paradigms.

Outcomes of the secondary analysis

Evidence of the utilization by nurses of non-conventional therapeutic modalities

The identification of therapeutic modalities that, though known by many, had not been, until now, added to Engebretson's model: therapeutic massage; reiki; relaxation techniques; tone of voice; use of humor; intentional use of silence and conversation; hypnotherapy; spiritual support and prayer; comfort temperature; use of scents; use of color and light; use of music and aesthetics of the environment - adds to the meaning of nursing care, specifically as therapeutic instruments used by nurses. A systematic review

of the literature looking for evidence of therapeutic instruments used by nurses (Lima-Basto, M. et al, 2010), showed there is scientific evidence of the usage of several modalities - i.e. humor and non-conventional therapies such as music, mindfulness, massage - and added that the nurse herself is a therapeutic instrument. The holistic approach of the person by nurses makes necessary the use of therapeutic instruments, as part of professional interventions, plural in their diversity, coming from different paradigms of knowledge.

Positive and generally consistent outcomes of non-conventional therapeutic modalities have been evaluated by Snyder and Lindquist (2006), but there is a need for further reliable research. The less developed knowledge on non conventional modalities is their therapeutic outcomes. The primary study supports this position.

Several authors question the validity, relevance and clinical importance of randomized controlled trials (RCT) to measure outcomes of interventions based on a therapeutic relationship, as is the case of most of non conventional therapeutic modalities (Walter& Sofaer, 2003). They state that qualitative research methods are appropriate when seeking comprehension, meaning, feelings, beliefs and expectations, among others. This option does not mean less rigor, on the contrary, the adequacy of the method to the research questions and the epistemological and ontological congruence are a guarantee of those criteria, avoiding the biases that come with an inappropriate method (Waker & Sofaer, 2003).

The variety of nursing classification systems, such as NANDA's diagnosis (1982), Nursing Interventions Classification (1992) and Nursing Outcomes Classification (1997), as pointed out by Cruz (2007), all of them in their early development stages, might also be a factor related to the less developed knowledge on non-conventional therapeutic modalities´ outcomes, though in accordance with nursing science and the profession's stage of development (Dossey et al, 2005; Cruz, 2007; Sousa et al, 2008; Lima, 2009).

Holistic care is nursing's choice

The primary study showed that nurses, even when working in health environments where the dominant paradigm is a deductive/positivist approach to care, will find ways to utilize non-conventional therapeutic modalities that are in accordance with their beliefs about holistic care.

The number and variety of non-conventional modalities identified in the primary study expresses the connection between paradigms and care modalities. This connection confirms the holistic perspective of nursing, allowing an interwoven of therapeutic modalities originally from different paradigms that potentiate the development of clinical practice.

From the different concepts of holism, the following are the main ideas, common to semantic variations of respected authors' positions (Brennan,1993; Kim, 1999; Watson, 1999/2002; Morin, 2008): the idea of the whole and its parts in mutual interaction; the essential character of the whole, different from the sum of various parts that constitutes it; the nature of the parts, determined by the whole, that gives them an ontological meaning; the whole, as an emergent entity, evolves continually into a process of increasing diversity and complexity; the whole is in a constant interaction with its environment.

Nevertheless, holistic care requires more than just a synthesis of different domains of knowledge. It requires that, from those domains, the nurse achieves a transformative synthesis resulting in a *whole person*, different and larger than the sum of its parts. As Watson (1999) states, the holistic perspective in nursing has yet to be totally understood and put into practice.

Over the years nursing has integrated practices born in other areas, mainly from medicine (Watson, 2002) and, at the same time, has left for other emerging professional groups some of its activities. The increasing number of professional areas (Dubar, 1997; Rodrigues, 1997) has risen the question of inter professional boundaries.

A multi paradigmatic model for a holistic nursing

The primary study findings led to propose an expanded version of the original Engebretson's multi paradigmatic model. It constitutes a position within the disciplinary movement searching for itself, its identity, stating that non-conventional therapeutic modalities are a resource for nursing' self definition and self affirmation.

Accepting as a generic concept of "model" – a way of describing what is done and what can be

done - (Adam, 1994; Lima-Basto, 2009) – we believe that a complex phenomenon, such as health-disease process, is better represented as a complex model. Considering it is nursing's intention to care for sick persons, persons with potential health problems or going through situational or developmental transitions (Meleis, 2010), a guiding model of practice, reflecting the various levels of complexity involved, is needed. This epistemological position clarifies and legitimizes several possible choices, based on the singularity of each caring situation. Several well-known nursing scholars such as Rolfe (1996) have argued for models of nursing praxis, that include deductive and inductive thinking, which is another way of saying that nursing practice is guided by both paradigms. Engebretson overcomes the traditional dichotomy proposing two types of orientation guiding nursing interventions: from positivist to metaphysical and from material to non material.

The emergence of new caring professions and the growing value of multidisciplinary endeavors, intensifies the need to clarify the specific contribution of each caring profession, its theoretical representation, in order to organize and guide each discourse and practice.

The place of holism in health and nursing paradigms

In modern history of the health-disease phenomenon there are three scientific eras/periods in the health sciences field, each one characterized by a model (Table 5) – specific perspective and praxis, with the corresponding nursing paradigms (Reed & Ground, 1997; Reis, 1998b; Dossey, 1991, cited by Watson, 2002):

- ERA I (1860-1950, still influential): mechanistic paradigm (biomedical model), characterized by a physical and mechanistic medicine. Emphasis is given to the body and disease as an objective entity, giving preference for chemical medication and surgery. In nursing, emphasis was on functional tasks, and *doing*, centered in the role of the caring professional.

- ERA II (since 1951; continues to develop): Interactive-integrated paradigm (biopsychosocial model), recognizing the importance of perceptions, feelings and emotions in health, a body-mind medicine, in the sense of brain-body. In nursing, the value of the person as the centre of care emerges, with the subsequent attendance to its psychosocial and emotional needs. Roper, Logan and Tierney's model (1995) based on a model of life that identifies living activities in which the nurse can intervene, is an example.

- ERA III (since 1970, starting to be recognized): Unitary-transforming paradigm (Multiparadigmatic model), along with quantum physics development and the concept of unlimited human consciousness, in time and space. It corresponds in nursing to the post-modern paradigm, open to new concepts such as energy, consciousness, intentionality, and transpersonal caring-curing (Watson, 2002).

Discussion

Wisdom and knowledge develops in cycles and it is interesting to note that some of the "new" concepts have been found in societies that existed millions of years ago, making these "new" concepts more powerful. An example is man's seven dimensions construction, proposing seven types of manifestation of human nature. It was developed in Ancient Egypt and India, with a strong influence of Hinduism and certain schools of Buddhism that continue to be studied today. Using our present language, human nature is presented as a triangle (man's spirituality) linked to a square below (mortal part of human nature). The triangle contains – upwards – three levels: man's intuition/pure mind, understanding/enlightenment, and man's will. The square contains – upwards – the physical body (organs), the vital body (energy), the astral body (emotions) and the mental body (concrete rationality and desires). These levels are simultaneously ways of manifesting and of receiving (Blavatsky, 1982. p.153-158).

Within the health sciences, in this post-modern era, nursing is developing a leading movement, not only at the praxis level, such as therapeutic touch (Krieger, 1970), but also with philosophies and grand theories (Tomey & Alligood, 2004) emerging, such as Philosophy and Science of Human Caring formulated by Jean Watson (1979/1985/1999/2002), Parse's (1998) Human Becoming Theory and Martha Rogers' Theory of Unitary Human Being (1970/1992).

Remembering Nightingale's spiritual tradition, the nursing paradigm of Era III unites pre-modern with post-modern, moving towards new concepts and an ontological change (Watson, 1999/2002).

Table 5 – Characterization of the main models of health and illness

Model **Dimensions**	**Biomedical** (mechanistic paradigm – Era I)	**Biopsychosocial** (Interactive-integrated paradigm – Era II)		**Multiparadigmatic** (Unitary-transforming paradigm –Era III)
		Interactionist	**Dialectic**	
Conception	Reductionist: the primacy of physical / biological	Multidimensional; Hierarchical	Multidimensional; Integrated	Holistic
Production of knowledge / investigation	Quantitative methods; objective data	Quantitative and qualitative methods	Quantitative and qualitative methods	Triangulation of methods; valorization of subjectivity; phenomenological approach
Interdisciplina-ry relationship	Authoritarian: medical power	Vertical: doctor is epistemological authority	Horizontal: power of team decentralized; contingencial	Horizontal: ontological development of skills
Epistemologi-cal and ontological status of the person	Mechanistic: the body as a machine	Dualistic: body-object, property Physician	Dialectic: body-object and subjective body	Transpersonal body, lived body, spirit embodied
Conceptual-emotional autonomy	Not recognized: medical knowledge	Neglected: promoting passive role in patient	Prized: promoting patient autonomy	Prized: Caregiver and receiver are co-participants in the process
Professional-pacient relationship	Medical decision	Based on the epistemic authority of the therapist	Epistemological partnership	Relationship of intersubjectivity. Intentional and conscious Meeting
Didactic of health and disease	Normativity of medical knowledge	Patient processes and reproduces information transmitted to it	Promotion of reflection and autonomous construction of meanings	Philosophy of human freedom, choice and responsibility

Within the profession and the discipline of nursing, some values, concepts, wisdom, knowledge and practices from various paradigms co-exist. Developing at different paces, questioning the *status quo*, showing new paths, updating old therapeutic modalities, and attributing them new meaning, nursing expands its theoretical space and makes use of corresponding practices, in response to new concepts of health and well being and identified care-cure needs. Nursing finds, in this context, its historical responsibility of caring (Bittes-Júnior, 2003).

Science in general and health sciences in particular continue to change. Engebretson proposes a multi paradigmatic model, bringing together classic with post modern paradigms of care. Within this theoretical context and based on scientific evidence and reflection, the authors suggest that non-conventional therapeutic modalities are a feature of self-definition and self affirmation of nursing. Simultaneously this model offers a range of therapeutic instruments that allow responding to human complexity of the nursing client. The expanded model (Santos, 2013) offers more opportunities of integrating newly identified modalities.

Nurses who value holistic care, use non-conventional therapeutic instruments that mediate their caring relationship with patients, even when the environment is not friendly. This probably shows how holistic care characterizes nursing even if nurses do not always act accordingly, having difficulty in verbalizing their beliefs. The traditional logic used in health care does not help the theoretical development of nursing. Does holistic care synthesize the influence of paradigms considered opposing each other until now? As stated by Risjord (2010), non-conventional therapeutic modalities, bringing a new look to the theory, knowledge and values of nursing, can contribute to its development.

Certain concepts and values used for a long time with different names and not being visible might have a similar meaning, but different weight in different periods of time. Holistic care characterizes post-modern nursing in accordance with western society's development, illuminating concepts, values and innovative therapeutic practices in nursing, that help clarify its position in the academic world as well as improving care.

Conclusion

With this article we introduced evolutionary movement of a nursing model - the multiparadigmatic model, formulated by Engebretson in 1997 and expanded in 2013 by Santos, fitting the paradigm shift in the sciences in general and nursing. The investigation which led to the expansion of the model was developed in some hospitals in Portugal, verifying a membership of nurses' unconventional practices by recognizing the therapeutic effects of the same, which is corroborated by patients.

The congruence of this practice with the philosophy of nursing is another strong reason for this membership, based mainly on the holistic principle widely stated in the disciplinary literature and assumed by the participants.

Multi paradigmatic models were confronted with the models developed in the health sciences, in modern style, highlighting the leading role of nursing in openness to new scientific paradigms. We closed the cycle, identifying the date of the pre-modern knowledge with the post-modern; a movement that, from Nightingale, expands and diversifies, allowing nurses to provide holistic care, translating into practice what they have long been complaining in discourse.

We believe this reflection is a contribution for the clarification of nursing's identity. Further research is needed to confirm the influence of non-conventional therapeutic modalities used by nurses in strengthen nursing practice and the fit between practice and guiding conceptual models / theories.

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