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ERICKSONIAN HYPNOTHERAPEUTIC APPROACHES IN CHRONIC CARE SUPPORT GROUPS: A ROGERIAN EXPLORATION OF POWER AND SELF DEFINED HEALTH PROMOTING GOALS

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TABLE OF CONTENTS

continued

continued

LIST OF TABLES

continued

LIST OF FIGURES

CHAPTER I

THE PROBLEM

Introduction

An estimated fifty percent of North Americans will experience chronic health problems during their lifetimes (Lyons, Sullivan & Ritvo, 1995). People are living longer and their lives are challenged and complicated by the changes associated with chronic disabling health problems (Coyne & Fiske, 1995). Chronic health related conditions such as arthritis, diabetes, cancer, respiratory and cardiac diseases have been theoretically linked in the literature with pattern manifestations such as powerlessness (Iocalano, 1994; Lindsey, 1997; Miller, 1992), helplessness and hopelessness (Gregg, Robertus & Stone, 1989), depression and anxiety (Gregg, Robertus & Stone, 1989; Meyerowitz, Heinrich & Schag, 1983; Telch & Telch, 1986) pain and declining health (Kabat-Zinn, 1990; National Institute of Health, 1995; Peper & Holt, 1993). Interventions reported to help promote health and relieve patients' suffering include support groups (Antoni, 1997; Bauman, Gervey & Siegel, 1992; Goldfarb, Brotherson, Summers & Turnbull, 1986; I. Fawzy, N. Fawzy, Hyun, & Wheeler, 1997; Lyons et al., 1995; Miller, 1998; Nicholas, 1984; Spira, 1997a; Telch & Telch, 1986; Yalom, 1995) and hypnotherapeutic approaches (Ewin, 1978; National Institute of Health, 1995; Rosen, 1985; Spiegal, 1993; Zahourek & Larkin, 1995). Ericksonian hypnotherapy is a non-invasive modality of health patterning that can be provided

in support groups, which may potentiate health for persons experiencing chronic health related conditions.

The purpose of nursing, according to Rogers (1990), is to promote health and well-being for all persons. Nursing in the twenty-first century will be promoting health by emphasizing noninvasive modalities (Rogers, 1994). Promoting health in Rogerian science has been described as "a process of actualizing potentials for well-being by knowing participation in change" (Barrett, 1990a, p. 33). Eliciting active participation in change to promote health and well-being is implicit in Ericksonian hypnotherapy.

Power in Rogerian science is knowing participation in change (Barrett, 1987). Power implies awareness, choices, freedom to act intentionally and involvement in creating change in one's life. Intention to enact a health promoting choice involves establishing goals. In the Rogerian framework, actualizing desired choices and potentials should be decided by clients (Barrett, 1990a) and health patterning goals should be self defined (Matas, 1997a). Eliciting active participation of the client in actualizing health promoting goals is patterning inherent in Ericksonian hypnosis. Ericksonian hypnotherapy involves learning strategies of focusing awareness on desired healthful evolution while striving to promote growing awareness, exploration of choices and actualization of potentials. As persons with chronic illness are frequently confronted with limitations and reduction of choices, enhancing power and actualizing self defined health promoting goals are warranted foci of nursing.

. The purpose of this study was to examine changes in power and self defined health promoting goals for persons with chronic conditions who

participate in an Ericksonian hypnotherapeutic support group as compared to those who participate in a support group which does not provide Ericksonian hypnotherapeutic approaches.

General Research Question

What are the changes in power and self defined health promoting goals for chronic care patients who do and do not participate in an Ericksonian hypnotherapeutic support group?

Specific Research Questions

Does power vary differently over time for chronic care patients who do and do not participate in an Ericksonian hypnotherapeutic support group?

Do self defined health promoting goals vary differently over time for chronic care patients who do and do not participate in an Ericksonian hypnotherapeutic support group?

Definitions

A chronic health condition signifies "a long term [health related] condition encompassing a course that may be stable, unpredictable or progressive" (Lyons et al., 1995, p. 5). Long term is defined as six months or greater in duration. Chronic care patients are persons who have been diagnosed with a health related condition (such as arthritis, chronic respiratory conditions, cardiac conditions, cancer, diabetes and irritable bowel syndrome) that is projected to continue and/or progress throughout the life span (Lyons et al., 1995).

Comparison support group is a group in which a facilitator utilizes verbal support encouraging the expression of feelings and personal stories of living with chronic illness. The comparison group met for five weekly 1.5 hour sessions in groups of persons with chronic conditions such as arthritis, chronic respiratory conditions, cardiac conditions, cancer, diabetes and irritable bowel syndrome. Audiotaped sessions of the comparison groups were reviewed by members of The New York Milton H. Erickson Society of Psychotherapy and Hypnosis to confirm that Ericksonian hypnotherapeutic approaches were not used in these groups.

Ericksonian hypnotherapeutic support group is a group in which a facilitator uses pacing, leading, direct and indirect therapeutic suggestions, therapeutic storytelling and metaphors, reframing, education in progressive relaxation and imagery and support by encouraging the expression of feelings and personal stories of living with chronic illness. Erickson's principles of hypnotherapy were provided for five weekly 1.5 hour sessions in groups of persons with chronic conditions such as arthritis, chronic respiratory conditions, cardiac conditions, cancer, diabetes and irritable bowel syndrome. Audiotaped sessions of groups were reviewed by members of The New York Milton H. Erickson Society of Psychotherapy and Hypnosis to confirm the use of Ericksonian principles.

Power is the "capacity to participate knowingly in the nature of change characterizing continuous patterning of the human and environmental fields. Power is being aware of what one is choosing to do, feeling free to do it, and doing it intentionally" (Barrett, 1986, p. 174). Power was measured by the Power as Knowing Participation in Change Tool (PKPCT), Version II (Barrett, 1998).

Self defined health promoting goals are client formulated goals focused on health promoting and individually desired change (Matas, 1996). Self defined health promoting goals (SDHPG) were measured by the SDHPG visual analogue scale developed by Matas (1996).

Delimitations

Participants were at least 18 years of age and had a minimum of a high school education, which is required for completion of the PKPCT (Barrett, 1987). Groups were conducted in English; therefore, participants had to be able to understand and communicate in English. Persons on psychotropic medications with serious cognitive and/or psychopathological disorders such as schizophrenia, delusional paranoid disorders and dementias which may inhibit individuals' participation in group process were delimited from the study (J. Kabat-Zinn, personal communication, December 3, 1996).

Theoretical Rationale

Rogers' Science of Unitary Human Beings (SUHB) provides the theoretical framework for this study. Rogers (1970) described human existence as a "unified phenomenon" (p. 41) with unitary human beings viewed as irreducible wholes (Rogers, 1992). Studying the whole is advocated in Rogerian science as individuals are irreducible energy fields, different from the sum of their parts and integral with their respective environmental fields (Rogers, 1992). Continuous change is the unifying concept for nursing practice within the Rogerian

framework, and a nurse's intent is to facilitate change, which promotes health as defined by each client.

The fundamental postulates within the SUHB include energy fields, pattern, openness and pandimensionality (Rogers, 1992). Energy fields are described as unifying concepts that are infinite, pandimensional, dynamic in nature, continuously open and identified by pattern. Pattern is the distinguishing characteristic which identifies the field and continuously changes. Although pattern is not directly observable, manifestations of field patterns, such as symptoms related to chronic illness, can be perceived. Within the Rogerian perspective, the universe is viewed as open systems, and each human field is recognized as unique and integral with its own unique environmental field (Rogers, 1992). Pandimensionality characterizes human and environmental fields; it is a way of perceiving reality as an "infinite domain without limit" which "expresses the idea of a unitary whole" (Rogers, 1992, p. 31). Pandimensional awareness of infinite potentials is also inclusive within the process of facilitating therapeutic change with Ericksonian hypnotherapy. Phillips (1991) emphasized human field research involving imagery and meditation can help people participate knowingly "to deliberately pattern their fields to actualize their potentials" (p. 143) and "concentrate on creating desired change" (Phillips, 1990a, p. 55). Facilitating therapeutic change in accord with clients' preferences and health promoting goals is a primary intention of Ericksonian hypnotherapy (Otani, 1990).

The dynamic nature of change is depicted in Rogers' (1992) three principles of homeodynamics. These principles include resonancy, which

describes change as continuous in human and environmental fields and progressing from lower to higher frequency wave patterns; helicy depicts change as continuous, innovative, unpredictable and increasing diversity in human and environmental field patterns; and integrality acknowledges that change in human and environmental fields is in continuous mutual process (Rogers, 1992).

Rogers' principles of homeodynamics similarly postulate the nature of change in a group field (Rogers, 1990). A group field, comprised of two or more individuals, is viewed as irreducible and a unitive whole, different from the sum of the parts and integral with its own environmental field. Within the group field, noninvasive modalities may be provided to facilitate change.

Sargent (1994) utilized the SUHB to describe a healing group of persons with AIDS in which participants were taught relaxation and imagery. Sargent noted that power was enhanced as group members participated knowingly in change and actualized their well-being potential. A group field designed to teach Ericksonian hypnotherapy with a group of persons with chronic illness may similarly augment knowing participation in change and health potentials as it strives to facilitate change by acknowledging one's experience and opening up awareness of choices and therapeutic possibilities for actualizing desired health promoting goals.

Yalom (1995) describes a therapeutic group as a direct agent for facilitating change. Spira (1997b) emphasizes how support groups for the medically ill can facilitate change existentially, by helping participants live life well and fully. Nicholas (1984) emphasized that therapeutic change occurs in a group when participants experience growing awareness and "obtain a new outlook

or new perspective on a problem or situation" (p. 9). Rogers (1992) described the experience of growing awareness and discovery of new perspectives within the SUHB as analogous to the story of Flatland (Abbott, 1952). This classic fictional tale metaphorically depicts limited awareness in a land of two-dimensional geometric shapes. In this story, an educator 'square' discovered and attempted to teach others expanded awareness of three-dimensionality. The square described his expanded awareness in his memoirs, and concluded with the hope that his work "may stir up a race of rebels who shall refuse to be confined to limited Dimensionality" (p. 102). Rogers similarly refused to be confined to awareness of limited dimensionality. Her pandimensionality implies awareness that is unitive and transcends to experience the whole; it is awareness that "everything in the universe is nonlinear and infinite" (Phillips, 1994, p. 15). Ericksonian hypnotherapy strives to facilitate therapeutic change and actualization of desired goals through growing awareness and discovery of new perspectives and potentials (Erickson, Rossi & Ryan, 1985; Gilligan, 1987; Rosen, 1982; Yapko, 1990).

Rogers (1970) postulated in the SUHB that the nature of change progresses emergently with patterns of increasing diversity. "Change begets change... and change in one part creates change in the whole" (p. 51). Persons with chronic conditions experience abundant change; however, much of this change is depicted in the literature as limiting, problematic and counter to well-being (Goldfarb et al., 1986).

Voluntary mutual patterning is when the nurse uses unitary field practice modalities to facilitate well-being and knowing participation in change (Barrett,

1998b). Ericksonian hypnotherapy is voluntary mutual patterning as a modality which promotes well-being and expands self-awareness and mastery (Walters & Havens, 1993). Each individual changes and increases awareness in a manner that is most appropriate for him or her, as Ericksonian inductions "point in the general direction, but...leave the specifics up to the individual" (Walters & Havens, 1993, p. 57). Erickson emphasized that clinicians should evaluate and utilize a patient's uniqueness together with the exigencies of his or her ever-changing life experience to achieve satisfying therapeutic change (Erickson, Rossi & Rossi, 1976). Erickson described how promoting therapeutic change can evoke a snowballing phenomenon, in which small changes can lead "to other more significant changes in accord with the patient's potentials" (cited in Watzlawick, Weakland & Fisch, 1974, p. ix). Rogers (1990) similarly emphasized the uniqueness of each human-environmental field and each group field, hence therapeutic change strategies to facilitate goal actualization and power need to be shaped to the uniqueness of each field.

Barrett (1983) derived her theory of power from Rogers' science of unitary human beings. Power is described as "being aware of what one is choosing to do, feeling free to do it, and doing it intentionally" (Barrett, Caroselli, Smith & Smith, 1997, p. 32). This capacity to participate knowingly in the nature of change characterizes the continuous patterning of human and environmental fields (Barrett, 1986). Barrett (1992) relates power to health by helping clients augment awareness, choices, freedom to act intentionally and involvement in creating change. Health patterning in the SUHB is the process in which clients are assisted in enhancing power as knowing participation in change (Barrett,

1990a). Matas (1996) suggests such noninvasive health promoting modalities of hypnosis, imagery, meditation and therapeutic touch may enhance Barrettian power and facilitate actualization of self defined goals as individuals deepen awareness of their unitary nature.

Power enhancement implies how humans actualize some health potentials for change rather than others (Barrett, 1990a). Goals and priorities for health promoting change should be "decided by the client" (Barrett, 1990a, p. 38). The importance of patients creating their own self defined health promoting goals was similarly emphasized by Matas (1996) at her Centering Clinic of Arizona State University. Matas described self defined health promoting goals as conceptually congruent with Rogers' SUHB, as the emphasis is on supporting each client's unique potentialities.

Pender (1996) stated a primary function of support groups is to promote achievement of clients' health goals. The American Nurses Association (1995) noted that nursing practice is to promote patterns that facilitate healthy living and "support self-defined goals of individuals, families, and communities" (p. 11). An Ericksonian hypnotherapeutic group is one possible way to achieve this.

As the prevalence of chronic conditions increases, provision of voluntary mutual health patterning to facilitate clients' knowing participation in change and actualize self defined health promoting health goals warrants investigation. This study examined the unitary field modality of Ericksonian group hypnotherapy for actualizing power and self defined health promoting goals for persons experiencing chronic illness who agree to participate in a support group which integrates Ericksonian hypnotherapeutic approaches as compared to persons who

participate in a support group which does not integrate Ericksonian hypnotherapeutic approaches.

Need for the Study

Since 1968, there has been "a steady reduction of deaths due to a wide variety of infectious diseases ... however, the extension of life produced by medical advances has been accompanied by an increase in the number of persons that require long-term, expensive care" (Burish & Bradley, 1983, p. xvii). Lyons et al. (1995) estimated one-half of North Americans will develop chronic health problems during their lifetimes.

A diagnosis of a chronic illness is viewed as a crisis which can provoke stress, anxiety and depression (Burish & Bradley, 1983; Lindsey, 1997; Telch & Telch, 1986) and feelings of helplessness and powerlessness (Iocolano, 1994). Chronic health conditions have a progressive changing nature (Gregg et al., 1989) marked by unpredictability in symptom development and prognosis (Lyons et al., 1995). Living with chronic illness, people do not merely face one crisis at diagnosis, but more likely must contend with many crises throughout the course of the illness (Gregg et al., 1989). Implicit in the basic trajectories of chronic illness is that "little control can be exercised" (Lyons et al., 1995, p. 109); one must learn how to live with unpredictable change. More research is needed to enhance knowledge of how health care practitioners can better help persons diagnosed with a chronic disease live well with unpredictable change.

Helping persons with chronic illness achieve personal health goals can reduce feelings of powerlessness (Stapleton, 1992). Matas (1996) recommends

future research should explore how self defined health promoting goals and power may be augmented with non-invasive health patterning modalities. Wall (2000) emphasizes nurses need to explore noninvasive strategies to facilitate individuals' well-being. Lyons et al. (1995) report support groups can play a major role in helping people live with chronic health conditions. Support groups that intend to assist patients with chronic conditions are typically available through such organizations as the American Cancer Society, American Heart Association, hospitals and private organizations. There is, however, a paucity of research that adequately explores therapeutic strategies that can be employed in groups to help people with chronic disease augment power and actualize self defined health promoting goals. Stuifbergen and Becker (1994) emphasize that persons with chronic conditions are too rarely included in research and intervention programs that focus on health promotion, and suggest educational programs that promote health for persons with chronic illness be a priority in the health care professions. Dreher (1997) posits an urgent scientific and moral imperative for research to focus on teaching people with chronic illness health promoting strategies in groups.

The body of literature on hypnotherapeutic approaches for helping persons with chronic illnesses is primarily anecdotal, with strong recommendations for further research. Arroz (1979) claims providing hypnosis in groups is a valuable and cost effective approach that can teach patients strategies that can ease distress, resolve problems and promote comfort. Hypnosis is described as helpful in facilitating health and easing symptoms associated with chronic illness such as pain, fatigue, depression, helplessness, hopelessness and powerlessness (Ewin,

1978; Hall, 1982; Hilgard & LeBaron, 1984; Hoffman, 1982; LaBaw & LaBaw, 1990; Olness, 1993; Rosenberg, 1982; Spiegel, 1993; Zahourek & Larkin, 1995). Spira (1997a) reports hypnosis in groups can help medically ill patients increase comfort, reduce distress and facilitate resolutions of problems. Levy (1984) reviewed studies on the psychoneuroimmunological implications of emotions and cancer progression and emphasized helplessness and poor coping are associated with lower survival rates from cancer. Hypnosis is a health promoting modality that can counter the experience of helplessness and enhance patient's active participation in care (Zahourek & Larkin, 1995). Barrett's power as knowing participation in change may be enhanced as persons with chronic illness learn hypnosis for health promotion in groups.

The unitary field modality of Ericksonian group hypnotherapy as a means of actualizing power and self defined health promoting goals for persons diagnosed with chronic conditions warrants examination. No study to date has examined from a Science of Unitary Human Beings perspective the process of integrating Ericksonian hypnotherapeutic approaches in support groups of persons with chronic illness and its potential to augment power and self defined health promoting goals.

CHAPTER II

REVIEW OF RELATED LITERATURE

Ericksonian Hypnotherapy and Rogerian Science

Rogers' SUHB provides the ground for and context for perceiving Ericksonian hypnotherapy. Ericksonian hypnotherapy is derived from the principles and patterns of communication and hypnosis of Milton Erickson (1901-1980). Described as "the world's leading medical hypnotherapist" (Haley, 1986, p. 18), Erickson's approaches are hypnotherapeutic communication strategies individually tailored and based on "the knowledge, observation and utilization of the client's unique patterns" (Zahourek & Larkin, 1995, p. 43). Implicit in Ericksonian hypnotherapy is accepting and utilizing a client's unique patterns and frames of reference and then therapeutically guiding that client to explore and evoke patterns and perceptions that are experienced as more healthful and life affirming. Rogers (1990) similarly emphasized the importance of nurses accepting people as they are while helping them achieve their own potentials.

Erickson described hypnosis as awareness, which is characterized by increased receptiveness to ideas (Erickson, Rossi & Ryan, 1985). The experience of hypnosis, according to Erickson, is a process in which learning and openness to change are likely to occur (Rosen, 1982). Lankton and Lankton (1986) wrote of Erickson's hypnotherapy that his therapeutic intention was to help people achieve

enjoyment in "living and changing" (p. 78). Hypnotic inductions are intended to stimulate meaningful changes in persons' realities while facilitating human potentials (Gilligan, 1987). Ericksonian hypnotherapy suggestively provides a multitude of therapeutic choices while encouraging actualization of meaningful therapeutic change as desired by each unique individual. This is congruent with Rogers' (1970) emphasis in the SUHB that humans have the capacity to knowingly exercise choices in fulfilling desired potentials.

In the Rogerian framework, the purpose of nursing is to promote health and well-being (Rogers, 1992). Ericksonian hypnosis is described as facilitating esteem and tranquility, as Erickson thrust patients into positive, life enhancing experiences, emphasizing eudaimonistically "the existing skills and abilities of his patients, not their disabilities" (Walters & Havens, 1993, p. 5). Phillips (1990b) similarly describes the eudaimonistic model of health within the SUHB as optimistic, as it is concerned with augmenting therapeutic change by also focusing on individuals' resources and strengths. Eudaimonistic health is viewed as the most comprehensive view of health, encompassing well-being, self-realization and actualizing potentials (Smith, 1981). This view of health transcends the limited perspective that health merely implies freedom from illness.

Transcending limiting views, like emerging from Flatland (Abbott, 1952), is illustrative of pandimensionality as a principle of homeodynamic change. Pandimensionality in Rogerian science is a nonlinear awareness that transcends three-dimensional reality (Phillips, 1991). Ericksonian hypnotherapy similarly strives to promote a more comprehensive point of view by widening the frame to expand awareness, discover possibilities and help free individuals from limiting

perspectives (Erickson & Rossi, 1989). Moch (1989, 1998), in her "health within illness" eudaimonistic perspective, suggests an experience of illness can accelerate personal growth and potentials through increased awareness and transformational change. Ericksonian hypnotherapy similarly helps do this. As persons with chronic illness frequently anticipate change as limiting and indicative of illness progression, nurses who practice within a Rogerian framework can help transform this perspective to be inclusive of power, strengths and awareness of potentialities that facilitate patients' healthful evolution and actualization of desired goals. One way nurses can do this is by teaching patients Ericksonian hypnotherapy.

Malinski (1986) proposes that in Rogers' science nurses strive to facilitate "the total openness of experience, allowing us to reframe obstacles as opportunities" (p. 30). Ericksonian hypnotherapy utilizes reframing to help individuals change the meaning of a situation so that it can be experienced more favorably (Larkin, 1988). Rossi emphasized, "by continually reframing our innermost experiences on ever more subtle levels, we have a means of progressively evolving our own human nature" (Erickson, Rossi & Ryan, 1985, p. xiv).

An underlying principle of Ericksonian hypnotherapy is the acceptance and utilization of patients' unique patterns to facilitate therapeutic change, in accordance with patients' preferences and goals (Gilligan, 1987). Erickson emphasized the need for facilitators to initially accept and utilize aspects of the patients' presenting patterns of language, interests, beliefs and frames of reference, behavior and symptoms and then help guide them, suggestively, toward

discovery of strengths and potential solutions to problems (O'Hanlon, 1987). This utilization of patterns has been termed pacing, matching or joining the patient with an intention to deepen rapport. An example of nonverbal pacing is when a facilitator aligns his/her breath to match the patient's breathing patterns, or moves his/her head to match the patient's voice inflections. Verbal pacing frequently involves utilizing the language and frame of reference of patients, accepting their truths and perception of their experience. This aligning of patterns proceeds with leading, or guiding patients' awareness with suggestive introduction of potential healthful discoveries and changes in patients' perceptions and patterns of living. Utilization, pacing and guiding with therapeutic suggestions continue throughout the process and provision of Ericksonian hypnotherapy.

Much of Ericksonian communication pertains to the use of direct and indirect suggestions. Direct suggestions are usually associated with traditional hypnosis and are typically more autocratic and limited in choices. Indirect suggestions are often more permissive and inclusive of a variety of choices (Gilligan, 1987; Larkin & Smith, 1991; Yapko, 1990). Suggestive double binds are indirect suggestions that provide two or more health promoting options, all of which guide change toward actualization of therapeutic goals. Inductions which include the fail safe introductory suggestion to "feel free to change any of my words or ideas into whatever will be more healthful for you to experience" invites clients' active participation, involvement and freedom to explore their awareness, experience and choices.

Erickson often provided therapeutic suggestions in the form of metaphors and storytelling. By telling a story about how another patient with similar problems successfully evoked therapeutic change in his or her life, a listener is then free to explore whether similar actions might facilitate his/her healthful growth. Metaphors that are isomorphic, or similar in some way to a patient's experience, are often provided that relate to the themes of replenishment, relaxation, learning, flexibility and therapeutic growth. For example, the story of Flatland (Abbott, 1952) can be viewed as an isomorphic metaphor that suggests one might look beyond perceived limitations, increase pandimensional awareness and discover possibilities that may not have been apparent formerly.

Ericksonian inductions are often interspersed within conversations during therapeutic sessions, and frequently several hypnotherapeutic inductions are offered in a single session. Lewis (1992) examined chronic pain patients' (n = 36) analgesic responses to four inductions provided in single sessions as compared to four separate single inductions provided on a weekly basis. Complete analgesia for one year was reported for 14 of the 20 patients who received four separate single inductions on a weekly basis, and 11 of the 16 patients who received four multiple inductions in one session. Patients were heterogeneous with chronic conditions of neurological lesions, spinal lesions, arthritic conditions and carcinomas. Pain reduction was assessed by the McGill pain questionnaire of present pain intensity. Lewis reported that although the two modes of induction achieved similar analgesic results for persons with chronic pain, the advantage of the multiple induction single session approach is economy of time for both patient and facilitator. Despite the small sample size, these

findings are consistent with Erickson's recommendation that patients often need trance training to become proficient in evoking self hypnosis and support the weaving of multiple inductions and interspersed suggestions to facilitate therapeutic change toward desired goals.

Appel (1990) presented case reports depicting hypnosis as a tool for facilitating change in progression toward therapeutic goals established by patients in a rehabilitation setting. For persons with chronic illness, hypnosis can help them change perceptions, reframe perspectives and experience greater mastery in living with their conditions. An 81 year old female recovering from a right cerebral vascular accident reported learning hypnosis helped her achieve her goal "to relax and feel more in control" (Appel, 1990, p. 87). A 16 year old wheelchair bound female with rehabilitation goals to recover well postoperatively from bilateral total knee replacements, transfer independently and walk for limited distances used hypnosis, and the interdisciplinary team reported great therapeutic progress in her goal attainment. There was no indication how this was validated. Physician follow-up seven months later indicated she continued to use self hypnosis as "her hypnotic practice made daily living easier" (Appel, 1990, p. 89).

Power

There are many depictions of power which render inconsistencies in meaning. "Power over" views of authority and subordination contrast with "power to" perspectives that imply cooperation. Similarly, in hypnosis there are many misguided views of power, with traditional hypnosis associated with autocratic communication and "power over" the person. "Power over" was

described by Hawks (1991) as forcefulness, a capacity to control, achieve dominance and competitiveness. This is consistent with the traditional view of power described by Weber (1947) as imposing one's will over others. This view of power as domination and control over others is evident in nursing, as Heinenken and Wozniak (1988) described the power perspectives of 188 nurse managers who viewed power as control over others. Chinn (1995) describes the "power over" perspective as a paternalistic, "Do as I say, I know what is best for you" (p. 9). "Peace power" is described by Chinn (1995) as a preferred perspective which encourages change, freedom and emerging awareness. Other nursing literature associates power with knowledge (Doering, 1992; McClure, 1985).

Ericksonian hypnosis is typically more permissive, cooperative and invitational of choice; hence it is aligned more with the "power to" perspective. "Power to" suggests "to be able," as derived from the Latin word "potere" (Caroselli & Barrett, 1998); this implies effectiveness, communication, participation and co-operation. Hawks (1991) linked "power to" with achieving goals, as the "capacity to achieve objectives" (p. 768). Labonte (1994) linked promoting health and achieving therapeutic goals with power and suggests professionals should recognize patients' power and see their strengths, abilities and opportunities in facilitating therapeutic change.

Barrett's (1992) power is more consistent with the "power to" perspective. Barrett developed her theory of power subsequent to Rogers' (1970) claim that people "knowingly make choices and with awareness of the mutual process and integrality of human-environmental fields..., can actively participate

in patterning the field in accord with [personal] desires" (p. 71). Barrett's power theory describes how awareness and choices provide persons with freedom to act intentionally and actualize selected health potentials and goals (Barrett et al., 1997).

Feeling "free to act as one wishes" (Caroselli & Barrett, 1998, p. 9) is implicit in Barrett's power. This view of power is "the capacity to participate knowingly in the nature of change characterizing the continuous patterning of human and environmental fields as manifested by awareness, choices, freedom to act intentionally, and involvement in creating change" (Barrett, 1990b, p. 108). These interrelated concepts constitute power, more simply described as "being aware of what one is choosing to do, feeling free to do it, and doing it intentionally" (Barrett, 1986, p. 175). With awareness, people can choose potentials they wish to actualize (Barrett, 1994). Awareness permeates the power process and the integral nature of the measurable manifestations of awareness, choices, freedom to act intentionally and involvement in creating change that constitutes power (Caroselli & Barrett, 1998). Power implies freedom to make aware health promoting changes (Barrett & Caroselli, 1998). Similarly in Ericksonian hypnotherapy emphasis is on facilitating therapeutic change by increasing clients' awareness of choices and freedom to actualize desired intentions.

Caroselli and Barrett (1998) suggest nurses use the power theory to guide their unitary practice and emphasize the importance of testing how power can be enhanced with noninvasive health patterning modalities. Support groups and Ericksonian hypnotherapy are noninvasive patterning modalities that can be

provided with grounding in Rogerian science. With such noninvasive health patterning modalities, nurses can help people with chronic illness to use their power and freely and continuously choose with awareness health promoting changes they wish to create (Caroselli & Barrett, 1998).

Barrett's Power and Chronic Illness

The trajectory of chronic illness implies unpredictable change. Iocolano (1994) conducted a narrative study identifying patterns and themes of the lived experience of four women with breast cancer and their first four months after surgery. Themes of powerlessness were evident, as women tried "to control the uncontrollable..." and were "ardently pursuing information in order to become an active participant" (p. 145). Themes emerged supporting the need for health care professionals to facilitate power to help persons living with chronic health related conditions knowingly participate in their experience of unpredictable change.

Schneider (1995) examined the experience of three women diagnosed with chronic health conditions and their process of healing. Utilizing the Rogerian perspective, Schneider related the emergent themes which facilitated healing and higher frequency patterning were augmenting awareness and power as knowing participation in change. Becoming increasingly aware and using focused awareness to make decisions and to participate more fully in pursuing their own choices in the healing process were described as facilitating healing for these women with chronic illness (Schneider, 1995). Augmenting awareness, pursuing choices and actively participating in health promotion are inclusive in Ericksonian

hypnosis and group therapy. In this qualitative study, Schneider suggests direction in nursing practice regarding augmenting power in health promotion.

A. Smith (1993) explored 33 cardiac rehabilitation patients' perceptions in managing their chronic illness. She found support for Barrett's power theory as the emergent themes in interviews with patients were congruent with the four constructs of awareness, choices, freedom to act intentionally and involvement in creating change. Smith emphasized nursing actions for persons with chronic illness should include strategies that encourage knowing participation in change and actualization of goals that best suit patients' interests and needs.

Rapacz (1991) conducted a descriptive and exploratory study within the SUHB perspective on the nature of chronic pain, power and human field motion as manifestations of human field patterning. A convenience sample of 226 adults was matched on age, gender, race and geographic location to form 113 pairs of participants in either the chronic pain or the comparison group of adults without chronic pain. Chronic pain was viewed as unitary and different from the sum of the parts and was self defined by individuals as "hurt" that had been present for six months or longer. Barrett's Power as Knowing Participation in Change Tool (Barrett, 1983) and Ference's Human Field Motion Tool (Ference, 1979) were utilized as measures of human pattern manifestations. A high positive correlation of the PKPCT and HFMT was obtained within the chronic pain group ($r = .71$, $p < .0001$) and within the comparison group ($r = .78$, $p < .0001$), and multivariate analysis of variance indicated significant differences between the chronic pain and comparison groups ($p < .001$) with lower scores in the chronic pain group. The mean scores for the chronic pain group on the PKPCT ($X = 5.1$, $SD = .99$), and on

the HFMT ($\underline{X}$ = 4.6, $\underline{SD}$ = 1.3) were significantly lower than the mean scores for the comparison group on the PKPCT ($\underline{X}$ = 5.6, $\underline{SD}$ = .78) and on the HFMT ($\underline{X}$ = 5.5, $\underline{SD}$ = .93). Rapacz concluded that the chronic pain group exhibited lower frequency patterning manifestations and suggests nursing strategies such as hypnosis, meditation and therapeutic touch may facilitate change toward higher frequency patterning.

Malinski (1997) reported a significant inverse relationship of power and depression in a canonical analysis of 400 women with and without depression ($\underline{r}$ = -.53, $\underline{p}$ < .001). Within the SUHB framework, Malinski (1997) described depression as lower frequency field patterning manifesting characteristics often associated with chronic illness, such as hopelessness, helplessness, despondency and powerlessness (Haber, 1992). Malinski (1997) emphasized that people can change the nature of their participation in the change process. She recommends that nurses and patients mutually explore manifestations of pattern and together knowingly participate with health patterning modalities such as imagery, meditation and storytelling. Such knowing participation may facilitate actualization of health promoting choices for persons experiencing depression associated with chronic illness.

D. W. Smith (1991) studied persons with the chronic illness of polio and examined the relation of power as knowing participation in change and spirituality as a way of experiencing change through commitment to the actualization of positively viewed potentials for persons who did and did not have polio. This view of spirituality is markedly similar to self defined health promoting goals as potentials persons desire to actualize. A positive relationship

between Barrett's power and spirituality was reported ($r = .34$, $p < .001$) in a sample of 172 polio survivors and 80 persons who had not had polio.

McNiff (1995) examined the relationship of Barrett's power, perceived health and life satisfaction in adults with long term care needs that were frequently associated with chronic illness. Utilizing Rogers' science, McNiff hypothesized that power, perceived health and life satisfaction are positively related as human-environmental field patterning manifestations representing change. Life satisfaction was measured by Campbell's Index of Well-Being, Perceived Health by the Cantril Ladder for Health and Power by Barrett's PKPCT, Version II. For adults ($n = 68$) with long term needs, power was related to life satisfaction ($r = .60$, $p < .001$) and life satisfaction was related to perceived health ($r = .41$, $p < .001$), however the relationship of power and perceived health for adults with long term needs was not found to be statistically significant ($r = .24$). For adults ($n = 68$) without long term needs, power was positively related to perceived health ($r = .42$, $p < .001$) and life satisfaction ($r = .63$, $p < .001$), and life satisfaction and perceived health were also positively related ($r = .52$). No statistically significant difference in power was found between the two groups ($p = .940$). Life satisfaction, like Smith's depiction of spirituality, is similarly associated with actualization of potentials (Walker, Sechrist & Pender, 1987). Supplementary analysis indicated persons both with and without long term needs who engage in prayer or meditation more than once a day revealed a significantly higher score on power ($p = .05$) than those persons who did not pray or meditate. The experience of Ericksonian hypnotherapy is described as similar to meditation;

however, Ericksonian hypnosis typically includes more purposeful direct and indirect suggestions for therapeutic goal attainment.

Wynd (1989) conducted one of the few studies on change in Barrett's power following a non-invasive intervention. She examined the use of guided imagery to enhance power for smoking behavior change. With a convenience sample of 84 adults, a quasi-experimental, longitudinal, pre and post treatment repeated measures design, Wynd (1989) compared differences between the three groups of participants who received no treatment ($n = 27$), relaxation imagery ($n = 29$) and guided power imagery ($n = 29$). Relaxation imagery involved guiding participants into a relaxed state with spontaneous images of peaceful, calming and pleasant scenes. Guided power imagery involved guiding participants to focus their awareness on self defined images and experiences from their pasts which evoked "powerful feelings of self-confidence, hope, strength, freedom, and harmony with nature" (p. 5).

Participants in the treatment groups attended a seven-session stop smoking program with a total treatment and observation phase of ten weeks. In addition to group support and education regarding stress management and smoking cessation, participants were taught relaxation imagery or guided power imagery in the two treatment groups on a weekly basis at sessions 2 through 5. Findings indicated significant change in the dependent variables of power, smoking rate and smoking behavior change ($p < .05$). Guided power imagery was found to be more effective in enhancing power scores than relaxation imagery. Both relaxation imagery and guided power imagery were reported similarly effective in reducing smoking behavior (Wynd, 1989).

Another study examining noninvasive strategies for promoting power was conducted by Wall (2000), who examined changes in power and hope for 97 preoperative lung cancer patients. Participants in Wall's study were randomly assigned to an exercise or non-exercise group. Power and hope were measured at three points of time by repeated measures ANOVA, and results indicated a progressive increase in power for the exercise group from T1 to T3 with $t(48) = -3.73$, $p = .001$. Conversely, power decreased from T1 to T2 in the no-exercise group, with $t(50) = 2.72$, $p < .01$ and from T2 to T3 $t(47) = -.29$, $p = .78$. Wall (2000) additionally reported a positive correlation between hope and power over 3 points in time, with T1 ($r = .62$, $p < .001$), T2 ($r = .59$, $p < .001$) and T3 ($r = .64$, $p < .001$). Wall emphasized the need for nurses to explore noninvasive strategies that can facilitate individual's well-being and sense of future orientation and hope as an "ability to envision a better future" (p. 234). Hopeful individuals, according to Wall (2000), are active in goal directed actions through knowing participation in change.

Power was also explored in a phenomenological study of the meaning of the lived experience of mental imagery in persons with the chronic condition of asthma (Epstein, Barrett, Halper, Seriff, Phillips & Lowenstein, 1997). Multidimensional benefits of imagery training were described for 14 participants who completed the imagery component in a National Institute of Health study on the effects of guided imagery on asthma which included enhancement of participants' sense of power and capacity to actively participate in health promoting choices. The participants who were randomized in the imagery group met with Dr. Epstein for four guided imagery training sessions at weeks 1, 4, 10

and 16. The initial imagery session was one hour and subsequent sessions were one-half hour in duration. Several questionnaires were administered at these time points, which pertained to asthma symptoms, use of medications, psychosocial functions, as well as spirometry assessments. Findings indicated 47% of participants in the imagery group significantly decreased or discontinued use of asthma medications as compared to 18% of the control group; the two groups were reported statistically different ($p < .05$). The authors state long term follow up studies are underway to examine the relations between imagery, pulmonary status and medication use (Epstein et al., 1997).

Additionally, two months after the completion of the NIH study, the 17 participants in the imagery group were invited to participate in a phenomenological qualitative study examining the meaning of mental imagery as a treatment. The 14 consenting participants were asked to write their responses to three research questions regarding the common elements in experiencing the meaning of mental imagery, how and why imagery is valuable in treating disease and "If mental imagery facilitated the experience of power, what are the common elements of power experienced in relation to imagery?" (p. 43). Thematic analysis of responses was conducted by Dr. Barrett, and structural descriptions supported the use of imagery as a tool which can change feelings of powerlessness and helplessness to power as "awareness of freely made choices to actualize intentional changes" (p. 49). Like Ericksonian hypnotherapy that individualizes inductions according to the utilization approach, Dr. Epstein's imagery sessions were individualized for each patient. In this study the imagery consisted of one or several imagery exercises selected from seven imagery

inductions that Dr. Epstein developed and utilized in his clinical practice with asthma patients. The choice of exercise was determined by Dr. Epstein's clinical assessment of individual responsiveness. Each participant was asked to practice the exercises three times a day for one to two minutes for cycles of twenty-one days followed by seven days of no imagery. Thematic responses indicated support for Barrett's power theory, with the common elements emerging of active participation and power enhancement with greater awareness, choices, freedom to act intentionally and involvement in creating change.

Ericksonian hypnotherapy similarly integrates individualized imagery with suggestions that invite client choice and permissively guide participants' awareness to experience unique hypnotic experiences. "Go to a place of nature that is peaceful for you and be there full sensory..., notice the colors of that place, the sounds, the kinesthetic feel, olfactory smell, gustatory taste, and all the additional senses that blend and create a multidimensional experience of deep replenishment, comfort, relaxation and peace. You can memorize that experience and retrieve it whenever you need it, want it, whenever it is appropriate." Additional specific suggestions for progressing toward desired health promoting goals are typically woven throughout the inductions. As the Rogerian science of unitary human beings describes the nature of change, and Barrett's tool measures power as knowing participation in change, Ericksonian hypnotherapy in groups may potentially augment persons with chronic illness knowing participation in change and actualization of desired health promoting goals.

Self Defined Health Promoting Goals

Goals imply something desired, a change toward a desired potential. Self defined health promoting goals are potentialities that are health promoting choices which persons strive to actualize. Rogers' description of human becoming implies change that is emergent and rich with possibilities. Goals precede actualizing choices in the relative present; they are potentialities within the process of becoming. Ericksonian hypnotherapy involves facilitating change in actualizing goals of futuristic potentialities as choices are explored in the relative present. Gilligan (1990) described the Ericksonian hypnotic strategy of pseudo-orientation in time in which individuals hypnotically image their age progression and the perceived necessary steps toward goal actualization. Facilitating actualization of self defined health promoting goals are nursing priorities (ANA, 1995). Matas (1996) emphasized self defined health promoting goals are congruent with Rogers' SUHB as they evolve from individuals' unique perspectives, and she suggests deliberate mutual patterning strategies such as imagery and hypnosis may facilitate goal actualization.

As goals are potentialities, they imply choices. However, at times therapeutic choices may not be apparent, as individuals view their experience from a Flatland perspective. Opening awareness to therapeutic possibilities, pandimensionality and infinite potentials are therapeutic intents in Ericksonian hypnosis. Establishing and actualizing a desired health promoting goal may facilitate knowing participation in creating therapeutic change. Promoting therapeutic change is an intention in support groups (Yalom, 1995) and in

Ericksonian hypnosis (Otani, 1990). Integration of these approaches may facilitate change in the direction of persons' preference and value of health.

Stuifbergen and Becker (1994) emphasize the importance of providing health promoting intervention programs for persons with chronic conditions and suggest expanding the definition of health beyond the "absence of illness" to help persons with chronic illness establish and achieve health goals. Several nursing theorists agree that health promotion is a primary focus in nursing (Newman, 1994; Parse, 2000; Pender, 1996; Rogers, 1992; Watson, 1988).

Pender (1996) associated health promotion with increasing well-being and actualizing health potentials to promote therapeutic change and growth, and emphasized the importance for clients to identify their own personal health goals. In Pender's (1996) description of a positive model of health, emphasis is placed on clients' "strengths, resiliencies, resources, potentials and capabilities rather than on existing pathologies" (p. 16). Erickson similarly emphasized persons' strengths and potentials in creating therapeutic change, and facilitators utilizing Ericksonian hypnotic approaches intentionally start where the patient is and suggestively guide his or her awareness in pandimensional exploration of possibilities and potentialities. Groups also can facilitate an augmentation of members' lens of awareness (Nicholas, 1984), particularly when intentions are to promote knowing participation and change toward desired potentialities and goals.

To adequately describe health promoting goals which are self defined, it is necessary to initially describe various perspectives of health and health promotion. Rogers described health as a value which is self defined (Barrett,

1994). J. Smith (1981) categorized the following four perspectives of health: eudaimonistic is viewed as ever evolving well-being and self-realization; adaptive is described as the capacity to flexibly adapt to the environment; role performance is considered the capacity to do one's job; and clinical is viewed as the absence of symptoms of disease.

Eudaimonistic health is the category most congruent with the Rogerian framework. Eudaimonistic health is "oriented toward change and growth" (J. Smith, 1981, p. 49) and is linked to power as Barrett (1992) states, "By means of awareness, choices, freedom to act intentionally, and involvement in creating changes, power is related to health" (p. 159). Health patterning is the process of facilitating unitary well-being by helping clients with knowing participation in change (Barrett, 1998) and actualization of selected potentials.

Actualizing self defined health promoting goals with therapeutic touch and centering strategies was reported by Matas (1996) at the Sixth Rogerian Conference. In this pilot study forty-three clients who were receiving therapeutic touch at a centering clinic of a major southwestern university agreed to participate in the study. Data were collected via the standardized format of a 100 mm visual analogue scale (VAS) (Gift, 1989) which was individualized for each participant with a title and anchoring adjectives of a self defined health promoting goal. Baseline goals were initially determined and participants marked the VAS where they felt they were on an average in relation to their selected goal. Participants completed the VAS during each visit prior to receiving therapeutic touch. The number of visits were individualized according to participants' needs and practitioner availability. The mean number of visits for the participants was 6.5,

although one participant with breast cancer came for 77 visits, which may have skewed the findings. Ninety percent of the participants reported positive change and progression toward achieving their goals, with an average percent change of 42.4%. T-test analysis indicated a significant difference between the first and the last mean VAS scores ($p < .001$) (Matas, 1996).

Matas recommended future studies include Barrett's Power as Knowing Participation in Change Tool and narrative logs for additional data regarding promoting health with deliberative mutual patterning modalities. Ericksonian hypnotherapy is a deliberate patterning modality which may facilitate change as eudaimonistic health promotion.

Support Groups for Persons with Chronic Illness

Support of persons with chronic conditions is viewed as a primary health concern (Spira, 1997a). Spiegal (1993) suggests that groups are helpful for supporting patients and emphasized the importance of patients' participation in the decision making process for helping ease distress, anxiety and depression. Nicholas (1984) reports that in support groups "the emphasis is on the client's taking responsibility for making changes on his own behalf" (p. 8). Yalom (1995) describes multidimensional benefits of support groups promoting universality, hope, interpersonal learning and therapeutic change. Long and Bluteau (1988) advocate heterogeneous chronic care support groups to augment group diversity and resources, and emphasize the benefits of active participation in helping members ease anxiety and depression. Pennebaker (Dienstfrey & Pennebaker, 1999) suggests the experience of disclosure, or the sharing of lived stories in

support groups can augment the health and healing for individual participants. Sargent (1994) describes applying Rogers' Science of Unitary Human Beings to healing groups, and encourages integrating non-invasive modalities such as relaxation and imagery to facilitate active participation and "promote power enhancement" (p. 123). Lackner (2000) conducted 60 qualitative interviews with persons with the chronic conditions of multiple sclerosis or fibromyalgia and concluded that these participants eased their stress by actively engaging in their own social support. Active participation, relaxation and imagery are frequently inclusive in Ericksonian hypnotherapy (Yapko, 1990).

Pender (1996) emphasized the primary functions of support groups are to augment clients' strengths and promote achievement of goals. Arroz (1979) emphasized hypnosis is a valuable modality which should be integrated in support groups. Lovern (1991) claims Ericksonian approaches are easily adapted to groups to help persons progress toward their therapeutic goals. Spira (1997b) suggests support groups for medically ill persons are dramatically underutilized. Ornish described support groups for patients as important as diet, exercise and meditation in enhancing quality of life and in increasing longevity (Miller, 1998).

Spiegal, Bloom, Kraemer and Gottheil (1989) conducted a longitudinal study in which the health promoting benefits of support groups and education in self hypnosis were examined for 86 patients with metastatic breast cancer. Both the intervention group ($n = 50$) and the control group ($n = 36$) received routine oncological care. The intervention group additionally met for one year in weekly, 90 minute support groups in which participants were taught self hypnosis for pain management and were encouraged to share their feelings regarding their illness

and its effect on their lives. Results indicated the mean survival time for the intervention group was 36 months, which was significantly longer ($p < .0001$) than the mean survival time of 18 months for the control group. The support groups were described as helping patients mobilize their resources and more actively participate in their medical treatments and health care. The education in self hypnosis for pain management was described as possibly helping the intervention participants exercise and maintain routine activities, which may have additionally influenced their health and longevity (Spiegal et al., 1989).

Fawzy, Cousins, Fawzy, Kemeny, Elashoff and Morton (1990) conducted a prospective, longitudinal study evaluating immediate and long-term effects on psychological distress and coping methods for 66 post-surgical patients with malignant melanoma who participated in a structured psychiatric group intervention. Patients were randomly assigned to intervention or control groups and baseline data regarding affective states and coping styles were obtained utilizing the Profile of Mood States (POMS) and the Dealing with Illness Coping Inventory. The patients who were assigned to the intervention groups ($n = 38$) participated in a 6 week structured psychiatric group intervention consisting of health education, enhancement of problem solving skills, relaxation and stress management techniques and psychological support. These are implicit in Ericksonian hypnotherapy. Groups of 7 to 10 patients met for one and one half hours on a weekly basis for the duration of six weeks. All groups were co-led by the primary author, Dr. Fawzy and Norman Cousins (1979), a prominent health advocate and author of a book attributing his own healing of a life threatening

condition to harnessing active participation in his care and utilizing therapeutic humor.

At six weeks, when the groups terminated, a repeated measures covariance model was used to compare the POMS scores and the dealing with illness coping scale. Findings indicated significant improvements in vigor ($p \leq .026$) at six weeks for the intervention group. At six months after the support group ended, the POMS scores for the intervention group showed significantly less depression/dejection ($p \leq .017$), fatigue-inertia ($p \leq .022$), confusion-bewilderment ($p \leq .013$), total mood disturbance ($p \leq .006$) and significantly more vigor-activity ($p \leq .001$) than the control group.

Telch and Telch (1986) conducted a comparison of strategies study of the efficacy of groups designed to enhance cancer patients' adjustment to their disease. Forty-one patients were randomized to one of three groups of group coping skills instruction, support group therapy, and the no treatment control group. The coping skills group was similar to Ericksonian hypnotherapy as participants received instructions in relaxation and stress management, assertive communication, cognitive restructuring and problem solving, goal setting, feelings management and pleasant activity planning. The support groups were non-directive and patients were encouraged to share their feelings. Patients were administered at pretest and the 6-week post-test a 21 question Likert scale interview designed to determine overall psychological adjustment. Concurrent validity of the interview was reported with correlation with the POMS ($r = .69$). Patients were also administered the Perceived Self-Efficacy Scale, assessing patients' awareness regarding their ability to cope. The coping skills group had a

significant ($p < .001$) increase in total score in self efficacy and both groups indicated satisfaction with their group. Intervention patients completed an anonymous 10 item form describing satisfaction with their group. Patients in the coping skills group also rated their frequency of skills practice.

Using a repeated-measures analysis of covariance design with the pretest score as the covariate, results indicated the patients in the coping skills group had significantly lower scores on tension, depression, anger, fatigue and confusion subscales and higher scores on the vigor subscale compared with support groups or no-treatment patients. The coping skills group was reported superior over the supportive group and the control group demonstrated deterioration in psychological adjustment.

CHAPTER III

METHOD

Design

This exploratory study was designed to measure changes in power and self defined health promoting goals for chronic care patients who over ten weeks time did and did not participate in an Ericksonian hypnotherapeutic support group. Power was measured by the Power as Knowing Participation in Change Tool, Version II (PKPCT, VII) (Barrett, 1998) (see Appendix A) at seven time intervals. Self defined health promoting goals were measured by the Self Defined Health Promoting Goals Scale (SDHPG) (Matas, 1996) (see Appendix B) at seven time intervals. The seven time intervals were: the initial orientation session in which baseline data and demographics (see Appendix C) were obtained (T1), the five group sessions (T2 - T6) in which the PKPCT, VII and SDHPG were obtained, and at a time four weeks following the completion of the groups (T7) in which the PKPCT, VII, SDHPG and the evaluation of satisfaction with groups (see Appendix D) were obtained. The study utilized repeated ANOVA measures to compare the two groups over 10 weeks time in power and self defined health promoting goals.

Sample

Persons living with chronic conditions such as arthritis, cancer, heart disease, respiratory disease, neurological conditions, diabetes and irritable bowel were recruited from the practices of health care professionals, medical centers and the general population of lower Westchester county New York area. Although the initial proposal for this study stated that a convenience sample of 48 adults with chronic conditions with 24 in each group would provide 336 data points, which exceed Cohen's (1988) recommended parameters for a power of .80, medium effect size and a statistical significance of .05 for repeated measures, 50 participants actually completed the study. One outlier from the traditional support group was omitted from the analysis to yield a total sample of 49 participants, 30 in the hypnotherapeutic group and 19 in the traditional support group.

Data Collection

Following approval from the Committee for Protection of Human Subjects at New York University, telephone contact was made to the person(s) responsible for initiating appropriate procedures to obtain human subject approval at a medical center in the lower Westchester, New York area, where all groups were held. Written application was submitted in compliance with the hospital's protocols. This included a copy of the research proposal, research instruments and consent form (see Appendix E). Permission was obtained from the medical center institutional review board to conduct this study (see Appendix F).

Recruitment initiatives for the study included flyers (see Appendix G) and letters of invitation (see Appendix H) personally distributed and/or sent by mail to

persons who had expressed interest to the hospital's community education program regarding support services for chronic illness. These flyers and letters of invitation were additionally distributed to health care providers, health organizations, libraries and schools. Three press releases were published in local newspapers (see Appendix I). A phone number to contact the researcher or an assistant for further information was provided on the flyers, letters and press releases. Additional recruitment occurred when some participants who had completed the support groups referred friends, family or acquaintances to subsequent groups. The researcher found recruitment challenging as many potential participants refused to enroll in the study citing they would participate only if they were assured randomization in the hypnosis group.

Persons who called for information were provided a standardized description (see Appendix J) by a research assistant/registered nurse. The description stated that the study would examine health promotion with different forms of support groups. Delimitations and type of chronic illnesses were assessed in this initial phone conversation. As the SDHPG scale required personal assessment of a desired health promoting goal, generalized guidelines were provided during this initial phone conversation to formulate a goal that the participant felt was reasonably attainable (see Appendix K).

Potential participants who were eligible and interested in joining the next group were advised of the scheduled orientation session and the dates, times and location of the upcoming group. When persons were unable to attend the orientation session, the investigator called and scheduled another orientation session prior to the first group meeting. This occurred ten times for the nine

groups in this study. Several participants also conveyed they were unable to commit to attending all five group sessions. Most of their scheduling difficulties were because of conflicting doctors' appointments. All participants were informed that they could remain in the study if they attended the orientation session and at least three of the five sessions.

When potential participants who met the study criteria attended an orientation to the study (see Appendix L), they received a packet which contained the consent form and the two research tools which were administered in a counterbalanced order. During this orientation session participants completed the Power as Knowing Participation in Change Tool (Barrett, 1986; 1998) and formulated and recorded their self defined health promoting goal with their chosen anchoring adjectives on the Self Defined Health Promoting Goal Scale (Matas, 1996). Participants also recorded how difficult they felt their self defined health promoting goal was to achieve and how committed they were in achieving their goal (see Appendix M). Although the initial proposal stated that consenting participants would be matched by the researcher on self rated goal difficulty and then randomized into either the Ericksonian hypnotherapeutic support group or the comparison support group, this actually occurred only for the initial Ericksonian support group and comparison support group. Because the subsequent numbers of consenting participants were too small for two groups, it was decided upon consultation with the researcher's dissertation chairperson to instead offer only one type of group at a time. The subsequent groups in this study were randomly selected to be either Ericksonian hypnotherapeutic support groups or comparison support groups.

During the orientation session, the researcher answered questions and informed each participant of the time and place of the first group meeting. When participants submitted their completed orientation packet, they received a parking token if needed and were invited to return the next week for the initial support group meeting. Names, addresses and phone numbers of consenting participants were obtained and kept in a locked file by the researcher. Approximately one week after the orientation session the groups began and met weekly for five weeks. All groups were audiorecorded for analysis of group process strategies.

At the first group session, the researcher informed participants of the type of group to which they were randomly assigned. Participants randomized to the experimental group participated in a five week (1.5 hours per week) Ericksonian hypnotherapeutic support group facilitated by the researcher, an advanced practice health care professional experienced in conducting support groups for persons with chronic illness and Ericksonian hypnotherapy. Participants randomized to the comparison group participated in a five week (1.5 hours per week) support group facilitated by an advanced practice registered nurse experienced in conducting support groups in which expression of feelings and sharing of life stories were encouraged without providing relaxation techniques, imagery, meditation or hypnosis. Both the experimental and comparison groups were co-facilitated, when possible, by advanced practice registered nurses experienced in conducting support groups in which expression of feelings and sharing life stories about living with chronic illness was encouraged. All facilitators received standardized guidelines for conducting support groups (see Appendix N). The primary distinction of the groups was the provision of support group processes

only (the comparison groups) as compared to the provision of support group processes and Ericksonian hypnotherapeutic approaches (the experimental groups). S. Rosen (personal communication, May 8, 1998) suggests that five group sessions are sufficient to facilitate therapeutic change with Ericksonian hypnotherapy. The initial proposal stated group size would be less than 12, as suggested by Yalom (1995) as a good group size.

Each week near the end of the group session all participants in both the experimental and comparison groups recorded their scores on the SDHPG scale and the PKPCT, VII. These research instruments were stapled together in a counterbalanced order over time. Half of each group received the SDHPG scale first and the PKPCT, VII second and the other half received the PKPCT, VII first and the SDHPG scale second. In the succeeding weeks, the tools continued to be stapled together and presented in a counterbalanced order. Each person's goal and word or phrase that described fully achieving the goal and not at all achieving the goal were recorded by the researcher on the SDHPG scale for T2-T7. To protect participants' confidentiality, each participant was invited to use his/her first name or a made-up name only during the support group sessions. Each participant was identified on the research tools by a code number, which was utilized throughout the study.

One month following the termination of the Ericksonian hypnotherapeutic support group and the comparison group, all participants received the questionnaire assessing satisfaction with their support group, the SDHPG scale and the PKPCT, VII by mail with a stamped return envelope. This provided the long term follow-up information on participants' power and self defined health

promoting goals. Upon receipt of the completed tools, all participants received a self-hypnosis/relaxation/imagery audiotape by mail for compensation and appreciation for their participation in this study.

Group Protocols

Phillips (1997) describes the nature of mutual process and ever changing patterning of human and environmental fields as a dynamic unpredictable flow of energy, so each group process naturally unfolded creatively. Facilitators' patterning intentions for both the traditional comparison support groups and the Ericksonian hypnotherapeutic support groups included presencing with verbal support and encouragement for participants to express their feelings and share their stories regarding living with chronic illness. The Ericksonian hypnotherapeutic support groups also received education and experiential inductions which included progressive relaxation, imagery of peaceful places in nature, therapeutic stories and metaphors with interspersed direct and indirect suggestions for learning, increasing comfort, flexibility and capacity to acknowledge one's experience and open up therapeutic possibilities for actualizing desired health promoting change and goals. Appendix O illustrates the group protocols for both types of groups.

All groups were audiotaped for analysis and confirmation of patterning strategies provided in the support groups and the Ericksonian hypnosis groups. Three members of The New York Milton H. Erickson Society of Psychotherapy and Hypnosis reviewed random selections of the 1.5 hour audiotaped sessions of the traditional comparison and Ericksonian hypnotherapeutic support groups.

These reviewers confirmed that formal Ericksonian hypnotic inductions were not offered in the traditional support groups and were offered in the Ericksonian hypnotherapeutic support groups.

Instruments

Power as Knowing Participation in Change Tool

The Power as Knowing Participation in Change Tool, Version II (Barrett, 1987, 1998) is a 52 item semantic differential test in which participants rate bipolar adjectives on a seven point scale. Barrett's initial study (1983) examined four dimensions of power in the three contexts of "myself," "family" and "occupation." Since congruence coefficients of contexts were .99, Barrett subsequently developed PKPCT, VII (Barrett, 1987), which is context free. The four dimensions of power include awareness (knowing that one has the capacity to change oneself and one's environment), choices (accepting or rejecting what is offered by a situation; determining the nature of change), freedom to act intentionally (ability to take a stand or make a decision regarding the meaning of change) and involvement in creating change (active participation in actualizing choices involved with change). These pattern manifestations of power identified by Barrett are the four subscales of the PKPCT. Each subscale contains twelve semantic differential bipolar adjectives, such as: constrained - free; assertive - timid; shrinking - expanding. The adjectives are prefaced with a phrase related to the subscale, for example: "My awareness is constrained - free" or "My freedom to act intentionally is shrinking - expanding." One pair of bipolar adjectives is

repeated in a reversed form in each subscale for assessing retest reliability, hence the total items that are scored are 48.

Face and content validity of the PKPCT Version I was established with two judges' studies. Judges were New York University faculty members who were well versed in Rogers' SUHB and assessed the concepts and bipolar adjective pairs for congruence in Rogers' science. A subsequent pilot study ($\underline{N}$ = 267) was conducted with a national sample of volunteers who had completed high school. Construct validity was established by factor analysis, and scales that did not load on any factor or loaded on more than one factor were deleted. In the final validation study ($\underline{N}$ = 625), Barrett reported factor loadings with a range of .56 to .70 as validity coefficients. One factor emerged with an eigenvalue greater than one, accounting for 48% of the variance. Barrett perceived the loading of scales onto one factor as supporting the integral nature of the four dimensions of power. In Barrett's pilot study ($\underline{N}$ = 267) reliability for variances of factor scores ranged from .55 to .99, and reliability for the retest items in each scale ranged from .60 to .90 (Barrett, 1983). In the final study ($\underline{N}$ = 625), item-retest reliability for the revised version without contexts ranged from .70 to .78. High internal consistency was reported for the PKPCT Version II with Cronbach alphas of .96 (Trangenstein, 1988), .95 (Caroselli-Dervan, 1991) and .94 (Rapacz, 1991). Coefficient alphas for subscales ranged from .86 to .92 (Trangenstein, 1988), .83 to .89 (Caroselli-Dervan, 1991) and .77 to .82 (Rapacz, 1991).

Item scores of 7 and 1 represent extreme responses and 4 represents neutrality. One nonscored retest item is provided in each subscale for assessing reliability of participant response. Scoring requires reversing the negatively-

scored items and summing the 48 scored items. The range of scores possible for the 48 items of the PKPCT is from 48 to 366. Lower numbers represent less power and higher numbers depict greater power. Permission to use the PKPCT was obtained from the author (see Appendix P).

The Self Defined Health Promoting Goals Scale

The Self Defined Health Promoting Goals Scale (SDHPG) (Matas, 1996) is a vertical visual analogue scale (VAS) 100 mm long with anchors at each end illustrating extremes of a health promoting goal as selected by each participant. The SDHPG scale was established by Matas (1996) to examine the magnitude of change in movement toward selected goals of health and well-being as defined by each individual. Matas developed this scale in response to McKeehan, Cowling and Wykle's (1986) depiction of the relevance of self-anchoring as a research approach consistent with Rogers' unitary framework and emphasis on the uniqueness of individuals. The self-anchoring process provides a continuum in which individuals' unique perceptions and goals for therapeutic change can be measured.

Matas (1996) initially utilized the SDHPG scale in a research project examining the effectiveness of Therapeutic Touch for health promotion in a general population of university faculty, staff and students ($N = 53$). Data collection was standardized in the format of a vertical visual analogue scale of 100 mm long, and was individualized for each participant with the health goal title and anchoring adjectives self-defined. Matas (1996) administered the SDHPG scale at baseline, prior to the provision of therapeutic touch and at each

subsequent visit prior to receiving Therapeutic Touch. Ninety percent of participants demonstrated a positive change from baseline VAS to the final VAS, and the average percent change toward self-defined therapeutic goals was 42.4%. T-tests evaluating the differences between first and last mean VAS scores indicated significant change ($p < .0001$).

Although originally developed by Freyd in 1923, VAS scales grew in frequency since the 1960s for measurement of various subjective phenomena such as moods, anxiety, alertness, clinical symptoms, quality of life and pain. Advantages of the VAS are that it is a simple, brief and easy to score tool with well established reliability and validity for subjective phenomena (Wewers & Lowe, 1990)

Visual analogue scales are usually 100 mm long with anchors at each end, illustrating extremes of subjective phenomena (Gift, 1989). Anchors can vary and the VAS validity remains constant (Gift, 1989; Price, McGrath, Rafii & Buckingham, 1983). Strong correlations with the VAS were obtained with a simple descriptive pain rating scale ($r = .75$) (Scott & Huskisson, 1976). Downie et al. (1978) reported a range of strong correlations with the VAS for simple descriptive pain scales ($r = .71$ to $.78$) and with an 11-point numerical pain rating scale ($r = .62$ to $.91$). Grossman et al. (1992) compared the Hopkins Pain Rating Instrument with the VAS and reported a high correlation of $r = .99$. Concurrent validity for depression was reported with the Beck Depression Inventory ($r = .65$) (Davies, Burrows & Poyton, 1975). Discriminate validity for quality of life VAS was examined by comparing physician's ratings with back pain patient's improvement following a program of Transcutaneous Electrical Nerve Stimulator

(TENS) and acupuncture (r = .70) (Price et al., 1983). Clearly written instructions at the top of the scale help to insure a valid response, as some individuals may have difficulty converting subjective phenomena into a straight line (Guyatt, Townsend, Berman & Keller, 1987).

Reliability of the VAS has been reported using the test-retest method over one hour period, with participants reliably repeating measurement of subjective experiences (Flaherty, 1996; Luria, 1975; Revill, Robinson & Rosen, 1976). Grossman et al. (1992) utilized the test-retest method with 71 cancer patients with and without pain and reported a high correlation (r = .97) for the VAS. K. Matas (personal communication, November 1, 1997) reports a high correlation (r = .90) for the SDHPG scale test-retest measure for 41 nursing students who were measured over a one hour period. The VAS is reported as a more sensitive measure of subjective sensations than 4-point or graphic rating scales (Joyce, Zutshi, Hrubes & Mason, 1975).

The VAS is scored by measuring the number of millimeters from the lowest anchor to the participant's mark. High intersubject repeatability has been reported using this method of measurement (Gift, 1989; Revill et al., 1976). Gift (1989) reports that the VAS is a valid, reliable and sensitive self report measure of subjective experiences and measurement of change. A higher score on the SDHPG scale indicates greater progression toward the self defined health promoting goal. Permission was obtained from the author for the use of the SDHPG scale (see Appendix Q).

Data Analysis

The Statistical Package for the Social Sciences (SPSS, Version 9 and 10 for Windows) was used to analyze the data. Cronbach alpha coefficients were computed for the PKPCT, VII. The total power score was used to test the research questions. Before conducting the repeated measures analysis of variance, variables were assessed for outliers through frequency distributions, measures of central tendency and skewness.

The research questions used an alpha level of .05 as the criterion for statistical significance and were tested with repeated measures analysis of variance with power and self-defined health promoting goals as the dependent variables of the interactional effect of Ericksonian hypnotherapeutic support groups and time and the comparison support groups and time. Ancillary analyses were conducted on the demographic data and evaluation forms. Random samples of matched audiotaped recordings of the traditional and Ericksonian hypnotherapeutic support groups were reviewed by three members of The New York Milton H. Erickson Society of Psychotherapy and Hypnosis for confirmation of group process strategies.

CHAPTER IV

RESULTS

This study examined changes in power and self defined health promoting goals for persons with chronic illness who participated in an Ericksonian hypnotherapeutic support group or a traditional support group. The traditional support group emphasized expression of feelings and personal stories of living with chronic illness, and the Ericksonian hypnotherapeutic support group emphasized expression of feelings and personal stories of living with chronic illness and provided education in Ericksonian hypnosis. Power was measured by the Power as Knowing Participation in Change Test, Version II (PKPCT, VII) (Barrett, 1998) and self defined health promoting goals were measured with the Self Defined Health Promoting Goals Visual Analogue Scale (VAS) over seven points in time. The sample of 49 persons diagnosed with a chronic physical illness was recruited from hospitals, outpatient clinics, private offices of health care providers and the general population of lower Westchester county in New York. Data were analyzed using the Statistical Package for the Social Sciences, Versions 9 and 10 for Windows (SPSS) (1999).

Description of the Sample

Of the 64 persons who enrolled in the study, 50 persons completed the study. Thirty of these participants were randomly assigned in the experimental

hypnosis group and 20 in the comparison traditional support group. Fourteen persons completed the orientation but subsequently dropped out of the study for varying reasons. Three conveyed to the investigator they dropped out because of job opportunities, 2 because of car problems, 1 because she felt she was "the wrong age group" (too young), 2 because of health problems, and 2 because they wanted to be in the hypnosis group. The remaining 4 did not specify why they chose not to continue in the study. One participant in the comparison group was found to be an outlier and was omitted from the analysis. The final sample was 49.

Nine groups of 5 weeks duration were conducted at a Westchester medical center during an 18-month period from July 1998 to November 1999. Group type and membership were randomly assigned according to Wynd's (1989) protocol, which involved random selection of lots drawn from a hat by an uninvolved party. Five groups were randomly chosen to be traditional support groups and 4 were randomly chosen to be hypnosis groups. The traditional support groups were facilitated by advanced practice nurses experienced in conducting support groups who were either enrolled in their final practicum experience or recent graduates of a masters degree in holistic nursing program. These support group facilitators were trained by the researcher and were given copies of the support group protocol as described in Appendix N. The hypnosis groups were facilitated by the researcher, who is experienced in conducting support groups and in providing education in Ericksonian hypnosis. When possible, co-facilitators who were advanced practice holistic nursing students participated in the groups. Three of the traditional support groups and two of the hypnosis groups had co-facilitators.

As Rogers emphasized, group fields naturally evolve uniquely, with individual human field group participants in unique mutual patterning process with the environmental field. In this study, unexpected environmental field patterning events influenced participants' experiences. For example, the first group session for the initial hypnosis group and support group occurred in July of 1998 during a heat advisory warning that suggested children, the elderly and infirm remain in a cool environment. Unfortunately, participants in the first session in the hypnosis group were in an insufferably hot classroom with no fan or air-conditioning as no other room was available. This occurred while the investigator was hypnotically encouraging them with interspersed suggestions to "feel more comfortable." The traditional support group, however, was held across the hall in a classroom with air-conditioning. Three participants subsequently dropped out of that hypnosis group, citing health reasons and time constraints, as compared to one drop out because of emergency dental surgery from the concurrent traditional support group. Future summer groups were only scheduled in rooms with adequate air-conditioning.

Another unforeseen and unfortunate event happened when the second traditional support group met for its first session. Painting and construction were occurring across the hall, patterning the environmental field with toxic fumes. As some participants were suffering from respiratory conditions, the researcher obtained a substitute room in the overcrowded facility and the group began 20 minutes after the scheduled time. Interestingly, this group evolved most cohesively, with continued voluntary meetings beyond the duration of the research. This extended group has been opened subsequently to all other research

participants and continues to meet in a local church on a bi-monthly basis.

Table 1 illustrates the completion rates for the participants in this study. Participants needed to attend an orientation session and at least three of the five group sessions to be considered a participant who completed the study. A t-test indicated there were no statistically significant differences between the number of participants who completed the study in the traditional support groups and the number of participants who completed the Ericksonian hypnotherapeutic support groups. Participants in the traditional support groups and the Ericksonian hypnotherapeutic support groups attended a mean of 4.2 group sessions.

Table 1

Completion Rates of Participants by Group

Group	Time 1 n (%)	Time 2 n (%)	Time 3 n (%)	Time 4 n (%)	Time 5 n (%)	Time 6 n (%)	Time 7 n (%)
Traditional Support Group	19(100%)	16(84%)	14(74%)	16(84%)	14(74%)	18(95%)	19(100%)
Ericksonian Hypnosis Support Group	30(100%)	26(87%)	24(80%)	26(87%)	27(90%)	23(77%)	27(90%)

Table 2 depicts the personal characteristics of the participants. Participants ranged in age from 26 to 81 years, with a mean age of 57 years for the total sample. An independent samples t-test revealed the mean age for participants in the traditional support group to be 60 years old as compared to the

mean age of 54 years old for participants in the hypnosis group. This difference was not found to be statistically significant with t (47) = 1.62, p = .11.

Table 2

Personal Characteristics

Characteristics	Traditional Support Group n (%)	Ericksonian Hypnosis Support Group n (%)	Total n (%)
Age			
25-34	1 (5%)	2 (7%)	3 (6%)
35-44	2 (11%)	7 (23%)	9 (18%)
45-54	4 (21%)	5 (17%)	9 (18%)
55-64	4 (21%)	9 (30%)	13 (27%)
65-74	6 (32%)	7 (23%)	13 (27%)
75-84	2 (11%)	0 (0%)	2 (4%)
Gender			
Female	16 (84%)	27 (90%)	43 (88%)
Male	3 (16%)	3 (15%)	6 (12%)
Ethnicity			
Asian	1 (5%)	1 (3%)	2 (4%)
African American	0 (0%)	5 (17%)	5 (10%)
Hispanic	1 (5%)	1 (3%)	2 (4%)
White	17 (90%)	22 (73%)	39 (80%)
Other	0 (0%)	1 (3%)	1 (2%)

Note: Traditional Support Group = 19, Ericksonian Hypnosis Support Group = 30
May not equal 100% due to rounding off.

No statistically significant difference was found in chi-square analysis between the traditional support groups and the Ericksonian hypnosis support groups in terms of gender, X^2 (1) = .36, p = .54; marital status, X^2 (4) = 3.51, p = .47; ethnicity, X^2 (4) = 4.39, p = .36; education,

X^2 (6) = 7.60, p = .27; or employment, X^2 (4) = 3.43, p = .49. Forty-three participants (88%) in the total sample were female. There were six males (12%) who completed the study of which three had been randomly assigned to the traditional support groups and three had been randomly assigned to the hypnosis groups. In terms of ethnicity, the majority of participants were Caucasian (80%), with only 10% African American, 4% Hispanic, 4% Asian and 2% Other. These statistics depart from the ethnic ratio of the local community in which the support groups were held, in which 69% are Caucasian, 16% are African American and 9% are Hispanic, 3% are Asian and 3% are Other (Westchester County Department of Planning Databook, 1998).

Table 3 reflects participants' marital, educational and employment status. Twenty-eight of the participants in the total sample were married (57%), with eight (16%) widowed, six (12%) single and six (12%) divorced or separated. The educational status of participants in the total sample ranged from high school to doctoral degrees, with 23 participants (47%) having obtained bachelor's degrees or above. Seven participants (14%) described their educational status as "other." These participants had at least a high school education, which was required for admission in the study. Four of the participants who checked "other" wrote that they had completed some college.

Twenty-one participants (43%) described their employment status as retired or unemployed and fourteen (29%) conveyed they were working part time. Only eight participants (16%) were employed full time. The various occupations of participants included: attorney (n = 2), artist/art teacher (n = 3), registered

nurse (n = 7), teacher (n = 8), social worker (n = 3), psychotherapist (n = 2), homemaker (n = 6), actress/singer (n = 1), graphic designer (n = 1), school lunch program manager (n = 1), proofreader / writer (n = 1), production assistant /

Table 3

Marital, Educational and Employment Status

Characteristic	Traditional Support Group n (%)	Ericksonian Hypnosis Support Group n (%)	Total n (%)
Marital Status			
Single	2 (11%)	4 (13%)	6 (12%)
Married	9 (47%)	19 (63%)	28 (57%)
Divorced	3 (16%)	2 (7%)	5 (10%)
Separated	1 (5%)	0 (0%)	1 (2%)
Widowed	4 (21%)	4 (13%)	8 (16%)
No Response	0 (0%)	1 (3%)	1 (2%)
Educational Status			
High School Diploma	4 (21%)	6 (20%)	10 (20%)
Vocational School	0 (0%)	2 (7%)	2 (4%)
Associate Degree	5 (26%)	2 (7%)	7 (14%)
Bachelor's Degree	6 (32%)	8 (27%)	14 (29%)
Master's Degree	1 (5%)	6 (20%)	7 (14%)
Doctoral Degree	0 (0%)	2 (7%)	2 (4%)
Other	3 (16%)	4 (14%)	7 (14%)
Employment Status			
Full Time	2 (11%)	6 (20%)	8 (16%)
Part Time	7 (37%)	7 (23%)	14 (29%)
Retired	8 (42%)	9 (30%)	17 (35%)
Unemployed	1 (5%)	3 (10%)	4 (8%)
Other	1 (5%)	5 (17%)	6 (12%)

Note: Traditional Support Group = 19, Ericksonian Hypnosis Support Group = 30
May not equal 100% due to rounding.

writer (n = 1), entrepreneur (n = 1), broadcast journalist (n = 1), printer (n = 1), computer specialist (n = 4). Some participants indicated they had more than one occupation.

Thirty-one participants (63%) reported in the demographic form that they had experienced a major change or crisis in the past six months and 21 of these participants (43%) wrote that the change or crisis pertained to their health. A chi-square analysis indicated there was no significant difference, X^2 (1) = .17, p = .68 in terms of major changes or crises for participants in the traditional support groups and the Ericksonian hypnotherapeutic support groups. Forty participants (82%) stated they were never diagnosed with a psychiatric illness. The nine participants (18%) who reported a former psychiatric illness conveyed depression as the predominant diagnosis. Depression is commonly cited in the literature as associated with chronic illness (Gregg et al., 1989; Meyerowitz, Heinrich & Schag, 1983; Telch & Telch, 1986).

Thirty-two participants (65%) described practicing some form of prayer, meditation or relaxation techniques on a daily or more than daily basis. Only 3 (6%) stated they never practiced prayer, meditation, relaxation techniques, imagery or self hypnosis. Most of the practicing participants (58%) cited prayer as their first and most common practice. A chi-square analysis indicated there was no significant difference, X^2 (4) = 6.11, p = .19, in terms of practice of prayer, meditation, relaxation techniques, imagery or self hypnosis for participants in the traditional and Ericksonian hypnotherapeutic support groups. Only 28% of the participants stated they were formerly hypnotized, with 72% reporting they had never been hypnotized. A chi-square analysis indicated no

significant difference, X^2 (1) = 2.79, p = .10, in terms of former hypnosis experience for participants in the traditional and Ericksonian hypnotherapeutic support groups.

Half of the participants stated they had previously or were currently participating in support groups and half conveyed they had never before participated in support groups. In the traditional support group, 13 participants had formerly or were currently participating in support groups as compared to 12 in the Ericksonian hypnotherapeutic support groups. A larger distinction between the groups was found in the participants who had never participated in support groups. In the traditional support groups, 6 reported no prior experience with support groups as compared to 18 participants in the Ericksonian hypnotherapeutic support groups. A chi-square analysis demonstrated a statistically significant difference between the traditional and Ericksonian hypnotherapeutic support groups regarding support group participation, X^2 (2) = 6.04, p = .05.

Table 4 depicts participants' chronic illness in the identifying language of the participants. Twenty-three participants (47%) conveyed they were living with multiple chronic illnesses.

A mean of 2.44 from a Likert scale of 1-4 (with 1 as excellent, 2 as good, 3 as fair and 4 as poor) on perceived general level of health suggests most participants considered their health between good and fair in response to the demographics health question. When participants were asked in the demographics to define what health meant to them, descriptions ranged from physical manifestations of clinical health and absence of symptoms to

Table 4

Participants' Chronic Disease

Chronic Disease	Traditional Support Support	Ericksonian Hypnosis Support Group
Allergies (Environmental Toxicity)	2	0
Arthritis	6	5
Asthma	1	1
Breast Tumors	1	0
Cancer	0	5
Chronic Brain Disorders and Seizures	1	0
Diabetes	3	3
Esophagus Junction Leiomyoma Tumor	1	0
Fibromyalgia	0	2
Gout	0	1
Heart Disease	1	5
High Blood Pressure	0	4
History of Stroke	0	1
Irritable Bowel/Crohn's	3	0
Kidney Disease	1	1
Lupus	2	3
Lyme's Disease	1	1
Macular Degeneration	0	1
Multiple Sclerosis	1	2
Neck/Back Pain/Injury	1	6
Osteoporosis	0	1
Pancreatitis	0	1
Parkinson's Disease	0	1
Raynaud's Syndrome	0	1
Scoliosis	1	0
Sjorgens Syndrome	0	1
Thyroid Condition	0	2

Note: Traditional Support Group = 19, Ericksonian Hypnosis Support Group = 30

descriptions more closely aligned with eudaimonistic health and unitary well-being. Appendix R illustrates participants' descriptions of health in their own language.

Psychometric Evaluation of the Instruments

Power as Knowing Participation in Change Tool

Results of the alpha reliability of the total PKPCT, VII and the four subscales are displayed in Table 5. The internal consistency for the total PKPCT, VII was observed to be high, with a range of .95 to .98 for the seven time periods, which is congruent with other PKPCT research findings (Caroselli & Barrett, 1998). The internal consistency of the four subscales was similarly high, with an observed range of .78 to .94.

Table 5

Alpha Cronbach of the PKPCT and Subscales

Time Period	Total PKPCT	Awareness	Choice	Freedom	Involve	N
1	.95	.87	.86	.82	.87	49
2	.95	.81	.88	.88	.79	42
3	.95	.89	.86	.85	.78	38
4	.97	.89	.92	.91	.92	42
5	.98	.91	.93	.92	.92	41
6	.98	.94	.92	.93	.91	41
7	.98	.94	.92	.93	.92	46

The final item in each subscale of the PKPCT, VII is a reversed retest item

to assess the reliability and stability of each participant's pattern of responses. The observed high correlation of most of these duplicate items suggests the strong reliability of the PKPCT, VII. Table 6 illustrates the obtained correlation coefficients of stability for the repeat items. The T2 involvement repeat items of superficial-profound was the only reversed retest item which did not reach significance in this correlation coefficient of stability analysis.

Table 6

Correlation Coefficients of Stability over a Ten-Week Period for Repeat Items on the PKPCT Subscales

Time Period	Awareness Unpleasant/ Pleasant	Choice Timid/ Assertive	Freedom Orderly/ Chaotic	Involvement Superficial/ Profound	N
1	.57**	.61**	.92**	.74**	49
2	.73**	.75**	.66**	.30	42
3	.85**	.72**	.80**	.40*	36
4	.88**	.65**	.83**	.70**	42
5	.56**	.67**	.90**	.73**	41
6	.59**	.40**	.74**	.51**	41
7	.92**	.88**	.90**	.86**	45

Note: N varies from Table 1 due to missing responses.
*p < .05 **p < .001

The Self Defined Health Promoting Goals Scale

The Self Defined Health Promoting Goal Scale (Matas, 1996) assessed the magnitude of change in progression toward individually selected goals of health and well-being. Data collection was standardized in the form of a vertical 100

mm visual analogue scale, and it was individualized for each participant with health goal title and anchoring adjectives self defined. Table 7 illustrates participants self selected health promoting goals and anchors in the identifying language of the participants.

Table 7

Participants' Self Defined Health Promoting Goals

Goal Title	Top Anchor	Bottom Anchor
Improve Memory	Improve Memory	Forgetting
Less Pain	No Pain	Constant Pain
Working full time in good health	Working full time in good health	Needing to be hospitalized again
Feeling myself at my best – improved sleep and concentration	Best/Improved sleep and concentration	Worst
Feeling myself at my best	Best	Worst
Increased Comfort	Pain free – comfortable	Pain & discomfort
Generosity towards others and their ways of reacting	Open	Closed
I can relax to help myself "Old outlook back"	Pain Free, Warm Free mind/Thinking/ Clear Head	Hurting, Cold Dark outlook
Sense of optimism	Waking each day with sense of joy of life	Depression

Continued

Table 7 (Contd)

Participants Self Defined Health Promoting Goals

Goal Title	Top Anchor	Bottom Anchor
Eat healthy/exercise to live in a peaceful state-trust God with life	Taking care of myself - Self love	Out of control - daily pain
Pain free & return to full function regarding my back	Pain free with full function	Chronic pain with limitations
Life returns to normal – can function pain free and without restrictions	Pain free without restrictions	Chronic pain with restrictions
Free to enjoy life – happy to explore willingness	Free to enjoy life, happy to explore, willingness	Feeling empty, frightened
Adequate personal time	Don't feel pressured with obligations	Felt overwhelmed with obligations
Keeping my blood pressure to normal by following health promotion measures	Normal BP	High BP
To be pain free	Comfort, no pain	Very painful
Learn to manage pain	Patience re: pain	Anger re: pain
Walking more easily	Hiking	Creeping
Getting a complete grip on my disease	Complete grip	Losing control of self
An optimistic happy outlook on life	Serenity	Deep Depression

Continued

Table 7 (Contd)

Participants Self Defined Health Promoting Goals

Goal Title	Top Anchor	Bottom Anchor
Well me – well thee	Well me, well thee	Suppressed well me, well thee
Pain free and functional for daily living	Pain free and functional for daily life without medication	Pain stimulator/ morphine pump
Losing 10 pounds	Lose 10 pounds	No change in weight
Serenity	Serenity	Depression
Reduce pain	No pain	Pain as bad as can be
Bursting with available energy	100% energy	Fatigue
Weight loss	Lost 10 pounds	Lost zero pounds
Eating the right food	Diet	Drink too much
Prevention of pancreatitis with proper eating	Proper eating	Not eating properly
Loosing weight – my life	Hard work – commitment losing 20 pounds	Giving up – not losing weight
Controlling symptoms	Positive	Not positive
Easy breathing	Free breathing	Not an option, death
Daily exercise for 30 minutes per day	Exercise everyday	Don't exercise any day

Continued

Table 7 (Contd)

Participants Self Defined Health Promoting Goals

Goal Title	Top Anchor	Bottom Anchor
To live long	Life	Death
Take charge of my decisions for my good	Take charge	Do not take charge
Stop smoking	Stopped smoking and potent	Still smoking and impotent
Positive attitude	Maintain a positive attitude	Negative and hopeless; overwhelmed
Increased physical activities	Increased physical activities	Not able to do social physical activities – not able to handle daily routine functions
Improved kidney function	Normal level of creatine/ BUN	High level of creatine/ BUN
Free of pain	Free	Not free
Relinquish	Peace	Chaos
Increased clarity	Full clarity	Lack of clarity
Whoopee	Smiling face	Sad face
Well being	Good health	Poor health
Freedom to focus without anxiety and/or pain	Confidence and competence	Too anxious to relax and be fully functional

Continued

Table 7 (Contd)

Participants Self Defined Health Promoting Goals

Goal Title	Top Anchor	Bottom Anchor
Steady blood sugar range 80-175	In balance	Yo-yo
Sleeping better at night	Sleeping 6 hours at night	Not at all – 3 hours
Remain cancer free	Free	Increased risk

Data Analysis

Variables were initially examined for outliers through frequency distributions, measures of central tendency and skewness. The skew for power at Time 5 was 2.89, which was greater than the required skew of 2.58. One participant from the traditional support group was therefore deleted from the analysis as an outlier. When the outlier was deleted from the analysis, the skew changed to an acceptable 2.29. Missing data were handled in the following manner. When participants omitted an item on the PKPCT, the mean of the corresponding subscale was utilized. For example, if an item on the awareness subscale was omitted, the mean of the awareness subscale was utilized for the missing item. When participants missed one or two groups or when participants omitted a full response on the PKPCT or SDHPG scale, means were calculated by utilizing the scores obtained from the previous week and the scores obtained from the week following the missed group. Three participants did not send back their

final T7 packet, hence the N for T7 is forty six.

Descriptive statistics were computed for the PKPCT and SDHPG scale. The measures of central tendency for the PKPCT are displayed in Table 8 and suggest a progressive increase in mean PKPCT scores for the total sample from the T1 mean of 261.90 to a T7 mean of 281.48.

Table 8

Measures of Central Tendency for the PKPCT at Seven Time Points for the Total Sample

Time	N	Mean	SD	Minimum	Maximum
1	49	261.90	35.38	175.50	333.00
2	42	267.86	33.97	186.90	331.00
3	38	267.01	35.51	186.90	336.00
4	42	271.21	38.81	157.00	335.00
5	41	276.13	36.18	169.18	336.00
6	41	286.52	38.95	192.00	359.72
7	46	281.48	41.50	192.00	336.00

Note: Possible range of PKPCT is 48-336

Table 9 illustrates the measures of central tendency for the self defined health promoting goals visual analogue scale for the total sample. A progressive increase in mean scores for participants' self defined health promoting goals is observed with a T1 mean of 34.18 which significantly increased to 61.59 on T7. Ninety two percent of participants reported progress toward their goals from T1 to T6 and 84% demonstrated positive change toward their goals from T1 to T7. The mean magnitude of change toward actualizing goals in the total sample was

28.4% from T1 to T6. A slight decline was noted from T6 to T7, with a mean magnitude of change from T1 to T7 of 27.4%.

Table 9

Measures of Central Tendency for the VAS at Seven Time Points for the Total Sample

Time	N	Mean	SD	Minimum	Maximum
1	49	34.18	25.03	.00	89.00
2	42	38.77	26.26	2.00	95.00
3	38	42.86	25.59	.00	96.00
4	42	50.89	23.56	7.00	97.00
5	41	54.31	25.34	.00	95.00
6	41	62.61	26.62	6.00	99.00
7	46	61.59	28.61	.00	97.00

Note: Possible Range of VAS is 0-100

Table 10 depicts correlation findings for the Self Defined Health Promoting Goals Scale with the Power as Knowing Participation in Change Tool. It is noted that correlations at T1 for SDHPG and PKPCT are not significant ($r = .09$); however, the correlations progressively increase through time to a strong significant correlation of $r = .62$ at T7 ($p < .01$).

Research Questions

The general research question asked: "What are the changes in power and self defined health promoting goals for chronic care patients who do and do not participate in an Ericksonian hypnotherapeutic support group?"

Both the traditional support groups and the hypnosis groups significantly improved in power and self defined health promoting goals from T1 to T7. No significant difference was found between the traditional support groups and the

Table 10

Correlation Coefficients between Self Defined Health Promoting Goals Scales and PKPCT for the Overall Sample at Seven Time Points

SDHPG	T1	T2	T3	T4	T5	T6	T7
PKPCT							
T1	.09						
T2		.29*					
T3			.29*				
T4				.44**			
T5					.46**		
T6						.52**	
T7							.62**

* $p < .05$ **$p < .01$

Ericksonian hypnotherapeutic support groups in terms of power and self defined health promoting goals from T1 to T7. These findings are detailed below in response to the specific research questions asked in this study.

The first specific research question asked: "Does power vary differently over time for chronic care patients who do and do not participate in an Ericksonian hypnotherapeutic support group?" A repeated measures ANOVA was computed with power as the dependent variable and type of support group and time as the independent variables. The assumptions of homogeneity of dispersion, Box's M = 64.98; F (28, 5237) = 1.90, p = .003 and sphericity, Mauchly's W = .132; $X2$ (20, N = 46) = 84.57, p < .001 were not met. Therefore, multivariate tests were used. Findings revealed a statistically significant effect of time on power, Pillai's Trace = .520; F (6,39) = 7.04, p < .001. This means there was a significant improvement in power for the total sample over the ten weeks of time. No significant difference was found between treatment groups, F (1, 44) = .361, p = .55 and there was no significant interaction effect, Pillai's Trace = .066; F (6, 39) = .457, p = .836. Table 11 illustrates the results of this analysis.

Table 12 illustrates the mean change over time for power in the traditional support groups and the Ericksonian hypnotherapeutic support groups. Figure 1 illustrates change in power for the traditional support groups and the Ericksonian hypnotherapeutic support groups over the seven points in time for this study.

The second specific research question asked: "Do self defined health promoting goals vary differently over time for chronic care patients who do and do not participate in an Ericksonian hypnotherapeutic support group?"

Table 11

Summary of Analysis of Variance for the Traditional Support Group and the Ericksonian Hypnotherapeutic Support Group with Repeated Measures on Power

(N = 46)

Source	SS	df	MS	F	p
Between-Subjects					
Group	2714	1	2714.59	.36	.551
Error	330407.68	44	7509.27		
	Pillias Trace	df		F	
Within-Subjects					
Treatment	.52	6		7.04***	
Treatment *Group	.066	6		.457	
Error		39			

***p < .001

A repeated measures ANOVA was computed with self defined health promoting goals as the dependent variable and type of support group and time as the independent variables. The assumptions of homogeneity of dispersion, Box's M = 75.86; F (28, 5237) = 2.22, p < .001 and sphericity, Mauchly's W = .116; $X2$ (20, N = 46) = 89.95, p < .001 were not met. Therefore, multivariate tests were used. A statistically significant effect of time on self defined health promoting goals was found, Pillai's Trace = .595; F (6, 39) = 9.55, p < .001. This finding means that there was a significant progression toward

Table 12

Measures of Central Tendency for the PKPCT at Seven Time Points for the Traditional Support Groups and the Ericksonian Hypnotherapeutic Support Groups

Groups	Time	n	Mean	SD	Minimum	Maximum
Traditional	1	19	257.12	40.66	175.50	309.00
Support	2	16	265.57	32.77	186.90	310.00
Group	3	14	263.86	34.71	186.90	308.00
	4	16	268.93	45.26	157.00	325.00
	5	14	274.42	36.37	192.00	331.00
	6	18	286.29	36.23	192.00	336.00
	7	19	274.69	44.81	192.00	336.00
Ericksonian	1	30	264.92	31.96	213.00	333.00
Hypnosis	2	26	269.31	35.19	214.00	331.00
Support	3	24	269.01	36.46	209.82	336.00
Group	4	26	272.66	34.88	196.64	335.00
	5	27	277.22	36.64	169.18	336.00
	6	23	286.67	41.19	203.00	359.72
	7	27	286.26	39.18	212.00	336.00

Note: Possible range of PKPCT is 48-336

actualization of self defined health promoting goals for the total sample over ten weeks time. Findings indicated no statistically significant difference between treatment groups, F (1, 44) = 1.50, p = .227 and no significant interaction effect, Pillai's Trace = .140; F (6, 39) = 1.058, p = .404. The results of this analysis are depicted in Table 13.

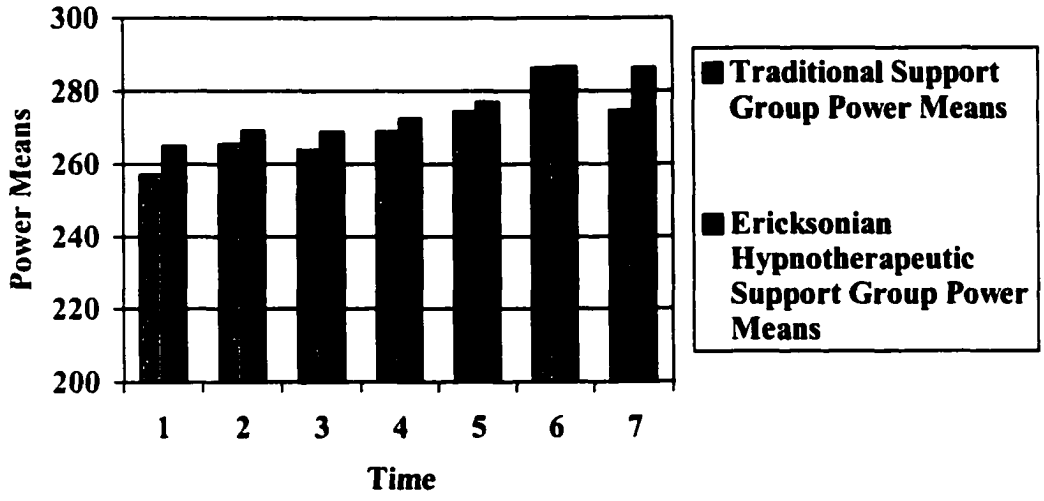

Figure 1. Using Mean Power Scores to Identify Power Over Seven Points In Time For The Traditional Support Group And The Ericksonian Hypnotherapeutic Support Groups

The magnitude of mean change toward health promoting goals was observed to be 18.4% from T1 to T6 and 18.0% from T1 to T7 for the traditional support group as compared to 34.8% from T1 to T6 and 33.9% from T1 to T7 for the Ericksonian hypnotherapeutic support group.

The mean change over time for self defined health promoting goals scale for the traditional support groups and the Ericksonian hypnotherapeutic support groups are illustrated in Table 14.

Changes in the Self Defined Health Promoting Goals Scale for the traditional support groups and the Ericksonian Hypnotherapeutic support groups over the seven points in time are depicted in Figure 2.

Table 13

Summary of Analysis of Variance for the Traditional Support Group and the Ericksonian Hypnotherapeutic Support Group with Repeated Measures on Self Defined Health Promoting Goals

(N = 46)

Source	SS	df	MS	F	p
Between-Subjects					
Group	4972.03	1	4972.03	1.5	.227
Error	145585.27	44	3308.76		
	Pillias Trace	df		F	
Within-Subjects					
Treatment	.60	6		9.55***	
Treatment *Group	.140	6		1.06	
Error		39			

***p < .001

Ancillary Analysis

A question on the evaluation of satisfaction with group process was: "Were you satisfied with your group?" A chi-square analysis indicated there was no significant difference in the traditional and Ericksonian hypnotherapeutic support groups in terms of their satisfaction with group experience. Eleven (58%) of the participants in the traditional support group conveyed they were very satisfied with their group as compared to 21 (78%) of participants in the Ericksonian hypnotherapeutic support group. In the traditional support group 6 participants (32%) reported they were moderately satisfied with their group as compared to 6

participants (22%) in the hypnosis group. Two participants (11%) in the traditional support group relayed they were minimally satisfied with their support group. No participants in the hypnosis group relayed minimal satisfaction with their group experience.

Table 14

Measures of Central Tendency for the Self Defined Health Promoting Goals VAS at Seven Time Points for the Traditional Support Group and the Ericksonian Hypnotherapeutic Support Group

Groups	Time	n	Mean	SD	Minimum	Maximum
Traditional	1	19	35.21	22.24	.00	89.00
Support	2	16	37.16	25.13	8.00	93.00
Group	3	14	42.38	24.70	13.66	95.00
	4	16	47.47	23.58	14.00	95.00
	5	14	48.75	25.22	15.00	95.00
	6	18	53.63	24.85	15.00	99.00
	7	19	53.26	26.18	19.00	97.00
Ericksonian	1	30	33.53	26.99	.00	85.00
Hypnosis	2	26	39.78	27.33	2.00	95.00
Support	3	24	43.17	26.39	.00	96.00
Group	4	26	53.05	23.67	7.00	97.00
	5	27	57.83	25.20	.00	89.00
	6	23	68.29	26.53	6.00	99.00
	7	27	67.44	29.26	.00	97.00

Note: Possible Range of VAS is 0-100

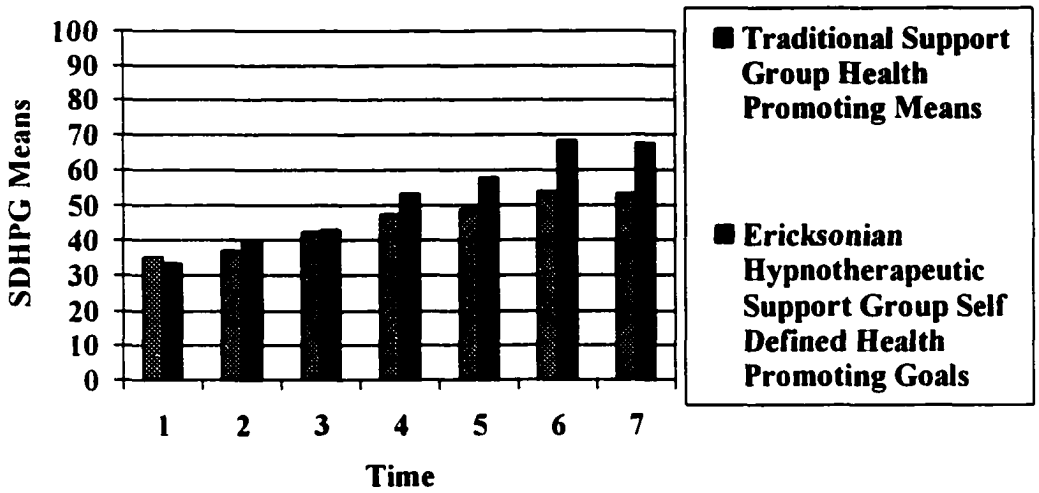

Figure 2. Using Mean Visual Analogue Scores to Identify Self Defined Health Promoting Goals Over Seven Points in Time for the Traditional Support Group and the Ericksonian Hypnotherapeutic Support Group

Some participants added qualitative comments on the satisfaction evaluation form. Sample comments include:

> It was my first experience of support group. I think it helped me to talk to other people who have the same kind of problems. It was a positive experience for me. I am looking forward to receive your tape and putting it to good use. Thanks for having me in your program.
>
> This group of people were very comfortable to be with. I think I like the sharing and listening and that seems to be the bottom line?
>
> I enjoyed hearing from the others what they have been going through with their illnesses and how they are coping. I felt caring and support from and for the others. That alone made it worth participating.
>
> I found the groups to be very helpful, very honest and very thought provoking. I had never been involved in a "group" session and I really enjoyed the freedom through which I expressed myself. Thanks for a great experience.
>
> The group taught me to accept and seek my rights and my role as a chronic pain sufferer. It gave me the insight that I do not need others to give me permission to voice my needs stemming from my condition.

I felt everyone was very supportive.

I would like to continue these meetings on a regular basis.

It was too short!

In addition to conveying verbally to the investigator their disappointment in not being randomized to the hypnosis group, some participants in the traditional groups wrote how they wanted to learn tools to help them live better in the future with chronic illness. For example, one participant stated,

> I really wanted 'tools' to use in helping me cope when on my own – which is most of the time. The self help group was helpful in that we would know there are people in similar situations coping with perhaps bigger problems. The companionship (sharing) was helpful at that time – but then we're on our own again – back to square one more or less.

Several participants in both types of support groups indicated a desire for a continuation of the support groups.

Random samples of matched audiotaped sessions of the traditional and Ericksonian hypnotherapeutic support groups were reviewed by three members of The New York Milton H. Erickson Society of Psychotherapy and Hypnosis. Although the primary purpose of these reviewers was to confirm that the participants in the traditional support groups did not receive formal inductions of progressive relaxation, imagery or hypnosis, it was noted that the reviewers additionally conveyed that the group processes in the traditional groups were primarily problem focused on a past and present orientation to time. Reviewers confirmed the use of many formal relaxation, imagery and hypnosis inductions in the Ericksonian hypnotherapeutic support groups and additionally described that

the Ericksonian hypnotherapeutic support group processes focused more on discovering solutions rather than dwelling with the problems of living with chronic illness. Time orientation in the Ericksonian hypnotherapeutic support groups was described by reviewers as more focused on the present and the future, particularly in terms of utilizing the awareness gained in the group so participants could ease their future life with chronic illness. Reviewers stated that many interspersed suggestions in the Ericksonian hypnotherapeutic support group had future orientation. Emergent themes regarding the groups in this study and described by reviewers include:

The pain is not better but I feel better.

Accepting what I can change.

The physical problems are the catalyst for changing patterns.

Turning to new arenas for healing.

Be gentle and patient till self healing begins.

The group as family.

Taking the support of the group home.

Be realistic.

One reviewer of the Ericksonian hypnotherapeutic support group said the primary theme in the group was awareness, and learning to focus on what's pertinent. Another reviewer described the traditional support group as very concrete and characterized by "a lot of advice giving... If this group improves it will be because the members are able to organize around a crisis. Perhaps the crisis itself, will provide the bridge to empowerment as long as they have the

group for mirroring." In general the comments by reviewers were more favorable regarding the health promoting benefits of the Ericksonian hypnotherapeutic support groups as compared to the traditional support groups.

CHAPTER V

DISCUSSION OF THE FINDINGS

Theoretical Perspective

Rogers' Science of Unitary Human Beings was the guiding theoretical framework for this study. Within the Science of Unitary Beings groups are unique patterning of individual human fields in mutual process with the environmental field. Rogers (1990) defined groups as "two or more individuals" (p. 8) and emphasized the principles of homeodynamics, which postulate the nature of change are applicable to group fields. Hence, resonancy, helicy and integrality are implicit in group field pandimensional emergent change. Manifestations of patterning in each group field are always innovative and emerge integrally with each group's own unique environmental field (Rogers, 1990).

Support groups are modalities for health patterning with human contact, authentic dialogue and meaningful presence, for, as emphasized by Barrett (1990a), "people need people" (p. 34). As people join together in support groups and grow in pandimensional awareness, discover their choices, have freedom to act intentionally and the capacity to involve themselves in creating desired change, power is enhanced and health promoting goals are actualized.

This study explored how traditional support groups and Ericksonian hypnotherapeutic support groups as Rogerian science patterning modalities

enhance power and facilitate actualization of selected health promoting goals for persons with chronic physical illness. Persons diagnosed with chronic illness need health promotion as they typically anticipate their future lives as evolving with emerging limitations, dependency, powerlessness, helplessness, hopelessness, passivity and declining health (Gregg, Robertus & Stone, 1989; Iocalano, 1994; Lindsey, 1997; Meyerowitz, Heinrich & Schag, 1983; Miller, 1992; Telch & Telch, 1986). Such a perspective of diminished power and anticipated declining health suggests a need for patterning modalities in nursing that may augment power and health for people living with chronic illness.

Martha Rogers (1970, 1990, 1992, 1994) consistently emphasized that the purpose of nursing is the promotion of health and well-being of all persons, particularly with the use of non-invasive patterning modalities. Support groups are non-invasive patterning modalities that help people with chronic illness for a variety of reasons. Yalom (1995) articulated 11 therapeutic factors that may emerge to help people in psychotherapeutic groups and Spira (1997b) suggests that these factors similarly can help people in support groups for medically ill patients. These therapeutic factors include instillation of hope, universality, imparting information, altruism, the corrective recapitulation of the primary family group, developing socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis and existential factors. These factors evolve through time in support groups and may influence participants' experience of power and progression toward self defined health promoting goals.

Ericksonian hypnotherapy is a non-invasive patterning modality in which

facilitators actively utilize therapeutic suggestions and hypnotic inductions in communication with clients. By patterning with pacing, leading, direct and indirect, interspersed suggestions, therapeutic storytelling and metaphors, reframing and providing education in progressive relaxation, imagery and self hypnosis, a facilitator utilizing Ericksonian hypnotherapy actively strives to help people learn ways to expand their awareness and discovery of therapeutic choices to facilitate ongoing actualization of meaningful and desirable health promoting change. The facilitator in the Ericksonian hypnotherapeutic support groups provided participants with Ericksonian hypnotherapeutic approaches and education in the life skill of self hypnosis. This additional education in self hypnosis could expand participants' awareness of options and choices regarding how they can participate more knowingly in change while living with chronic illness.

Barrett et al. (1997) emphasized that the goal in nursing is to facilitate power enhancement by changing the environmental pattern. Barrett (1983) described power within the Science of Unitary Human Beings as knowing participation in change. Barrett states that people have the capacity to utilize awareness and freedom to intentionally guide their participation in actualizing selected health promoting potentials.

Groups that are formed with specific health promoting, therapeutic intentions fulfill an unmet need in our fragmented society, as "people are hungry to be heard, comforted and supported" (Lawson, 1998, p. 21). As people with chronic illness support each other in groups, a sense of cohesiveness that evolves

can help group members experience hope for the future as they discover "many dimensions of themselves" (Lawson, 1998, p. 23). Helping people discover many dimensions of themselves supports Rogers' description of pandimensionality as an evolving capacity to enhance one's perspectives and increase one's awareness well beyond a limited view and experience of life that is reminiscent of Abbott's (1952) Flatland.

Phillips (1997) suggested that unitary nursing patterning of the environmental field can facilitate health promoting change and unitary well-being. The use of support groups for persons with chronic illness within a hospital setting changes the patterning of the environmental field and conveys possibilities for power and health promotion despite a diagnosis of chronic disease. The patterning process of being in a support group may be instrumental in promoting improvement in power and progression toward desired health goals for participants in both types of support groups.

Support groups and education in self hypnosis are patterning-healing modalities that can be integrated into nursing practice to facilitate power and health for persons living with chronic physical illness. However, the health promoting and power enhancing benefits of traditional and Ericksonian hypnotherapeutic support groups for people living with chronic illness have not been systematically explored. Based on a Rogerian framework, this study posed research questions that examined changes in power and self defined health promoting goals for 49 chronically ill adults who participated in traditional or Ericksonian hypnotherapeutic support groups. As the findings in this study

suggest, power and self defined health promoting goals are positively correlated, discussion regarding the significant improvement in power and progression toward health promoting goals for the participants in both types of groups are naturally interwoven.

Research Questions

The first specific research question asked, "Does power vary differently over time for chronic care patients who do and do not participate in an Ericksonian hypnotherapeutic support group?" Analysis for this question revealed that although there were no significant differences between the two types of groups, there was a significant increase in power over time for participants in both traditional and Ericksonian hypnotherapeutic support groups. The magnitude of mean change in power from T1 to T7 for participants in the traditional support groups was an increase of 17.57 points, from 257.12 to 274.69. The obtained effect size for the traditional support groups in power was a moderate .43. The mean change for the Ericksonian hypnotherapeutic support groups from T1 to T7 was 21.34 points, from 264.92 to 286.26. The obtained effect size for the Ericksonian hypnotherapeutic support groups was .67, which is a moderate to large effect size.

These findings are congruent with the findings of A. S. Smith (1993) in her qualitative study on power in which she interviewed 15 persons who attended a support group for cardiac rehabilitation. The participants in Smith's study reported that the process of being in a support group facilitated their recovery and

capacity to knowingly participate and make health promoting changes. A. S. Smith qualitatively analyzed and linked the support group participants' experiences to enhanced power as knowing participation in change.

Lackner (2000) emphasized that health promotion for persons with chronic illness is linked to their active participation in a support network. In a qualitative study of social support, Lackner conducted 60 interviews with chronically ill persons with multiple sclerosis ($\underline{n} = 30$) and fibromyalgia ($\underline{n} = 30$). Lackner described how participants who are actively engaged in their social support are able to experience some mastery in a life that may have formerly been dominated by a perception of having an uncontrollable illness. Although Lackner's study did not specifically examine power as knowing participation in change, the findings suggest that active participation in a support group can facilitate health for persons with chronic illness. As power involves knowing participation in change, possibly the participants in both types of groups in the present study experienced a significant increase in power because of their active participation in a support group. This active participation combined with the therapeutic factors of support groups as described by Yalom (1995) may have influenced the significant improvement in power and progression toward health goals for the participants in this study. Since both types of groups in the present study significantly improved in power and in progression toward self defined health goals, a between group difference was likely more difficult to detect.

The "sharing of life stories" may have helped in enhancing power for participants in both types of support groups (Bramlett, 1993). Bramlett found that

the process of reminescence significantly enhanced elders' power. Possibly in the present study the process of reminescence that naturally occurred as people shared their life stories influenced the significant increase in power demonstrated by participants in both types of groups. For example, one participant wrote on the evaluation form, "I enjoyed hearing from the others what they have been going through with their illnesses and how they are coping. I felt caring and support from and for the others. That alone made it worth participating."

The participants in the nine support groups in this study communicated a serious need for support groups for persons living with chronic illness, particularly with today's society and emphasis on individuality and independence. Lawson (1998), in the book Holistic Health Promotion and Complementary Therapies: A Resource of Integrative Practice, said that support groups for persons with chronic illness are essential in that they can facilitate power, freedom, discovery of resources and strengths and hope. Yalom (1995) and Spira (1997b) illustrate the therapeutic factors and healing capacities of groups for medically ill patients, and emphasize the importance for further research to demonstrate the efficacy of groups for improving the quality of life and physical health of medically ill patients. Yalom (1995) describes the instillation of hope as a crucial therapeutic factor for helping people in groups. Group facilitators are encouraged to capitalize on this factor "by doing whatever we can to increase patients' belief and confidence in the efficacy of the group mode" (p. 5). The task of instilling hope for healing begins before the group starts, in the pre-group orientation (Yalom, 1995).

Suggestions implying hope for a more healthful future were offered to participants in both types of groups in this study, which may have influenced their significant improvement in power. An intention conveyed to the participants in this study was that health promotion is possible for people living with chronic illness. This perspective of promoting health despite living with a chronic illness is congruent with Moch's (1998) health-within-illness model, which posits that "illness is a potential catalyst for growth" (p. 305). In a qualitative study, Moch interviewed 20 women regarding their experience with breast cancer. Themes that emerged from these interviews suggest congruence with power, in that illness can provide people with an heightened opportunity to create positive change and live with increased meaningfulness, connectedness/relatedness and awareness of self. This is the health-within-illness perspective, which was implied in the present study via therapeutic suggestions. One participant illustrated this perspective on the demographic sheet in which she described her health as, "Aside from this illness, I am OK."

All participants in the present study received an introductory therapeutic suggestion in the flyers that described the research project with a heading entitled "Promoting Health with Support Groups" (see Appendix G). Such a suggestion implies hope and gives a health promoting meaning to attending support groups. Additional therapeutic suggestions were offered at the initial meeting with participants during the orientation session, when the investigator introduced the two types of groups with the therapeutic suggestion that the literature suggests both types of support groups are health promoting. This suggestion again

emerged at the first orientation when several persons conveyed their hope that they would be randomized into the hypnosis group. Subsequently, this therapeutic suggestion implying hope for health was offered at all orientation sessions.

Wall (2000) demonstrated that hope is positively correlated with power in her study with ninety-seven lung cancer patients who participated in an exercise or no exercise preoperative program ($r = .62$, $p < .001$ at T1; $r = .59$, $p < .001$ at T2; $r = .64$, $p < .001$ at T3). Wall linked power with actualizing health goals, as hopeful individuals were described as those who actively participate in goal directed activities. In the present study, with the suggested hopeful awareness that support groups are health promoting for people with chronic illness, participants were able to freely choose to act intentionally and involve themselves in creating health promoting change by electing to attend the support groups and participate in the study. These suggestions received by all participants may have contributed to significantly enhancing participants' power in both the traditional and Ericksonian hypnotherapeutic support groups.

The therapeutic benefits experienced by participants in support groups are additionally influenced by the expertise of the facilitators (Spira, 1997a). All of the nurses who facilitated the groups in this study had expertise in Rogerian nursing science and employed unitary nursing practice (Barrett, 1998b) and pattern appreciation (Cowling, 1997) to facilitate group rapport, meaningful dialogue, disclosure and the sharing of each member's lived experience with chronic illness. The process of facilitating the groups in this study by utilizing

Rogerian nursing science may have positively influenced participants' significant improvement in power and progression toward their chosen health goals.

The experience of pattern appreciation in both types of support groups may have also contributed to significantly enhancing participants' power. Pattern appreciation is a unitary model of nursing science and practice derived from the concepts and principles of the Science of Unitary Human Beings (Cowling, 1997). Cowling describes pattern appreciation as the process of "being aware of, sensitive to, and grateful for the uniqueness of another's pattern" (p. 53). Pattern appreciation may have facilitated participants' experience of the therapeutic factors in the support groups in this study and its operation is suggested in the following comments participants wrote on the Evaluation of Satisfaction with Group Process form (see Appendix D).

> This group touched my heart and I felt very at ease with all of them otherwise I would never have been able to close my eyes and breathe, and let myself safely go inside my soul and learn about myself and my own ability to take care of the pain, fear, etc.
>
> The group taught me to accept and seek my rights and my role as a chronic pain sufferer. It gave me the insight that I do not need others to give me the permission to voice my needs stemming from my condition. The group helped me see myself through their eyes, their experience, their pain, and their interaction with others – in this way I came to find my voice for my condition which gave me back some control of my life that I had lost due to the "restrictions" of my chronic pain. I find that each and every day they [group members] still touch my life with a thought they had spoken, a conviction they shared, or a technique to help deal with the pain. The group therapy does not make the pain disappear, instead it helped me focus on it, treat it realistically and gave me techniques to try and deal with it so that I can take more control of my life.
>
> I found the groups to be extremely helpful in allowing myself to take inventory of myself! I came to realize I am responsible for how I create and act upon my environment and how I react to a situation determines its

> ultimate emotional outcome. And most importantly, learning how to breathe during stress is a priceless gift.

Cowling (1997) linked pattern appreciation to power in the following statements, in that "unitary pattern appreciation is knowing participation in one's own patterning" and "the participatory nature of unitary pattern appreciation is requisite to knowing participation in change" (p. 140). The traditional and Ericksonian hypnotherapeutic support groups in this study may have helped enhance power as members actively participated in an experience of group pattern appreciation.

The second specific research question asked, "Do self defined health promoting goals vary differently over time for chronic care patients who do and do not participate in an Ericksonian hypnotherapeutic support group?" Analysis for this question indicated that although there were no statistically significant differences detected between the two forms of support groups, there were significant changes in progression toward self defined health promoting goals over time for participants in both the traditional and Ericksonian hypnotherapeutic support groups.

In this study the traditional support group participants achieved an 18% magnitude of mean change toward their health goals from T1 to T7. The obtained effect size for this mean change was a strong .81. Participants in the Ericksonian hypnotherapeutic support group achieved a 33.9% magnitude of mean change toward their health goals from T1 to T7 and the obtained effect size was a strong 1.26. This compares favorably with Matas's (1997a) findings in which 65

persons who participated in her therapeutic touch and centering clinic achieved an average of 42% magnitude of change toward their health goals, as measured by the Self Defined Health Promoting Goals Scale utilized in this study. Instead of working in a group in which the chronically ill participants attended an average of four sessions, Matas worked with healthy and ill individual participants for an average of six sessions. Considering these differences in number of sessions and types of population, these findings suggest the need for further research on health promotion with non-invasive healing patterning modalities, particularly with support groups.

Anderson (2000) emphasized that groups warrant further exploration in Rogerian science because of health promotion and cost containment benefits. K. Matas's (personal communication, June 8, 2000) and Spira's (1997b) recommendations that support groups should be utilized by people living with chronic illness for health promoting benefits are illustrated in the following participants' comments on the Evaluation of Satisfaction with Group Process (see Appendix D) form: "I feel this kind of sharing and support is extremely important and helpful, emotionally and physically."; "I found the groups very helpful. My methods of coping with lung cancer and the loss of my good husband were reinforced."; "All in all it was a meaningful experience and I have used the relaxation technique innumerable times during this very taxing time in my life."

Additional explanations for why participants in both types of groups significantly progressed toward their desired health goals and enhanced their power could be related to the group facilitators' process of unitary nursing

practice. Unitary nursing practice occurs when nurses utilize awareness of healthful patterning in mutual process for the health promotion of all people.

In this study, unitary nursing practice was evident as pattern manifestation knowing and voluntary mutual patterning were utilized by all of the group facilitators. Pattern manifestation knowing is described by Barrett (1998b) as a continuous process of apprehending the human and environmental field manifestations that pertain to health. Voluntary mutual patterning (Barrett, 1998b) is the continuous process whereby the nurse assists client(s)/group(s) to freely choose with awareness ways to participate in facilitating their well-being. Hence, an unitary nurse group facilitator patterns the environmental field to promote harmony related to health (Barrett, 1988). In Rogerian practice, facilitating support groups necessitates ongoing pattern manifestation knowing and voluntary mutual patterning as the nurse group facilitator works together in mutual process with the unique group field to facilitate the health and well-being of each group member. As this study was publicized with flyers entitled Promoting Health with Support Groups, health was suggestively linked with support groups for persons living with chronic illness.

Health within the Science of Unitary Human Beings is viewed as a value defined by each individual. According to Barrett (1990a), health is linked to power as "a process of actualizing potentials for well being by knowing participation in change" (p. 33). This is congruent with the eudaimonistic model of health, a view of health which is concerned with well-being, actualization and self realization of potentials, strengths and resources (Phillips, 1990b) and Moch's

health-within-illness perspective. Health patterning, in Rogerian nursing practice, is the process in which nurses assist people in their eudaimonistic healing as knowing participation in change and enhance their ability to "transform themselves in creative mutual process with their environments" (Barrett, 1990a, p. 33). The health patterning evidenced in the nine support groups in this study facilitated creative mutual process transformation as group participants significantly progressed toward their chosen health goals. The provision of these nine support groups helped actualize Rogers stated purpose of nursing, "to promote the health and well-being for all persons wherever they are" (Rogers, 1990, p. 6). This is congruent with Justice's (1998) recommendation that health in the next century needs to be defined as well-being.

Phillips (1997) described how patterning our environmental field with patterning-healing modalities can facilitate health promoting change and unitary well-being. Sample attributes of unitary well-being as described by Phillips (1997) include compassion, freedom of choosing, participating in change, realizing potentials, peace, joy, experiencing mutual process, feelings of fulfillment, awareness of purpose and giving and receiving. In this study, participants in both the traditional and Ericksonian hypnotherapeutic support group's participants shared several expressions of feeling power and unitary well-being.

To illustrate, participants in the traditional support groups wrote the following in the comment section of the satisfaction evaluation form.

> I think it helped me to talk with other people who have the same kind of problems. It was a positive experience.
>
> Listening to others struggle with serious health issues allowed me to see that my worries are definitely "part of the package." It has been a great comfort to know that this 'Running Discussion' with myself is natural and a shared experience with others facing very serious and 'possibly' disabling illness. This was my first group experience and it will now be part of my life forever. Many, many thanks and best wishes.
>
> There was / is a feeling of freedom that I felt for the most part.

Similarly in the Ericksonian hypnotherapeutic support groups participants wrote the following, which suggest power and unitary well-being.

> I learned so much, I am using some of the things I learned.
>
> Enjoyed the meetings very much.
>
> My experience with this group was extremely positive.
>
> I felt automatically comfortable with the group. It was a great experience to meet and talk openly with a variety of people that I hardly knew. I was impressed and inspired by their attitudes and strengths in dealing with their situations. It was a good experience for me and one I hope will stay with me.
>
> It was a wonderful experience.
>
> I found the groups to be very helpful, very honest and very thought provoking. I had never been involved in a group and I really enjoyed the freedom through which I expressed myself. Thanks for a great experience.

These qualitative and general comments, combined with the quantitative findings in this study, suggest the need for further research and discovery of how support groups can facilitate power and unitary health as well-being for persons living with chronic illness.

Perspectives on the Changes in Power and Self Defined Health Promoting Goals

The following discussion regarding the nine support groups in this study may further illuminate pattern manifestations that facilitate power and progression toward self selected health promoting goals.

An a priori perspective of the investigator was that Ericksonian hypnotherapy is a health patterning modality that is closely aligned with Rogerian nursing science and the practice of facilitating power as knowing participation in change. As Ericksonian hypnotic approaches and linguistic patterns focus on enhancing awareness and discovery of health promoting choices while encouraging active participation in actualizing desired health promoting goals, this investigator was not surprised that participants in the Ericksonian hypnotherapeutic support group significantly enhanced their power and significantly progressed toward their chosen health goals. An intention of the Ericksonian hypnotherapeutic support groups was for participants to learn how to evoke self hypnosis to promote increased comfort and relaxation.

However, the investigator was somewhat surprised that participants in the traditional support group also similarly and significantly enhanced their power and progressed toward their desired health goals. In addition to experiencing the therapeutic factors described by Yalom (1995), members in the traditional support groups may have benefited from experiencing the following processes, which may have similarly influenced the significant enhancement of power and progression toward self defined health goals for participants in the Ericksonian hypnotherapeutic support group as well.

Pattern appreciation may have influenced participants' significant enhancement of power and progression toward their self selected health promoting goals in both types of groups. Pattern appreciation in unitary nursing practice involves openly appreciating the uniqueness of each human field pattern in mutual process within their own unique integral environmental field pattern. Openness, in pattern appreciation is considered "the grounding context for mutual sharing" (Cowling, 1997, p. 131).

As all of the group facilitators in this study had education and experiential practice in unitary nursing, personal pattern exploration, openness and pattern appreciation as "an art form for using knowledge creatively in practice" (Cowling, 1997, p. 135), both the traditional and hypnotherapeutic support group participants may have experienced pattern appreciation that subsequently enhanced their power and progression toward their desired health goals. The experience of intense rapport, meaningful dialogue and pattern appreciation with group facilitators and group members in this study may have positively influenced participants' power and progression toward actualizing self defined health goals. For example, one participant wrote on the Evaluation of Satisfaction with Group Process form (see Appendix D), "I found the groups to be very helpful, very honest and very thought provoking...I really enjoyed the freedom through which I expressed myself."

Additional health promoting benefits may have accrued from participants' experience of disclosure, as described by Pennebaker (Dienstfrey & Pennebaker, 1999). Disclosure involves "telling previously unacceptable aspects of one's life

story in a manner that leads to their acceptance as a legitimate part of one's life" (Booth, 1999, p. 171). Many participants in both the traditional and the Ericksonian hypnotherapeutic support groups relayed how often they avoided sharing with others their experiences of living with chronic illness because, as one participant conveyed, "people don't want to hear about it, it's easier to just say I'm fine." Such inhibition is contrary to the experience of disclosure and is considered harmful to the health of individuals (Traue & Deighton, 1999). Smyth (1999) found that written disclosure improved the health of 112 patients with the chronic conditions of asthma or rheumatoid arthritis. Although Smyth's study utilized disclosure through writing, Pennibaker also emphasized the health promoting benefits of disclosure can be experienced in support groups (Dienstfrey & Pennibaker, 1999). As both the traditional and Ericksonian hypnotherapeutic support groups emphasized sharing one's life story regarding living with a chronic illness, the experience of disclosure may have also influenced findings and enhanced participants' power and progression toward their self defined health promoting goals. For example, one participant wrote on the Evaluation of Satisfaction with Group Process form,

> I entered the group feeling alienated from the medical doctors as a whole, as people to turn to for help...I am feeling that one's own feelings give a lot of clues, directions to the path of health... your group gave me more insight, consciousness about how I am taking care of myself ...taking the kind of responsibility and finding individuals, one by one to help me firm up a new basis within myself was highlighted in the group....whatever happened in the group was vital to going on in my pursuit of healing.

Sharing therapeutic stories may have also contributed to the significant increase in power and progression toward self selected health promoting goals for

participants in both the traditional and Ericksonian hypnotherapeutic support groups. Therapeutic stories were regularly offered to participants in the Ericksonian hypnotherapeutic support groups; however, such communication patterns were also offered by group members in the traditional support groups. The reviewers of the audiotaped sessions of the traditional and Ericksonian hypnotherapeutic support groups confirmed the use of many therapeutic stories in both types of groups. A recognized difference in the groups was that the reviewers conveyed that the investigator, as the facilitator of the Ericksonian hypnotherapeutic support groups, encouraged the sharing of life stories among participants and initiated several therapeutic stories related to learning, discovery of possibilities and increasing comfort.

Conversely, in the traditional support groups, therapeutic stories were primarily initiated by other group members. For example, in one traditional support group, one woman described how she frequently meditated and therapeutically replenished by walking through the New York Botanical Gardens and she attributed such meditations to her improved health and well-being. This is an example of a therapeutic story, which provides indirect therapeutic suggestions on how one can meditate and healthfully replenish. Milton Erickson often utilized therapeutic stories to hypnotically suggest to clients health promoting actions and perspectives that they can then choose, if desired, to actualize (Rosen, 1982). In this manner, participants hearing such a therapeutic story may become increasingly aware of their choices and freedom to actualize self-selected health promoting potentialities as they become involved in creating

change.

The reviewers of the randomly selected audiotapes group sessions confirmed that the traditional support groups did not receive any formal inductions of hypnosis, relaxation and imagery. However, informal hypnotherapeutic suggestions in therapeutic storytelling may have influenced the traditional support group participants' significant increase in power and progression toward their chosen health goals. Further research is needed to clarify why participants in both the traditional and Ericksonian hypnotherapeutic support groups experienced a significant improvement in power and progression toward their self defined health promoting goals.

Several participants in this study emphasized in their responses on the Satisfaction with Group Process evaluation form that support groups are beneficial and should be ongoing as illustrated in comments written on the Evaluation of Satisfaction with Group Process form,

> I would have liked the group to continue... It was a really valuable experience for me....
> My suggestion is these kinds of groups should be ongoing....
> In my own case it took the 5 sessions for me to realize that we were all pretty lonely in the place we were and that the 5 sessions were preliminary to deeper work....
> It was too short!

Ancillary Findings

In support of the randomization process, no statistically significant differences were detected between the traditional support groups and the Ericksonian hypnotherapeutic support groups in terms of age, gender, marital

status, ethnicity, education or employment. No significant differences were revealed between the traditional and Ericksonian hypnotherapeutic support groups in terms of participants' experience of a major change or crisis in the previous six months, use of prayer, meditation, imagery or relaxation techniques or previous experience with hypnosis. A statistically significant difference between the traditional and Ericksonian hypnotherapeutic support groups was obtained regarding participants' previous or current support group experience. The primary distinction noted was that more participants in the Ericksonian hypnotherapeutic support groups reported no previous experience with support groups as compared to the participants in the traditional support groups. It is unclear how this may have influenced findings. Possibly, participants with more experience in support groups may have had an accelerated response to the health promoting benefits of the support group in this study because of prior learning effects.

Further ancillary analysis revealed no initial statistically significant correlation between power and self defined health promoting goals at T1. However, a statistically significant correlation was revealed from T2 - T7 with the correlation between power and self defined health promoting goals progressively strengthening through time. These findings provide encouraging support to Barrett's (1990a) perspective that power relates to health. In Rogerian science-based nursing health is viewed "as a process of actualizing potentials for well-being by knowing participation in change" (p. 33). This depiction of health implies a positive relationship between power and actualizing health goals.

However, the present study found no statistically significant relationship between power and self defined health promoting goals at T1 ($r = .09$). This finding at T1 is consistent with McNiff's (1995) findings in which power and perceived health as measured by the Cantril Ladder for health was found to be not significantly correlated ($r = .24$) in sixty eight adults with long-term care needs. McNiff's correlations were derived from a single point in time for the measurement of power and perceived health. In the present study, change was measured over time and the strength of correlation between power and self defined health goals was found to progressively increase over time, to show a significant correlation of $r = .62$ at T7 ($p < .01$). These findings support Barrett's (1990) description that "as the health patterning process evolves" (p. 113), knowing participation and actualizing potentials for human change are enhanced.

Methodological Issues

The research design utilized in this study was a quantitative analysis which examined changes in power and self defined health promoting goals over seven points in time for persons with chronic illness who participated in either a traditional support group or an Ericksonian hypnotherapeutic support group. This study found that both traditional support groups and Ericksonian hypnotherapeutic support groups significantly enhanced power and progression toward actualizing health promoting goals for 49 participants with chronic physical illness. Although no statistically significant difference was detected between the two types of groups, this may be related to the small number of

weekly group sessions or to the small sample size utilized in this study or the use of facilitators with homogeneous backgrounds in unitary nursing. A greater number of weekly group sessions and a larger sample size may have improved interpretability of the findings. However, as previously mentioned, recruitment was exceedingly difficult as many potential participants refused to participate in this study because they only wanted to be in the hypnosis group. The use of this small convenience sample limits the generalizability of these findings.

Within the Rogerian framework, a longitudinal design capturing patterns of changes over time is conceptually appropriate. The Power as Knowing Participation in Change tool developed by Barrett (1986) and utilized in this study was derived from Rogers' Science of Unitary Human Beings. As previously described, the PKPCT operationalizes four human field pattern manifestations which are integral with each other and constitute a person's power profile. The four measurable human field pattern manifestations are the constructs of awareness, choices, freedom to act intentionally and involvement in creating change.

The PKPCT has been critiqued in the literature as being too abstract for some participants, particularly in terms of the instructions (Barrett & Caroselli, 1998). To examine this issue, Barrett, Farren, Kim, Larkin and Mahoney (in press) conducted a study to examine the adequacy of the PKPCT instructions. Questionnaires were distributed to 175 undergraduate and graduate students to compare the PKPCT Version II instructions with a set of newly developed instructions. An independent t-test indicated no significant difference between

the Version II instructions and the newly developed instructions ($t = -1.33$, $df = 169$, $p = .185$). Further refinement of the instructions occurred and a second phase of this study surveyed 20 Rogerian scholars and methodological experts regarding the adequacy of the newly revised instructions. The experts recommended some clarifying and simplifying changes in the instructions which were instituted in Barrett's 1998 version of the PKPCT, VII, which this study utilized.

However, despite the use of the simplified instructions, during the initial orientation sessions some participants asked for clarification regarding the process of completing the PKPCT. Common questions pertained to a lack of understanding the four constructs of the tool. As the construct 'awareness' was the first construct encountered on the tool, participants frequently asked the investigator to clarify more specifically what this awareness pertained to, for example was this awareness to be focused on such things as their health condition, pain or health goals. These participants were again directed to the instructions on the PKPCT and the investigator typically reviewed them aloud. Some participants continued to convey less than full understanding of the tool, yet were able to complete the PKPCT with acceptable congruence for the repeat test item reliability for this sample. One participant from a traditional support group wrote on the evaluation form that the Barrett PKPCT was "vague, abstract, ambiguous and difficult to complete." The fact that some participants may have completed the tool without full understanding limits the interpretability of the findings in this study.

A different experience of the PKPCT was described by a participant in one of the traditional support groups. This participant reported to the investigator that her experience of completing the PKPCT was in itself therapeutic. She conveyed how profound the questions were and how in the process of contemplating her answers she expanded her awareness. She repeatedly expressed her appreciation of this tool throughout her group experience. Such a therapeutic experience by this participant (and perhaps others) with the PKPCT may have influenced the findings and be suggestive of patterns that may have increased participants' power in both the traditional and Ericksonian hypnotherapeutic support groups. It is still not fully known why some participants have difficulty with the instrument while others do not.

Matas (1996) stated the Self Defined Health Promoting Goals Scale is congruent with Rogers' science, as there is an emphasis on the unique diversity of each individual human field pattern. The Self Defined Health Promoting Goals Scale, as used in this study, recognizes such field pattern diversity as it measures each individual's self selected goal and anchors in the standardized, valid and reliable format of a visual analogue scale. As was promulgated by Rogers (1990), field pattern diversity between individuals makes explicit the need for individualization of nursing services. The SDHPG is both individualized and standardized for each participant. A methodological issue with this tool was that some participants in this study had initial difficulty and required some clarification regarding formulating their desired health goal. However, following this clarification, the SDHPG scale was generally quick and easy to administer

throughout the remainder of the study. Typically participants completed the SDHPG scale in less than one minute. No participant complained about this tool throughout the remaining duration of the study.

The repeated measures design utilized in this study was intended to statistically control for the field pattern diversity of individual differences among group participants. Possible problems with this design include carryover effects and learned responses as participants completed the research tools numerous times. However, Kim (2000) utilized the PKPCT in five repeated measures while examining health promoting benefits of magnets for persons experiencing chronic headaches. No report of statistical difficulty regarding the repeated administration of the PKPCT was reported (Kim, 2000). Kim (2000) did report greater variability for the correlation of the repeat item of superficial/profound on the involvement subscale, which was also observed in the present study. Kim's correlation on this item was .60 on T4 as compared to the present study's obtained correlation of .30 on T2. It is unclear how the variability of this superficial/profound repeat item on the involvement in creating change subscale might influence the reliability of the PKPCT.

Possibly if this study had continued over a longer period of time a between group difference may have been detected. In Telch and Telch's (1986) comparison of strategies study, 41 cancer patients met for 6 weeks in one of three groups. A significant difference was detected between a coping skills group (in which relaxation and communication techniques were taught), a nondirective support group and a no treatment control group. The coping skills group was

found to be statistically superior to the supportive group and the control group demonstrated a deterioration in psychological adjustment. Unfortunately, facilitators' expertise was not sufficiently discussed in the Telch and Telch study.

In Spiegel's (1993) study, a significant improvement in quality of life and longevity was found for a group of women with metastatic breast cancer who participated in support groups and received education in self hypnosis as compared to the comparison group who only received traditional medical treatment. The support group in Spiegel's study met weekly for one year. In the present study all support groups met for only five weeks. Possibly a longer duration of the support groups in the present study may have found a between group difference. Spiegal additionally collected data for several years following the completion of the group. In the present study, data were collected one month following the completion of the groups. Possibly a significant difference might have emerged if data could have been collected for a longer period following the completion of the groups in this study.

An additional unforeseen methodological issue was that the traditional support group facilitators had ample education in unitary nursing and pattern appreciation. The four traditional support groups in this study were facilitated by advanced practice nurses who were graduates or in their final practicum of a graduate program in holistic nursing and the five Ericksonian hypnotherapeutic support groups were facilitated by the investigator who is a faculty member at the same graduate program in holistic nursing. All of the group facilitators in this study may have been too homogeneous, as they all utilized a holistic/unitary

theory-based practice with an awareness of mutual process and human and environmental field patterning for promoting eudaimonistic health in support groups. Although the traditional group facilitators had not been trained in Ericksonian hypnosis, their professional holistic nursing training in presencing and dwelling with participants' expression of their lived experience with chronic illness may have facilitated patterning similar to Elkins' depiction of the experience of therapeutic hypnosis as an experience of intense rapport (Elkins & Larkin, 1995).

Possibly an experience of intense rapport facilitated a naturalistic and spontaneous experience of hypnosis among traditional support group members. For example, one participant in the traditional support group wrote in the comment section of the evaluation form about his experience of belonging and feeling a sense of freedom and comfort with the group. He stated, "I felt no pain when listening or talking with the group." In hypnosis, this would be considered suggestive of an experience of spontaneous hypnotic analgesia as this participant experienced such intense group rapport (Erickson, 1980e). In Rogerian science, this could be described as increasing pandimensional awareness, as he discovered increased comfort with awareness of presencing with his group. Such experiences in groups facilitated by unitary nurses, although not considered formal hypnosis, may have contributed to the significant improvement in power and progression toward self defined health promoting goals for participants for the traditional support groups in this study.

CHAPTER VI

SUMMARY, CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

Summary

Within the Rogerian framework, promoting power and progression toward self defined health promoting goals for persons with chronic illness in two types of support groups was achieved. Rogers stated the purpose of nursing is to promote the health and well-being of all people. Health in Rogerian science is viewed as eudaimonistic, evolving well-being which involves actualizing desired health promoting potentials with power as knowing participation in change. Barrett (1990a) described health as "a process of actualizing potentials for well-being by knowing participation in change" (p. 33). This study examined how traditional and Ericksonian hypnotherapeutic support groups facilitated self defined health promoting goals and power as knowing participation in change for 49 participants with chronic physical illness.

Approximately 50% of the population is projected to develop a chronic physical illness during their lifetime (Lyons et al., 1995). A diagnosis of a chronic illness is typically associated with evolving powerlessness, helplessness, hopelessness, isolation, depression and progressively declining physical health (Gregg et al., 1989; Iocalano, 1994; Linsey, 1997; Miller, 1992; National Institute

of Health, 1995). Patterning modalities such as the provision of support groups and education in self hypnosis have been proposed to facilitate health as well-being and power. The purpose of this study was to examine how traditional support groups and Ericksonian hypnotherapeutic support groups influence power and self defined health promoting goals for persons with chronic illness. Measurements of power and self defined health promoting goals were obtained seven times over a ten week period. Data collection points were at orientation (T1), weekly for the five-week support groups (T2 – T6), and then one month (T7) following the completion of the groups.

Forty-nine participants diagnosed with chronic illnesses were randomly assigned to either a traditional support group or an Ericksonian hypnotherapeutic support group. Nine groups of five weeks duration were held over an 18-month period of time. All participants were encouraged to share their stories and give and receive support in their group. Participants randomly assigned to the Ericksonian hypnotherapeutic support group additionally received education in self hypnosis. All groups were facilitated by advanced practice holistic nurses who utilized Rogerian science as a guiding unitary framework in their process of group facilitation.

In this study there were nine unique group fields of integral individual human fields in mutual process with the environmental field. Environmental field patterning varied in terms of times of group meetings, rooms in which groups were held, seasons and weather patterns, air-conditioning, nearby construction activities and current events that may have influenced group field patterning.

Despite such group and environmental field pattern diversity, power and self defined health promoting goals were significantly enhanced in both the traditional support group and Ericksonian hypnotherapeutic support group.

The following research questions were examined:

What are the changes in power and self defined health promoting goals for chronic care patients who do and do not participate in an Ericksonian hypnotherapeutic support group?

Does power vary differently over time for chronic care patients who do and do not participate in an Ericksonian hypnotherapeutic support group?

Do self defined health promoting goals vary differently over time for chronic care patients who do and do not participate in an Ericksonian hypnotherapeutic support group?

The results indicated that power and self defined health promoting goals significantly improved for participants in both the traditional support groups and the Ericksonian hypnotherapeutic support groups. There was no significant difference detected between the two types of groups in terms of participants' power and progression toward their chosen health goals.

Conclusions

The conclusions which can be drawn from the results of this study are that both traditional support groups and Ericksonian hypnotherapeutic support groups significantly enhanced power, Pillai's Trace = .520; F (6,39) = 7.04, $p < .001$, and facilitated progression toward self defined health promoting goals,

Pillai's Trace = .595; F (6,39) = 9.55, $p < .001$, for the forty nine persons with chronic illness who participated in this study. Although the two types of groups did not significantly differ in terms of power enhancement, F (1, 44) = .361, $p = .55$, nor in actualizing desired health goals, F (1,44) = 1.50, $p = .227$, this may be related to the brief duration of the groups or to the small sample size utilized in this study. It was exceedingly difficult to recruit for this study as most participants stated they only wanted to participate in the study if they could be in the hypnosis group. This challenge in securing participants seriously hampered the process of conducting this study, as it took 18 months to obtain a sample size of 49, which was sufficient for the proposed power of .80, medium effect size and statistical significance of .05 for repeated measures ANOVA analysis (Cohen, 1988).

The magnitude of mean change toward health promoting goals from T1 to T7 was 18% for the traditional support groups and 33.9% for the Ericksonian hypnotherapeutic support groups. The effect size indicating the strength of the intervention regarding progression toward desired health goals was a strong .81 for the traditional support groups and a stronger 1.26 for the Ericksonian hypnotherapeutic support groups. The mean change in power from T1 to T7 for was 17.57 points for the traditional support group and 21.34 points for the Ericksonian hypnotherapeutic support groups and the effect size for the traditional support group was a moderate .43 as compared to the moderate to strong effect size of .67, which was obtained in the Ericksonian hypnotherapeutic support groups. Although correlations for the self defined health promoting goals and

power were not initially significant at T1 ($r = .09$), the correlations progressively increased through time to a strong correlation of $r = .62$ at T7 ($p < .01$). This provides support for Barrett's claim that power relates to health.

A consideration regarding the conclusions in this study is that participants' improvement in power and progression toward health promoting goals may have been related to the therapeutic factors of support groups (Spira, 1997b; Yalom, 1995) and to the unitary nursing practice and pattern appreciation of all group facilitators in this study. The group facilitators' awareness of unitary nursing as a mutual process with an intention for promoting health may have influenced the knowing participation in health patterning and actualization of self defined health promoting goals for all group fields in this study.

Another issue that may have influenced all participants' power and progression toward their health goals could be related to the health and power promoting experience of completing the PKPCT. One participant repeatedly commented on how the PKPCT evoked a deep exploration of her evolving consciousness, and she considered this to be a health promoting experience.

As participants in both types of groups in this study significantly improved in power and progression toward their desired health goals, further Rogerian explorations of noninvasive health promoting patterning potentials in support groups for people with chronic illness is warranted. Phillips (1997) emphasized patterning-healing modalities are used to help people experience unitary well-being and that Barrett's power theory "is integral to the patterning-healing process" (p. 25).

Implications

The implications for the findings of this study warrant discussion and dissemination. Participants in both types of groups emphasized verbally and wrote on the evaluation form that such support groups should continue and be ongoing. Participants conveyed the serious need for such support groups, particularly with groups that meet over a period of time allowing relationships of support to develop. One participant wrote on the evaluation form, "I only wish the group had continued and that more of them were offered." Another wrote, "I also would have liked the group to continue beyond 5 meetings, since I feel a real void since the group ended." Despite the limited number of group sessions that were offered in this study, some participants conveyed evolving pandimensional awareness in that the experience of the group would continue in their future lives. For example, one participant wrote, "This was my first group experience and it will now be part of my life forever." Another relayed, "It was a very positive experience which I am interested in continuing in the present and the future." Evolving pandimensional awareness to discover therapeutic possibilities beyond learned limitations is further suggested in another participant's written comment, "Thank you for exposing me to a new point of view that promises to be helpful."

This perspective is congruent with pandimensional hope for a better future. Reviewers from the New York Society for Ericksonian Psychotherapy and Hypnosis (NYSEPH) commented on hearing suggestions of hope while listening to audiotapes of group sessions. Wall (2000) described hope as envisioning a better future. Envisioning a better future implies a time orientation that includes

possibilities not previously considered. For example, when the reviewers responded to open-ended guidelines regarding listening to the audiotaped group sessions, some commented on hearing different orientations to time in the two types of groups. Reviewers described the traditional support groups as being primarily present oriented and related to coping, with some focus on the past but very little orientation towards the future. For example, one reviewer wrote, "This group was present oriented primarily, to some extent past oriented, but not to the future." Another reviewer wrote of one traditional support group that it was a "much more problem focused group, pathology focused without reframing or opening up therapeutic possibilities."

Conversely, the Ericksonian hypnotherapeutic support group was described by reviewers as predominantly focused on present and future oriented time, which was implied with frequent interspersed suggestions to "acknowledge, open up therapeutic potentials." One reviewer wrote regarding the Ericksonian hypnotherapeutic support group that "the facilitator would frequently pick up on a participant's comment or story, highlight it with utilization, reframe it and drop in a suggestion for future behavior." This is congruent with Milton Erickson's description of hypnosis as a process of helping free people from learned limitations. Such expanding awareness can promote hope and is congruent with evolving pandimensional awareness.

A common theme expressed in these support groups was the poor communication of physicians. One participant wrote in the comment section of the satisfaction evaluation form,

> I felt it was very helpful to share my feelings about my health issues, poor doctor communications and treatment. Somehow I wish groups of doctors could hear our concerns and feel our pain. Maybe at some point you could videotape these sessions and show them to groups of MD's. I feel this experience has opened some doors for me to walk through and explore. I've counted on western medicine for 30 years and now they can't answer my questions, deal with my concerns or fears.

A reviewer of the audiotaped group sessions also wrote that doctors would benefit from listening to these tapes.

Health care professionals need to be much more aware and supportive of the benefits of groups for persons living with chronic illness. For example, one man with cancer who declined to participate in this study did so because when he spoke to his physician about the possible benefits of support groups he was told, "Why do you need a support group? You're not addicted to anything." Such a statement illustrates a serious lack of awareness regarding the health promoting potentials of support groups within the medical and health community.

Much more education and research are needed regarding the health promoting benefits of support groups. As health care professionals become increasingly aware of the health promoting benefits of support groups, they will recommend support groups for their clients, and the lay public will become increasingly aware of potentials for augmenting health despite having a diagnosis of a chronic disease. Anderson (2000) additionally emphasized the cost containment benefits of group field work. Working in groups is described as being more efficient, in that, "Using group field interventions can shorten the time it takes for clients to expand their awareness to include views of formerly

invisible options and choices" (Anderson, 2000, p. 58). This is reminiscent of Erickson's depiction of hypnosis as a process of helping free people from learned limitations.

The findings of this study counter society's prevalent view that a diagnosis of a chronic illness implies evolving limitations, powerlessness and diminishing health. Instead the findings are consistent with the Rogerian (1994) framework, Moch's (1998) health within illness and Smith's (1981) eudaimonistic health as ever evolving well-being. With illness, one can experience pandimensional health and power, particularly through use of support groups.

Barrett (2000) emphasized nurses need to facilitate groups in which people are taught, "how to thrive rather than survive" (p. 18). This is health patterning power, in which consumers learn in mutual process with nurses in group fields, that they are free to make aware choices regarding their involvement in life and health (Barrett, 2000).

Recommendations

The following are recommendations that may facilitate future researchers' experience of replication and expansion of this study.

Researchers are encouraged to replicate the present study with a larger sample size. As participants and potential participants who subsequently declined to participate in this study conveyed their strong preference to be randomized to the hypnosis group, recruitment for future studies will be easier if all participants are invited to participate in the hypnosis group. One person from the traditional

support group wrote on the evaluation form, "I was very disappointed that hypnosis/relaxation was not part of the sessions." Participants in this study conveyed they wanted to learn skills to ease their lives with chronic illness. For example, one participant from the traditional support group stated on the Satisfaction with Group Process evaluation form, "I wanted to learn tools." Future studies might benefit from creative or financial incentives to encourage more participants if a comparison group is to be offered in the study. All participants should be offered the alternate group approach following the completion of the study.

A recommendation for future studies is that the room in which groups are held should be consistent and reasonably comfortable for group members. The meeting rooms for the present study varied in terms of air quality, size and seating arrangements and some participants complained about the conditions of the meeting rooms for some of the groups. Yalom (1995) emphasizes the need for groups to meet in a physical setting that is free of distractions. Future studies will benefit by providing groups in a consistent space in which the group sessions have minimal extraneous environmental distractions.

Another recommendation for future studies is to increase the weekly group sessions to at least six weeks, as was utilized in the studies by Telch and Telch (1986) and Fauzy et al. (1990). Several participants in this study emphasized that support groups are beneficial and should continue for longer sessions. One participant illustrated the desire for more group sessions in her comment, "I would have liked the group to continue beyond 5 meetings, since I feel a real void

since the group ended." Researchers could possibly offer groups in six week sessions and then invite previous participants to sign up for subsequent groups. This procedure could satisfy the request of a participant in this study who wrote on the evaluation form, "I would like the groups to be ongoing." Another possibility is that the original group might choose to continue to meet independently beyond the six week group session. This occurred in the current study when participants who were randomized into the traditional support group expressed annoyance to the investigator because they were not going to learn hypnosis. These members started their own group following the completion of the study. This group continues to meet bi-weekly in a local church and all participants in the present study are invited to participate. In an interesting demonstration of power as knowing participation in change, this participant-led group invites holistic health practitioners to present at their groups and continues to use the group to share their stories and give and receive support.

Another benefit to future studies would be to continue the data collection process for six months or a year following the completion of the groups. This would provide important information regarding participants' capacity to continue utilizing the experiences obtained in the support groups to further expand their power and progression toward their desired health promoting goals.

In future studies, group sessions should be audiotaped so qualitative analysis of group process and communication patterns can be subsequently analyzed for themes. An in depth qualitative analysis of the transcripts of audiotaped group sessions utilizing such unitary research methodologies as

Cowling's (1997) "Pattern Appreciation" and Butcher's (1994) "Pattern Portrait" would strengthen future research and understanding of Rogerian nursing practice in groups. Such approaches can facilitate understanding of promoting health and power in group fields.

Future research should explore the relation and progression of hope and power in traditional and Ericksonian hypnotherapeutic support groups for people living with chronic illness. The reviewers of random selections of the audiotaped group sessions indicated the hypnotherapeutic groups had a greater emphasis on introducing therapeutic possibilities in a future orientation in time. As hope involves the capacity to envision a better future (Wall, 2000), its relation and enhancement with power for persons with chronic illness in support groups warrants exploration. As power is positively correlated with hope (Wall, 2000) and this study demonstrated positive correlations with power and actualizing health goals, possibly a future study will demonstrate positive relations of hope, actualizing health goals and power.

In future studies, researchers examining the power and health promoting benefits of support groups should ask participants to rate their health at the completion of the study, as well as at the beginning of the study. This would give a better understanding how perceptions of health may change with the use of groups. The inclusion of pre and post ratings and definitions of health in future studies will provide important information in unitary nursing science regarding health and power promotion in support groups.

Future studies are proposed which explore and describe the patterning characteristics of group facilitators. Interesting comparison of strategies studies could examine the power and health promoting benefits of other types of groups, possibly facilitated by psychodrama oriented facilitators, psychoanalytically oriented facilitators, or groups that focused on unitary nursing and pattern appreciation. In addition, because of mutual process, future studies should also analyze the power progression and actualization of desired health goals for the group facilitators as well. In support of Justice's (1998) recommendation that health in the next century be defined as well-being, further exploration of Rogerian science unitary nursing, Ericksonian hypnotherapy and healing in support groups for people living with chronic illness is warranted.

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APPENDIX A

POWER AS KNOWING PARTICIPATION IN CHANGE TEST, VERSION II

INTRODUCTION TO BARRETT'S PKPCT

The PKPCT is designed to help you describe the meaning of day-to-day change in your life. Four indicators of experiencing change are:

AWARENESS
CHOICES
FREEDOM TO ACT INTENTIONALLY
INVOLVEMENT IN CREATING CHANGE

It takes about 10 minutes to complete the PKPCT.

INSTRUCTIONS FOR COMPLETING BARRETT'S PKPCT

For each indicator, there are 13 lines. There are words at both ends of each line. The meaning of the words are opposite to each other. There are 7 spaces between each pair of words which provide a range of possible responses. Place an "X" in the space along the line that best describes the meaning of the indicator (AWARENESS, CHOICES, FREEDOM TO ACT INTENTIONALLY, or INVOLVEMENT IN CREATING CHANGE) for you at this time.

For example:
Under the indicator CHOICES, if your CHOICES are quite closely described as "informed," your answer might look like this:

informed___|_X_|___|___|___|___|___uninformed

If your CHOICES are quite closely described as "uninformed," your answer might look like this:

informed___|___|___|___|___|_X_|___uninformed

If your CHOICES are equally "informed" and "uninformed," place an "X" in the middle space on the line. Your answer might look like this:

informed___|___|___|_X_|___|___|___uninformed

Continued

REMEMBER:

- There are no right or wrong answers.
- Record your first impression for **each** pair of words.
- You can place an "X" in any space along the line that best describes the meaning the indicator has for you at this time.
- Mark only one "X" for each pair of words.
- Mark an "X" for every pair of words.

PLEASE BEGIN TO MARK YOUR X'S ON BARRETT'S PKPCT

(Please go to NEXT PAGE and continue)

BARRETT PKPCT, Version II

MARK AN "X" AS DESCRIBED IN THE INSTRUCTIONS

MY **AWARENESS** IS

profound	___	___	___	___	___	___	___ superficial
avoiding	___	___	___	___	___	___	___ seeking
valuable	___	___	___	___	___	___	___ worthless
unintentional	___	___	___	___	___	___	___ intentional
timid	___	___	___	___	___	___	___ assertive
leading	___	___	___	___	___	___	___ following
chaotic	___	___	___	___	___	___	___ orderly
expanding	___	___	___	___	___	___	___ shrinking
pleasant	___	___	___	___	___	___	___ unpleasant
uninformed	___	___	___	___	___	___	___ informed
free	___	___	___	___	___	___	___ constrained
unimportant	___	___	___	___	___	___	___ important
unpleasant	___	___	___	___	___	___	___ pleasant

MARK AN "X" AS DESCRIBED IN THE INSTRUCTIONS

MY **CHOICES** ARE

shrinking	___	___	___	___	___	___	___ expanding
seeking	___	___	___	___	___	___	___ avoiding
assertive	___	___	___	___	___	___	___ timid
important	___	___	___	___	___	___	___ unimportant
orderly	___	___	___	___	___	___	___ chaotic
intentional	___	___	___	___	___	___	___ unintentional
unpleasant	___	___	___	___	___	___	___ pleasant
constrained	___	___	___	___	___	___	___ free
worthless	___	___	___	___	___	___	___ valuable
following	___	___	___	___	___	___	___ leading
superficial	___	___	___	___	___	___	___ profound
informed	___	___	___	___	___	___	___ uninformed
timid	___	___	___	___	___	___	___ assertive

BARRETT PKPCT, Version II, PART 2

MARK AN "X" AS DESCRIBED IN THE INSTRUCTIONS

MY **FREEDOM TO ACT INTENTIONALLY** IS

timid	___|___|___|___|___|___|___	assertive
uninformed	___|___|___|___|___|___|___	informed
leading	___|___|___|___|___|___|___	following
profound	___|___|___|___|___|___|___	superficial
expanding	___|___|___|___|___|___|___	shrinking
unimportant	___|___|___|___|___|___|___	important
valuable	___|___|___|___|___|___|___	worthless
chaotic	___|___|___|___|___|___|___	orderly
avoiding	___|___|___|___|___|___|___	seeking
free	___|___|___|___|___|___|___	constrained
unintentional	___|___|___|___|___|___|___	intentional
pleasant	___|___|___|___|___|___|___	unpleasant
orderly	___|___|___|___|___|___|___	chaotic

MARK AN "X" AS DESCRIBED IN THE INSTRUCTIONS

MY **INVOLVEMENT IN CREATING CHANGE IS**

unintentional	___|___|___|___|___|___|___	intentional
expanding	___|___|___|___|___|___|___	shrinking
profound	___|___|___|___|___|___|___	superficial
chaotic	___|___|___|___|___|___|___	orderly
free	___|___|___|___|___|___|___	constrained
valuable	___|___|___|___|___|___|___	worthless
uninformed	___|___|___|___|___|___|___	informed
avoiding	___|___|___|___|___|___|___	seeking
leading	___|___|___|___|___|___|___	following
unimportant	___|___|___|___|___|___|___	important
timid	___|___|___|___|___|___|___	assertive
pleasant	___|___|___|___|___|___|___	unpleasant
superficial	___|___|___|___|___|___|___	profound

THANK YOU

APPENDIX B

SELF DEFINED HEALTH PROMOTING GOAL SCALE (T1)

CODE # _____
Date _____
Week # _____

Please take a few moments to reflect and focus your attention on something that would improve your sense of health or well-being.
Give your goal a title and write it on the space to the right. _____

The vertical line above represents a scale. Write on the top of this scale a word or phrase that describes fully achieving this goal, and on the bottom of the scale a word or phrase that describes not at all achieving this goal.

Draw a line across the scale where you feel you generally are at this time in relation to your goal.

SELF DEFINED HEALTH PROMOTING GOAL SCALE (T2- T7)

CODE # _____

GOAL TITLE_____

Date _____

Week # _____

Draw a line across the scale where you feel you generally are at this time in relation to your goal.

APPENDIX C

DEMOGRAPHICS

Code ID _____

Please circle or specify your response:

1. Sex
   1. Female
   2. Male

2. Age_____

3. Marital Status
   1. Single - Never Married
   2. Married
   3. Divorced
   4. Separated
   5. Widowed

4. Racial or Ethnic Identification
   1. American Indian
   2. Asian
   3. African American
   4. Hispanic
   5. White
   6. Other _____

5. Highest level of education completed
   1. High School
   2. Vocational School
   3. Associate Degree
   4. Baccalaureate Degree
   5. Master's Degree
   6. Doctoral Degree
   7. Other _____

6. What is the language that you read, write and speak best?
   1. English
   2. Other _____

7. Please specify the chronic illness you are diagnosed with
_____

8. When were you diagnosed? _____

9. What is your current or previous occupation?
   Please specify: _____

10. What is your employment status?
    1. Full Time
    2. Part Time
    3. Retired
    4. Unemployed
    5. Student
    6. Other: _____

11. How often do you practice any form of prayer, meditation, relaxation techniques, imagery or self hypnosis?
    Please specify form: _____
    1. More than once a day
    2. Daily
    3. Weekly
    4. Occasionally
    5. Never

12. Have you ever been hypnotized?
    1. Yes
       Please specify _____
    2. No

13. Have you experienced any major changes or crises in the past six months?
    1. Yes
       Please specify_____

       _____

    2. No

14. Have you participated in support groups?
    1. Yes, in the past
    2. I am currently participating in a support group
    3. Never

15. If you have participated in support groups, please indicate the type of group _____
    How often you met _____

    Was it helpful? _____

Other pertinent information_____

_____

16. Are you currently taking any medications regularly?
    1. Yes
       Please specify type of medication and frequency_____
    2. No

17. Have you ever been diagnosed with a psychiatric illness?
    1. Yes
       Please specify _____
    2. No

18. Please indicate the general level of your health
    1. Excellent
    2. Good
    3. Fair
    4. Poor

19. How do you define health?_____

_____

_____

APPENDIX D

EVALUATION OF SATISFACTION WITH GROUP PROCESS

1. Were you satisfied with your group?

_____ Very satisfied

_____ Moderately satisfied

_____ Minimally satisfied

_____ Not at all satisfied

2. Please feel free to share any thoughts regarding your group experience and/or suggestions for future groups.

Thank you again for your participation.

APPENDIX E

CONSENT FORM

I agree to participate in the research being conducted by Dorothy Larkin, a registered nurse and a doctoral candidate in the Division of Nursing at New York University. I understand that the purpose of this study is to aid in the understanding of health promotion with support groups for persons diagnosed with chronic illness.

I understand that as a participant I will be asked to attend an orientation session and then will participate in a support group. The groups will meet for one and one half hours weekly for five weeks. I understand that the support groups will be audio-recorded for research analysis of support group strategies and that I can use only my first name or a pseudonym of my choice during the group sessions. I understand I have the right to review all or any portions of the tape and request that it be destroyed if so desired. At the end of each weekly group session, I will be asked to complete two brief (10 - 15 minutes) questionnaires. These questionnaires will be collected at the end of each group session and returned to the investigator. One month following the completion of the group sessions, I will complete and submit the final questionnaires and will then receive a self hypnosis/relaxation/imagery audiotape in gratitude for participating in this study.

I am aware that all information that I provide will be kept strictly confidential and all data will be analyzed by code numbers only. I understand that my participation is voluntary and I can withdraw from this study at any time with no loss of services. My decision to participate or not to participate in this study will not affect the care I receive from my physicians, nurses, or any other health care personnel.

I am aware that the investigator will be available to answer any questions I may have regarding this study. If I have any questions I can reach the investigator at (phone number) or Dr. _____, Chairman of the Institutional Review Board at _____ at (phone number).

_____ _____

Signature of investigator Signature of participant

_____

Date

If you wish to receive a copy of the overall results of the study, please print your name and address in the space provided below.

_____

Name

_____

Address

_____

City, State, Zip Code

APPENDIX F

AUTHORIZATION LETTER FROM _____ INSTITUTIONAL REVIEW BOARD

May 19, 1998

Dorothy Larkin, RN

Dear Ms. Larkin:

This letter will serve to confirm that the Institutional Review Board (IRB) at its meeting on May 12, 1998 approved the "Ericksonian Hypnotherapeutic Approaches in Chronic Care Support Groups: A Rogerian Exploration of Power and Self Defined Health Promoting Goals" and its consent form, by a vote of 11-0.

This letter will also confirm that since you are the Principal Investigator on the study, you were absent from the meeting room at the time of voting, and therefore did not participate in voting on approval of the study.

As a reminder, the above study will be reviewed annually, and no changes may be made to the study without first submitting the changes to the IRB for approval. Any unanticipated problems must also be promptly reported.

Yours truly,

Chairman
Institutional Review Board

APPENDIX G

FLYER

PROMOTING HEALTH WITH SUPPORT GROUPS

FOR PERSONS WITH CHRONIC ILLNESS

If you have been living with a chronic physical illness for 6 months or longer, are over 18 years old and have graduated from high school, can read and communicate in English, you are invited to participate in a research project exploring the health promoting benefits of two different types of support groups. The groups will meet once a week for five weeks. There is no charge to participate. One month following completion of the groups and receipt of the final questionnaires, all participants will receive a self hypnosis/relaxation/imagery audiotape as thanks for participating in this study.

Interested persons can call _____, RN, at (phone number) for further information and registration in this study. Thank you.

APPENDIX H

LETTER OF INVITATION TO PARTICIPATE IN THE STUDY FOR PERSONS WITH CHRONIC ILLNESS

_____ Letterhead

Dear Sir/Madam:

I am writing to invite you to participate in a research study exploring potential health promoting benefits of two types of support groups. These support groups will be offered at no cost at _____ Medical Center of Westchester in New Rochelle, NY and are open to people who:

- ***have been living with chronic physical illness for six months or longer***
- ***are over 18 years old and have graduated from high school***
- ***can read and communicate in English.***

If you choose to participate, you will be asked to attend:

- ***one orientation session***
- ***weekly support group meeting for one and one-half hours for five weeks.***

A session to explain the project will take place one week before the groups start and brief initial questionnaires will be completed. Each participant will be randomly assigned to one of the support groups and will then meet in the assigned group for five weeks. Near the end of each one and one-half hour group session, participants will complete the brief questionnaires. All groups will be led by

advanced practice health care professionals. One month following the completion of the groups, you will be asked to complete and submit the final questionnaires by mail. You will then receive a self hypnosis/imagery/relaxation audiotape as thanks for participating in this study. Participation in this study is voluntary. No harm is expected and you are free to withdraw at any time without effecting the care you receive.

This study is part of my nursing doctoral work at New York University, Division of Nursing. The knowledge obtained from this study may help health care professionals provide better care for people living with chronic illness. Thank you for considering participating in this research. If you wish to enroll in this study, please call _____, RN at (phone number).

Sincerely,

Dorothy Larkin, RN, Ph.D. Candidate,
NYU, Division of Nursing

LETTER OF INVITATION TO HEALTH CARE PROFESSIONALS

NYU Letterhead

Dear

As a doctoral candidate at the Division of Nursing at New York University, I am conducting a study on examining two different types of support groups for persons with chronic physical illness. This knowledge may help health care professionals better understand factors related to caring for this population. I am requesting your help in obtaining volunteers to participate in this research study.

The sample will consist of 48 participants who have been diagnosed for six months or longer with a chronic physical illness, such as arthritis, cancer, heart disease, respiratory disease, irritable bowel syndrome and diabetes. To be eligible to participate in this study the participants must meet the following inclusion/exclusion criteria:

Inclusion criteria:

- Diagnosis of a chronic physical illness for six months or longer
- 18 years old or older
- Minimum of a high school education
- Ability to read, understand and communicate in English
- Interest in participating in a time limited support group for persons with chronic physical illness

Exclusion criteria:

- Self-reported history or current psychiatric illness that may preclude participation in a support group

A written description of the study along with the criteria for participation will be given to each potential participant by the researcher. The voluntary nature of the study, and confidentiality of information will be stressed. Participants will be asked to sign a consent form and complete two brief (10 - 15 minutes) questionnaires at the orientation and at the end of each group session.

The questionnaires include:

- a measure of the person's experience of change
- a measure of the person's progression toward achieving a self defined health promoting goal

Initial demographics and a final evaluation of participant satisfaction with the support groups will be additionally obtained.

All information provided will be kept strictly confidential and all data will be analyzed by using code numbers only. The only place where participants' name will be recorded is the consent form and the registration form, which will be kept in a locked file by the researcher.

Participation is voluntary. The decision to participate or not to participate in this study will in no way affect the care received from physicians, nurses or any other health care personnel. Participants are free to withdraw at any time without influencing the services they receive. If participants have any questions they are free to contact the investigator.

Please convey this support group availability to eligible patients who may want to participate in this study by circulating flyers and descriptions of the study. If you would like any other information please feel free to call me. Thank you for your consideration.

Sincerely,

Dorothy Larkin, RN, PhD Candidate
New York University
Division of Nursing
50 West 4th Street, Rm. 429
New York, NY 10003

(phone number)

Individuals who wish to enroll in this study should call _____, RN, at (phone number).

APPENDIX I

PRESS RELEASE

THE JOURNAL NEWS
Tuesday, May 11, 1999
"Across Our Towns"

CHRONIC ILLNESS: Promoting health for people with chronic illness for at least six months who are 18 or older and can communicate in English. A research study orientation session, 10:30 a.m. to noon May 18, _____ Medical Center of Westchester. Sessions will meet same time May 25 and June 1, 8, 15 and 22. Registration: Call _____, RN, (phone number).

APPENDIX J

INITIAL STANDARDIZED PHONE CONVERSATION DESCRIBING THE STUDY

This is a research study exploring potential health promoting benefits of two types of support groups. These support groups are free and open to people who have been living with chronic physical illness for six months or longer, are over 18 years old and can read and communicate in English. Participants will be asked to attend an orientation session which explains the project and a weekly support group meeting for one and one-half hours for five weeks. At the first session one week before the groups start, participants will complete the initial questionnaires and will record on the provided research tool a health promoting goal they want and are capable of achieving. Each participant will be randomly assigned to either the support group or the self hypnosis support group and will then meet in the assigned group for five weeks. Near the end of each one and one-half hour group session participants will complete brief questionnaires examining change and their desired health promoting goal. All groups will be facilitated by advanced practice health care professionals and will be audiotaped for research analysis of support group approaches. No harmful outcomes are expected and research suggests health promoting benefits associated with support groups may occur. Any participant is free to withdraw from the study at any time without affecting the care she/he receives. Confidentiality will be preserved via code identification and use of first names only or made up names in the group sessions.

Please answer the following questions:

- Have you been diagnosed with a chronic physical illness for six months or longer?_____
- What is the chronic illness you are diagnosed with?_____
- How old are you?_____
- Have you graduated High School?_____
- Can you read, write and understand English?_____
- Have you ever been diagnosed with a psychiatric illness?_____ Please specify_____
- Are you currently taking any medication? Please specify type and amount_____

APPENDIX K

STANDARDIZED INSTRUCTIONS FOR FORMULATING A SELF DEFINED HEALTH PROMOTING GOAL

Please reflect on a specific and realistic health goal you would like to achieve.

You will be asked to:

- State your health promoting goal in the positive and as if you have already achieved it. Write it on the line following the words "Goal Title."
- Place a word or phrase on the top of the vertical line that indicates you have fully achieved the goal.
- Place a word or phrase on the bottom of the vertical line that indicates you have not at all achieved the goal.
- Draw a line across the vertical line where you think you are right now in achieving the goal.

APPENDIX L

STANDARDIZED INTRODUCTION DURING ORIENTATION AND INSTRUCTIONS FOR COMPLETING SDHPG SCALE AND PKPCT V. II

First, I'd like to thank all of you for agreeing to participate in this study. This study will explore different therapeutic strategies that can be provided in support groups. The support groups will meet for five weeks for one and one half hours weekly for each group meeting. Each group will be facilitated by advanced practice health care professionals. During the last fifteen minutes of each group meeting, two brief questionnaires will be administered to assess your experience. The instructions for the questionnaires are on the forms. Your identity on the questionnaires will be held confidential by the use of code numbers. As all groups will be audio recorded for analysis of health promoting group process strategies, we invite you to only use first names or a made up name of your choosing during the group meetings. No harm is expected and you can withdraw from the study at any time without influencing the care you receive. At one month following the completion of the groups, you will be asked to complete the final two brief questionnaires and an evaluation of your satisfaction with the group. All participants will then receive a relaxation/imagery/self hypnosis audiotape in thanks for participating in this study.

APPENDIX M

SELF RATED GOAL DIFFICULTY

In looking at this goal, I believe it to be:

1. Very difficult to achieve
2. Somewhat difficult to achieve
3. Somewhat easy to achieve
4. Very easy to achieve

How committed are you in achieving this goal?

1. Very committed
2. Somewhat committed
3. Minimally committed
4. Not committed

Additional comments:

APPENDIX N

STANDARDIZED ORIENTATION FOR GROUP FACILITATORS

Group facilitators will receive a standardized orientation of supportive group process strategies that are to be offered in all groups.

These will include:

- Active listening with frequent eye contact and open body language
- Validating person's shared experience of living with chronic illness
- Reflecting back to participants what was heard for clarification
- Supportive encouragement
- Inviting discussion/sharing of thoughts/regarding chosen health promoting goals

In the event group members request information regarding the physical progression of their chronic illness, facilitators will refer them to their primary health care professional.

APPENDIX O

SUPPORT GROUP PROTOCOL

Support groups will be held every week for five weeks and each group session will last one and one half hours. Sessions will include the following content schedule:

Time 1. (Orientation meeting)
Welcome and orientation to the study and support groups
Instructions for formulating self defined health promoting goal
Instructions on instrument completion
Consent forms signed
Demographics and pretreatment measurements obtained

Following session 1, participants will be matched for self rated difficulty in achieving goal and then randomized into either the experimental or comparison group. An assistant will then telephone each participant and inform him/her of group assignment, time of meeting and location.

Time 2. (First session in support group)
Welcome to group and introduction of facilitators to group members. Norms established regarding confidentiality of information for all group members. As all groups are audiotaped, participants can elect to use only first names or pseudonyms during group sessions. Introduction of group members with chosen identifying name. Invitation to share experience and feelings regarding living with a chronic illness. Closure by thanking members for their participation. Request participants to complete and submit to facilitator in an unmarked envelope the PKPCT and SDHPG prior to leaving the room.

The experimental group will similarly unfold but will receive shortened group sharing and will additionally receive an introduction to relaxation techniques, imagery and self hypnosis. A guided experience in diaphragmatic breathing and progressive relaxation/imagery of a peaceful place in nature will be provided.

Time 3. (Second session in support group)
Welcome to group and begin sharing experiences and feelings regarding living with chronic illness. Closure with thanking members for their participation. Request participants to complete and submit to facilitator in an unmarked envelope the PKPCT and the SDHPG prior to leaving the room.

The experimental group will similarly welcome participants to group and will have a shortened group sharing of experiences and feelings regarding living with chronic illness. A guided experience in diaphragmatic breathing and progressive relaxation/imagery of a peaceful place in nature will be provided with interspersed hypnotic suggestions regarding awareness of comfort, relaxation, ease, replenishment and progressing toward chosen health goals.

Reorientation will occur with suggestions to memorize this experience so it can be retrieved whenever desired, and then to orient taking with you the comfort you created, feeling alert, refreshed and with a sense of energized calm. Closure with thanking members for their participation. Request participants to complete and submit to facilitator in an unmarked envelope the PKPCT and the SDHPG prior to leaving the room.

Time 4. (Third session in support group)
Welcome to group. Group process will unfold as described in Session 3.

Time 5. (Fourth session in support group)
Welcome to group. Group process will unfold as described in Session 3.

Time 6. (Fifth session in support group)
Welcome to group. Group process will unfold as described in Session 3. Additional discussion will focus on group termination and the one month follow up evaluation form which will be mailed to all participants in three weeks to assess satisfaction with their group and the final (T7) PKPCT and SDHPG. The completed tools are to be mailed to the researcher in a provided addressed and stamped envelope. Participants will enclose a self addressed envelope in a sealed unmarked envelope for receipt of the relaxation/imagery/self hypnosis audiotape. Participants will then receive by mail a relaxation/imagery/self hypnosis audiotape in thanks for participating in this study.

Time 7. One month following the completion of the groups in which the long term information regarding power and self defined health promoting goals are obtained.

APPENDIX P

AUTHORIZATION LETTER FOR PKPCT, V.II

Phone (212) 481-4312
Fax (212) 481-5078

This letter is to grant permission to_____

_____for use of the Power as Knowing Participation in Change Tool for your thesis. There is no charge to students for one time use of the tool for your research. However, I do request that you send me a copy of your completed thesis.

Good luck in your work.

Elizabeth Ann Manhart Barrett, RN, PhD, FAAN
Professor and Coordinator
Center for Nursing Research

Hunter-Bellevue School of Nursing 425 East 25 Street New York NY 10010-2590

APPENDIX Q

AUTHORIZATION LETTER FOR SDHPG

To : Dorothy Larkin

From: Katherine Matas

Date: 9/25/97

Re: Instrument permission

This is to confirm that you have full permission to use the instrument, the Self Defined Health Promoting Goals Scale for data collection as a part of your dissertation at New York University. Best wishes as you move toward completion of you studies for the PhD!!

I look forward to continuing close professional association with you as you complete your research and beyond.

APPENDIX R

PARTICIPANTS' DESCRIPTIONS OF HEALTH

Participants' Descriptions of Health From the Traditional Support Groups

To live without illness. If a person has a disease, which can be controlled with medicine or some other means. So that the life can be lived to its full extent, with minimum pain or limitation.

A state of inner peace.

Ability to participate in activities I enjoy. Absence of severe pain. Mental ability unimpaired (I think).

Aside from this illness, I am OK.

All internal systems working properly and a positive mental outlook.

Health is a state of being that allows optimal participation in life without the constant reminder that one can't do certain things – these being expressions of one's truly individualistic needs, desires and particular vision of growing into life as opposed to shrinking back to pain, discomfort and thoughts plaguing and drawing away energy. Health is positive and clear thinking in order to live fully and to have the strength to experience all the emotions and vagaries of life.

Health to me is a quality of being of the body, mind and spirit as well as the state of body itself and overall functional capacity.

Being able to be active and enjoying life.

A combination of emotional and physical well being.

Good physical and mental health.

Some days better than others–level of energy / discomfort impact on activity level of blood test readings.

I am not sickly, colds etc.

Well-being–free of major pain–free of major obstacles to "normal function."

General good feelings–physically-mentally–spiritually-emotionally.

Feeling good everyday.

The ability to function mentally and physically in a normal routine every day.

Well-being.

Ability to function without debilitating pain or anxiety.

Able to perform essential tasks, not being sent to ER unconscious!

Participants' Descriptions of Health From the Ericksonian Hypnotherapeutic Support Groups

Absence of pain and symptoms of illness; energy, ability to sleep normally, eat normally, participate in normal activities, including sports or other strenuous activity, to not have pain dominate your thoughts, limit your abilities, influence your mood, etc.

Not home bound–able to go outside and do the things most people can do.

Able to function daily with relative ease physically and mentally–walking, working and personal amusement. Being in good physical shape –not too overweight or underweight, active with adequate muscle strength. Able to sleep well. Having a positive mental attitude. Not feeling tired all the time.

An overall feeling of well being physically, emotionally and spiritually. Feeling my best.

Ability to do things I like and need to do without pain.

Physical, psychological and spiritual systems in balance.
Partly how I feel and partly the physical condition of my body parts–don't always match.

Health is emotional and physical well being.

Lots of energy–mental calm, sleep well–optimistic attitude.

Uncertain / try to deal on a daily basis.

No illnesses, general feeling of energy and well-being.

Physical and emotional and psychological well being allowing one to function to my natural maximum capability without pain or discomfort.

I define health as feeling ready to do whatever. Enjoying what you do, feeling free, no pain, no medicine, no stress.

Satisfactory control of mind and body.

On wellness and illness continuum–healthy body, mind and spirit.

Health is when your body and soul with no pain.

Waking up ready to take on the world–I was an "outdoor person" before I became ill.

Degree of health depends on: Being or having autonomy which means able to be independent and feeling good about it and having a positive body image: and to be physically able to be independent.

When you're able to take care of yourself and mind in good order. Feeling well most of the time.

Physical and mental health; feeling good about yourself and feeling good physically; a few pains or aches.

Living a full life, without the may aches and pain. Taking medication, looking to improve health. Proper diet and eating habits. Looking towards the future.

Being able to carry on or function in every day life–Daily goal breathing in – breathing out.

A state of physical and mental well being.

Ability to function well in all areas of life–work, family and recreation.

Being able to do what you want.

General well being.

Being able to awake in the morning and have a sense of well-being all day; no pains, no strains.

A feeling of well-being.