Health as Expanding Consciousness

Second Edition

Margaret A. Newman

Health as Expanding Consciousness

Second Edition

Margaret A. Newman
PhD, RN, FAAN

Professor, School of Nursing
University of Minnesota
Minneapolis, Minnesota

National League for Nursing Press · New York
Pub. No. 14-2626

toExcel
San Jose New York Lincoln Shanghai

Health as Expanding Consciousness

This edition was produced for on-demand distribution by iUniverse.com, Inc.
for National League for Nursing Press

For information address:
iUniverse.com, Inc.
620 North 48th Street
Suite 201
Lincoln, NE 68504-3467
www.iuniverse.com

The views expressed in this publication represent the views of the author and do not necessarily reflect the official views of the National League for Nursing Press.

Cover art entitled "Family Tree," by Susan Kattas.

Cover design by Lauren Stevens.

ISBN: 1-58348-199-0

Printed in the United States of America

Contents

Preface to the Second Edition

I now realize more fully that the theory of health as expanding consciousness is a radical departure from traditional concepts of health. When I first presented it at a nursing theory conference in New York (Newman, 1978), it had just come together for me—the basic assumptions, the key concepts and their relatedness, the critical insight regarding the wholeness of the evolving pattern. I was aware, as I presented these ideas to that large audience of nurses, that this was something different. There was a quiet stillness and expectancy in the audience. And when I finished, closing with "The responsibility of the nurse is not to make people well, or to prevent their getting sick, but to assist people to recognize the power that is within them to move to higher levels of consciousness," the response was thunderous. It was a turning point. The nurses in that audience in the interactive power of that moment resonated with the meaning of my words. I didn't realize at the time that I was calling for a revolution.

But the essence of the theory required a 180-degree turn. The idea of health held dear to most health professionals was

being pushed aside in favor of an idea that incorporated disease as a meaningful manifestation of the whole.

> A really new and radical theory is never just an addition or increment to the existing knowledge. It changes basic rules, requires drastic revision or reformulation of the fundamental assumptions of prior theory, and involves re-evaluation of the existing facts and observations. (Grof, 1985, p. 6)

Diagnosis and treatment of disease were being left to medical science and practice. Recognition of the pattern of the whole was pinpointed as the responsibility of nursing science and practice. This was not an easy shift to make. It could not be explained by reliance on cause-and-effect logic. It was not predictable. It *could* be seen retrospectively in the unfolding of life patterns. It could be experienced in the immediacy of the moment in insight regarding pattern. It is an emergent phenomenon. It makes a difference in the meaning of people's lives.

My early research placed an emphasis on separation of the concepts and control of the environment. This automatic alignment with the traditional scientific method yielded some insights regarding time as an index of consciousness and aging as a process of expanding consciousness but was not sufficiently in tune with the emergent reality of the theory to grasp the dynamic quality of the meaning of the theory for people's lives. As I sought to understand pattern, I gradually moved away from controlled, objective methods to a hermeneutic, dialectic approach. The theory came to life in the research, which I now see as praxis, since it both illuminates the theory and is the essence of practice.

One of the difficulties people have had with the theory of health as expanding consciousness is this: if it is true, it is

going to occur naturally. What then is the role of the nurse? In studying pattern recognition, I have become convinced that an important factor in patterning is the mutuality of the presence of someone (a nurse) who has been transformed by the theory with the person(s) being served. In such cases, the interpenetration of the fields of the nurse and client facilitates the transformative process for the client. Bentov once said, "You catch it (expanding consciousness) like you catch the flu." Being imbued with the vision of the theory makes a difference in one's practice.

The actualization of nursing as a learned profession has come a long way since 1985, when I was writing the first edition. Then I searched in vain in the yellow pages and elsewhere to find signs of life of nursing as an independent practicing profession. Now the signs are all around. The nurse case management movement was taking off about that time, especially under the leadership of Phyllis Ethridge, Cathy Michaels, and Gerri Lamb, at Carondelet St. Mary's, in Tucson, a place that has become a national and international center for nurse case management. My ongoing dialogue with these nurses convinces me that we finally (or again) have a model that allows the freedom of theory-guided practice. As health care reform occurs in the United States and abroad, nurses are taking their rightful place in serving society's health care needs.

We also have a much clearer view of the discipline of nursing than we did in 1985. The visions of nursing leaders of over a century have coalesced. The contributions of major nursing thinkers, from Nightingale to the present, have seemed to merge, focusing on two major concepts: health and caring, as interrelated phenomena. The merging of the two concepts seemed, to my colleagues, Marilyn Sime and Sheila Corcoran-

Perry, and me, to be expressed in the phrase: caring in the human health experience. The paradigm of nursing science heralded by Martha Rogers' theory of unitary human beings is integral to that focus. This paradigm specifies that the human being is unitary, that is, cannot be divided into parts, and is inseparable from the larger unitary field. Change takes place in a transformative manner, all-at-once rather than in linear fashion (Newman, Sime, & Corcoran-Perry, 1991; Parse, 1987; Rogers, 1970; Sarter, 1988). The methods of our research have changed considerably to reflect this unitary, transformative perspective.

Research as praxis has come into focus. In nursing's efforts to establish itself in the scientific arena, we devoted a great deal of time and effort to meeting the criteria established by and expected of "hard" scientists. Now with a more complete understanding of the nature of the nursing phenomenon and the emerging clarity of the prevailing paradigm, we can honor the praxis nature of our research. Praxis research is acutely relevant and brings about change in practice immediately. It has allowed my work as a nurse-theorist-researcher to unfold as an undivided whole. I am having more fun.

And we are finally recognizing that a difference in education corresponds to a difference in practice—a difference in the nature, not the value, of the practice. I still have doubts about the extent to which we submit to the hegemony of the medical regime in models of practice that incorporate acute care, but I will offer my perspective on differentiated practice that incorporates instrumental tasks of medical technology.

Many changes, therefore, have taken place since the publication of the first edition of this book. I have tried to make the content congruent with my most recent conceptualizations of theory, research, and practice, but I have left some sections

as they were because they represent ideas that have not been fully integrated into our thinking and merit further consideration. I have omitted some of the literature review based on old paradigm views. To update it would be at best tangential to the focus of our discipline. It is clear to me now that the focus of our discipline is the unitary field that combines person-family-community all at once. It is not, as we have argued in the past, individual vis-à-vis family vis-à-vis community nursing, and vice versa. These are false dichotomies based *not* on the discipline of nursing but on previous alignment with medical specialization (including preventive medicine). The focus of medicine *is* the individual, the individual's disease, and secondarily its relationship to the environment. The focus of nursing is the *pattern of the whole*, health as pattern of the evolving whole, with caring as a moral imperative. As we concentrate on this discipline, our practice and the lives of those we serve will be transformed.

M.A.N.
February, 1994

Introduction

*I*ntuition plays a large part in my life. The books I have chosen to read, the people I meet, the jobs I have taken, the places where I live somehow fit together in a pattern that is right for me. Sometimes I have been able to sense the pattern well in advance of its coming together. Other times I just plunge ahead because it feels right. Even seeming mistakes turn out all right in the long run, once you realize there is no such thing as a mistake. Every experience of life is a gift, to be claimed and learned from.

I learned early in life (each time I think of the first instance, I recall an even earlier instance) that events do not always turn out the way you want them to, and that you have a choice: you can be miserable because of it, or you can find a way to make a disagreeable experience meaningful and even enjoyable for you. I decided to pursue the latter.

The most pronounced of these experiences was my mother's nine-year struggle with amyotrophic lateral sclerosis, a degenerative disease of the motor neurons. Her early symptoms began as I was finishing high school and progressed to her partial incapacitation during the years I was away at col-

lege, almost unnoticed by me as I was struggling to establish my identity as a young adult. However, once I was back home after college graduation, I was confronted with the unmistakeable dependence of my mother on my brother and sister-in-law and me. I won't go into the details of the professional help we did and did not have, or the agony of the decisions we had to make and the frustration of the infringement on our lives that my mother's illness made. What I do want to share is my realization that life had to be lived in the present, and that if one were to be happy, it had to come one day at a time. I learned that my mother, though physically incapacitated, was a *whole* person, just like anybody else. I came to know her and to love her in a way I probably never would have taken the time to experience had she not been physically dependent. The five years I spent with her before she died were difficult, tiring, restrictive in some ways, but intense, loving, and expanding in other ways. As another person has described it, I have faced great difficulty and have come through it. I had the feeling then that I was preparing for something else.

I had been feeling a call to nursing as a career for a number of years. When I went off to Baylor, a Southern Baptist university, in 1950, I had no idea what direction my life would take. I was caught up in the religious fervor of my surroundings for several years and, true to the predominant values of the early fifties, I thought the ideal goal for my life was to be a conscientious and devoted wife. During my junior year, a gnawing conscience-like feeling began to haunt me and never left me alone for very long after that: the feeling that I should become a nurse. There couldn't have been a worse prospect as far as I was concerned! Nursing represented all the things I did not like: illness, hospitals, needles, and so on. The things

I did like, however—math, music, art, dance—did not seem to lead the way to a career for me.

When my mother died, I had just uttered a prayer of willingness to follow that lingering call to nursing. Within two weeks I was enrolled at the University of Tennessee School of Nursing in Memphis.

I knew, after only a few classes, that nursing was right for me. Contrary to my earlier projections, it focused on the complexity of human beings in health and illness, something I had experienced with my mother, and I realized that it was going to demand the best of my intellect as well as the utmost of my humanness. Upon graduation I went almost directly into graduate study, and under the tutelage of a very sensitive, intelligent teacher began to articulate a synthesis of my previous experience and learnings in terms of the essence of the experience of illness and what nursing had to offer.

Basic among these learnings was that illness reflected the life pattern of the person and that what was needed was the recognition of that pattern and acceptance of it for what it meant to that person.

Years later, I came to the conclusion that *health is the expansion of consciousness*. It frightens me to think I might have missed that revelation, it is so important to me now. But even my fear is unwarranted because the gist of all that I am saying is that one can trust the evolving pattern, that it is a pattern of evolving, expanding consciousness *regardless* of what form or direction it may take. This realization is such that illness and disease have lost their demoralizing power. I want to share this realization. We are in the wonderful process of expanding consciousness, of things becoming clearer, of moving from "seeing through a glass darkly" to knowing as we are known.

And there is much more. The expansion of consciousness

is unending. In this way we can embrace aging and death. There is peace and meaning in suffering. We are free from all the things we have feared—loss, death, dependency. We can let go of fear.

★ ★ ★

Throughout my career as an acknowledged theorist, I have been involved, if not embroiled, in the controversy of what is science and what is scientific. In order to side-step that issue here, I would like to say at the outset that this book is not about science in the traditional sense, but rather about *meaning*: The meaning of life and of health and of what those of us in the health professions can do about it. Ken Wilber (1983) captured the point in these statements:

> While we will not shun empirical data (that would miss the point), neither will we confine ourselves to empirical data (that would miss the point completely). (p. 33)

> A physician can describe the intricate biochemical processes that constitute your living being: he [sic] can to some extent repair them, cure them of disease, and operate to remove malfunctions. But he cannot then tell you the *meaning* of that life whose every working mechanism he understands. (p. 2)

The meaning of life and health, I submit, will be found in the evolving process of expanding consciousness.

This book is about a different way of viewing health and disease—a new paradigm. It is grounded in my own personal experience but was stimulated by Martha Rogers' insistence on the unitary nature of a human being in interaction with the environment (Rogers, 1970). While a student in Martha's

seminar, I was intrigued, and frustrated, by her statement that health and illness are "simply" expressions of the life process—one no more important than the other. How could that be? Well, possibly they are opposite ends of a continuum. No, she said. How about opposite sides of a coin? No, she said.

So I continued to struggle with this idea until a few years later in a conference with a graduate student about rhythmic phenomena, I had an "Aha" that revealed health and illness as a unitary process, and like rhythmic phenomena, becoming manifest in ups and downs, or peaks and troughs, moving through varying degrees of organization and disorganization, but all as one unitary process. Later my previous introduction to the antagonistic but complementary forces of order and disorder, so essential to our continuing development as self-organizing creatures, became more understandable within the context of health and disease.

Then I became acquainted with Itzhak Bentov's work, which provided logical explanations for many things I had taken on faith up to that point (Bentov, 1978). For instance, Teilhard de Chardin's belief that a person's consciousness continues to develop beyond the physical life and becomes a part of a universal consciousness had made sense to me (Teilhard de Chardin, 1965). Not only was it consistent with my Christian belief of life after death, but it just seemed reasonable that one would not spend a lifetime developing the knowledge and wisdom of one's total being (consciousness) and then have it dissipate into nothing. It made more sense that it continue to develop as part of a larger consciousness.

Bentov's explanations of the evolution of consciousness were matter-of-fact, logical and down to earth. I had the opportunity to hear Bentov speak and to participate in a workshop he led about that time, and I was convinced that this

spontaneous, unassuming man *knew* what he was talking about. When accused of talking about religion, he replied, "No, I'm talking about knowledge." When asked how he knew these things, he said, "I just know." What he said felt right. There comes a time when one seeks knowledge that is more than the observable facts.

David Bohm's theory of implicate order helped me to put these thoughts and experiences into perspective (Bohm, 1980). I began to comprehend the underlying, unseen pattern that manifests itself in varying forms, including disease, and the innerconnectedness and omnipresence of all that there is.

Arthur Young's theory of human evolution pinpointed the crucial role of insight, or pattern recognition, and concomitant choice (Young, 1976a, 1976b) and was the impetus for my efforts to integrate the basic concepts of my theory—movement, space, and time, as manifestations of consciousness—into a dynamic portrayal of life and health. Richard Moss's experience of love as the highest level of consciousness (Moss, 1981) provided affirmation and elaboration of my intuition regarding the nature of health and nursing.

As I sit here in awe and feel inadequate to the task of synthesizing these ideas in a meaningful way, I wonder how I could feel otherwise.

Chapter One

Paradigms of Health

The view of health as the absence of disease has pervaded most of our thinking from very early in life. From the immunizations that prevent devastating childhood diseases to admonitions to brush our teeth and drink our milk, the predominant view is that health (absence of disease) is within our control, and it is our responsibility to make sure we have it. This view is so strong that those who don't have it are viewed as inferior or even repulsive and don't belong with the responsible majority who have exercised the appropriate self-control with its concomitant (or so they think) perfect health. Indeed those who are labeled with a serious disease often question what they have done to deserve this fate or worry about whether or not their family will be able to continue to accept them in their diseased state.

The way we talk about health one would think it is a commodity that can be purchased. We say we can promote it and deliver it. We advise everyone to make sure they have it or get it, because apparently it is possible to lose it. We criticize those who do things that we consider destructive to it, and we even go so far as to disassociate ourselves from them.

We have become idolatrous of health. We have created places of worship of health at which we carry out the recommended rituals to obtain or maintain health. Then when one of the leading gurus dies while engaging in one of these rituals, we say in its defense, "How much sooner would he have died if he had not engaged in it." As if death were the antithesis of health, or the ultimate put-down.

There have been many attempts to get away from the notion of health as the absence of disease. Dunn (1959) was perhaps the first to use the term high-level wellness and portrayed health on a continuum from wellness to illness. Later he defined health as "an integrated method of functioning . . . oriented toward maximizing the potential of which the individual is capable" (Dunn, 1973, p. 7). Dubos (1965), another health spokesman of the sixties, characterized health as the adaptive potential of an individual. He was referring primarily to adaptation to environmental challenges. Others have viewed health in terms of coherence, life style, normality, conformity to social norms, and harmony (Antonovsky, 1979; Ardell, 1977; Dolfman, 1974; Parsons, 1958; Watson, 1985).

Although the authors of these concepts tend to reject the idea of health as the absence of disease, a prevailing notion throughout the health literature is the seeking and accomplishment of a disease-free state. A well-known contemporary, Lewis Thomas (1979), was probably the most explicit in this respect and was convinced that a disease-free state will eventually be accomplished through the work of medical scientists. A featured article based on genetic engineering in a Sunday newspaper magazine section set forth the claim, "Scientists explore the promise of tomorrow—a world without disease" (Ubell, 1985).

The prevailing views of health, then, might be portrayed on a continuum as illustrated below:

DISEASE	ADAPTATION TO DISEASE	ABSENCE OF DISEASE	HIGH LEVEL WELLNESS
ILLNESS ⊖			HEALTH ⊕

This conceptualization dichotomizes health and illness. Health is the positive state to be desired. Illness (disease) is the negative state. Even though many of the high-level wellness theorists speak of health and illness as integrated, dynamic concepts, a polarization is maintained as one strives for the positive state identified with health and avoids the negative state identified with disease. Disease has been regarded as the *enemy*, that may strike anywhere at any time. The person who is stricken is the *victim*. The troops that *fight* disease are led by the medical *armament*. These commonly used metaphors are illustrative of the way in which our language reinforces disease as the enemy to be overcome and as an entity separate from ourselves. A radical change in our point of view is needed in order to eliminate the dichotomizing of health and disease that has been so prevalent.

A NEW PARADIGM OF HEALTH

There is another view. For a number of years I have been saying that disease is a manifestation of health. This view requires another approach. Certainly we no longer would say we want to promote it or deliver it. On the contrary, we

spend a great deal of time and energy trying to prevent disease or get rid of it when it occurs.

Viewing disease as a manifestation of health is a revolutionary idea. The term revolutionary means a sudden, radical, or complete change; a rotation, or about-face; a turning point. To view disease as health, one has to reject a dichotomous or polarized view of health and disease. For those of us accustomed to thinking of these concepts as separate, it helps to apply Hegel's dialectical fusion of opposites and think in terms of a synthesized view: One point of view fuses with the opposite point of view and brings forth a new, synthesized view. In this case, DISEASE fuses with its opposite, absence of disease, NON-DISEASE, and brings forth a new concept of HEALTH:

DISEASE—NON-DISEASE → HEALTH

This synthesized view incorporates disease as a meaningful aspect of health. Jantsch (1980) goes further and asserts that process thinking transcends a synthesis of opposites, leaving only complementarity, in which the opposites include each other. This would mean that health includes disease, *and* disease includes health. Both of these ways of thinking are echoed by Bohm (1981):

> When you trace a particular absolute notion to what appears to be its logical conclusion, you find it to be identical with its opposite, and therefore the whole dualism collapses, as Hegel found. Reason first shows you that opposites pass into each other, then you discover that one opposite reflects the other, and finally you find that they are identical to each other—not really different at all. (p. 31)

Whichever way one chooses to look at it, the important consideration is that disease is a meaningful reflection of the whole.

Rogers' conceptualization of a person as a unitary being eliminated the usual dichotomy between health and disease (Rogers, 1970). She pointed out that health and illness should be viewed equally as expressions of the life process and that the meaning of these phenomena is derived from an understanding of the life process in its totality. Early critics of Rogers maintained that such a view was unscientific; however an increasingly large number of scientists and philosophers have recognized the limitations of the traditional scientific approach, especially as it relates to the life process and health of human beings, and are calling for an experiential, intuitive recognition of the total patterning of a person.

One of the difficulties in relinquishing a dichotomous view of health and disease is our fragmentary way of thinking and talking. It is easy for us to think of disease separately from health and to proceed to attend to it as a separate part. Dividing things into parts is useful, but eventually becomes more than just a way of thinking about things: It becomes reality itself. We begin to think of disease as really separate from the person it occupies and from the world within and around the person. Our language reinforces this separatism and promotes the idea that one object can act on another object, such as a virus acting on a person, or at best, that objects interact with each other . . . still with the idea of each being a separate, independent entity. This view is no longer sufficient to explain the reality of our world.

Science is demanding a non-fragmentary world view. Experiments at the particle level demonstrate that two particles separated in space display correlated movements simulta-

neously, indicating "that the various particles have to be taken literally as projections of a higher-dimensional reality which cannot be accounted for in terms of any force of interaction between them" (Bohm, 1980, pp. 186–187). To illustrate, David Bohm suggests envisioning projections of two television cameras (A and B) focused on the same phenomenon from different angles.

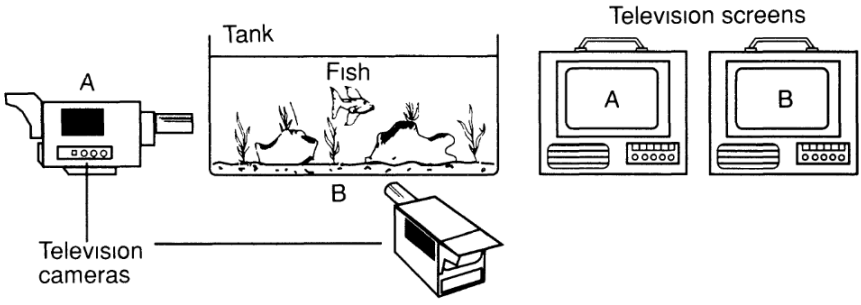

Figure 1.1 Reprinted with permission from Bohm, D. (1980). *Wholeness and the Implicate Order*. London: Routledge & Kegan Paul, p. 187.

Projection A and Projection B contain images that move at the same time and are somehow related, but there is no force of interaction between the two projections and neither portrays the whole picture. Rather, they are manifestations in two-dimensional form of a phenomenon of greater dimensions. The two projections are different points of view of the same larger reality.

Now think of the ways in which we have separated projections of mental phenomena from physical phenomena and substitute Mind and Body for Projections A and B (See Figure 1.2).

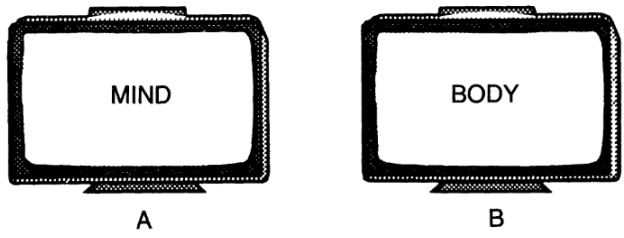

Figure 1.2

Using this analogy, we can see that mind and body are not separate interactive phenomena, but manifestations of the same larger reality. Contrary to previous thinking, one does not cause the other or control the other, as in "mind over matter" terminology, but each is a reflection of an underlying pattern of a phenomenon of greater dimensions. Each is reflective of the larger whole.

Take this point of view a step further. Substitute Disease and Non-Disease for Projections A and B.

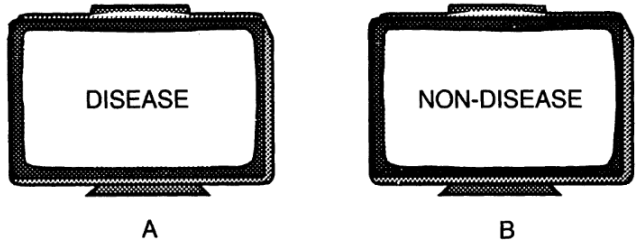

Figure 1.3

Disease and non-disease are not separate entities but *are each reflections of the larger whole,* a phenomenon of greater dimensions.

Reconsideration of the projected synthesis of health and disease reveals a new concept: PATTERN OF THE WHOLE. This is the primary, underlying, indivisible pattern which includes the context of the identified focus.

This point of view (health as pattern of the whole) is consistent with Bohm's theory of implicate order (Bohm, 1980). According to Bohm, there exists in our universe an unseen, multidimensional pattern that is the ground, or basis, for all things. This is the implicate order. Arising out of the implicate order is the explicate order, a kind of precipitate of the implicate order. The explicate order includes the tangibles of our world. These tangibles, the things we can see, touch, hear, feel, are so much more real to us than the underlying unseen pattern that we think the explicate order is primary—the real thing. Actually, according to Bohm, the implicate order is primary. The explicate order arises periodically from the implicate, like waves appearing and disappearing on the surface of the ocean. The explicate, whatever form it may take, is a temporary manifestation of a total undivided pattern, which Bohm refers to as the holomovement.

A number of people concerned with health have recognized the failure of a frontal attack on disease in bringing about significant changes in our sense of health and well being (Capra, 1982; Dossey, 1982; Pelletier, 1985). Relating the efforts of modern medicine to Bohm's theory of implicate order, Dossey (1982) stated:

> They focus only on the reality of the explicate order, the realm of our habitation, where the world is one of separate objects and events. The implicate domain, where the very meaning of health, disease, and death radically changes, is currently of no concern to medicine. (p. 189)

In the context of the theory of implicate order, *manifest health, encompassing disease and non-disease, can be regarded as the explication of the underlying pattern of person-environment.* Common observable phenomena—such as body temperature, blood pressure and heart rate; neoplasms and biochemical variations; immune reactions; diet and exercise; communication; family relations; environmental pollution—are explicate manifestations of the pattern of the whole. Viewing these manifestations as reflections of the underlying, dynamic pattern makes it possible for us to *see* the pattern of the whole and thereby begin to understand it.

The theory of biological rhythms is helpful in seeing health and illness as a unitary process, a fluctuating pattern of rhythmic phenomena. There are times when the pattern of a person becomes increasingly disorganized, similar to when one's physiological rhythms are out of phase. This situation can continue until the person becomes what we ordinarily regard as "sick." The sickness then can provide a kind of shock that reorganizes the relationships of the person's pattern in a more harmonious way. Consider the function of a high fever, or an emotional crisis, or the accident that occurs at a particularly crucial time. These, and other critical incidents, may provide the shock that facilitates a jump from one pattern to another, presumably at a higher level of organization. So, if we view disease as something discrete, something to be avoided, diminished, or eliminated altogether, we may be ruling out the very factor that can bring about the unfolding of the life process that the person is naturally seeking. Illness may accomplish for people what they secretly want but are not able to acknowledge even to themselves. Ferguson (1980) pointed out that people who get sick don't want to be their "old self"

again; she described a woman who had had a stroke and who "conceded that she hadn't faced the fact that she wanted to change her life. So the stroke changed her life" (p. 252).

THE PARADIGM SHIFT

Ferguson (1980) outlined the paradigm shift taking place in regard to health. Several of the changes are particularly relevant to the point being made here that disease is a meaningful aspect of health. The shift is from treatment of symptoms to a search for *patterns;* from viewing pain and disease as wholly negative to a view that pain and disease are *information;* from seeing the body as a machine in good or bad repair to seeing the body as a *dynamic field of energy* continuous with the larger field; from seeing disease as an entity to seeing it as a *process.*

This paradigm shift is apparent in the nursing literature. The conceptual models that originated in the 1950s and '60s were based on a view of the patient as a person in good or bad repair and needing more or less help from nursing to regain or attain a state referred to as maximum health or well being. Rogers' conceptualization of person-environment represented a turning point (Rogers, 1970). The absence of boundaries between person and environment and the emphasis on mutual simultaneous interaction of person-environment demanded a non-dichotomous view. Rogers' insistence on a unitary view of the pattern of person-environment demanded a view of the person as an emerging pattern of the whole.

The old paradigm of health, based on the medical model, recognizes separate parts and advocates an instrumental ap-

proach. One identifies what is wrong in a system and tries to fix it.

The new paradigm of health, essential to nursing, embraces a unitary pattern of changing relationships. It is developmental (Newman, 1992a). The task is not to try to change another person's pattern but to recognize it as information that depicts the whole and relate to it as it unfolds.

The instrumental paradigm is linear, causal, predictive, dichotomous, rational, and controlling. The relational paradigm is patterned, emergent, unpredictable, unitary, intuitive, and innovative. The new paradigm incorporates the old paradigm and transforms it. When Copernicus introduced the view of the universe with the sun, rather than the earth, as the center, his view retained the phenomena of the old view but explained them from a different standpoint. The shift in paradigms from Newtonian physics to Einsteinian and further to quantum theory presents a broader, more complete explanation of phenomena but reaffirms the old relationships under certain conditions. Therefore, it is important to think of the characteristics of the old paradigm of health as special cases of the new. Viewed within the context of pattern, information from the old paradigm will have new meaning.

Chapter Two

Pattern of the Whole

To see health as the pattern of the whole, we need to see disease not as a separate entity that invades our bodies but as a manifestation of the evolving pattern of person-environment interaction. The pattern being signalled by disease (as well as non-disease) can be seen and understood in terms of a pattern of energy. Physical illness or intense emotional activity may be regarded as manifestations of blocked energy beyond our awareness (Moss, 1981, p. 80). Although we cannot always "see" energy, we accept that it is a characteristic of the human field. Disease makes it possible for us to envision a general pattern of the energy flow of a person. For example, hypertension may connote a pattern of contained (pressured) energy, hyperthyroidism a pattern of diffuse, multidirectional energy, or diabetes the inability to use available energy. Each of these patterns vary, of course, according to the unique configuration of each person-environment situation. The disease can be regarded as a manifestation of pattern and can assist people in becoming aware of their pattern of interacting with the environment.

The following story illustrates this point. A number of

years ago a friend of mine was diagnosed as having hyperthyroidism and was being treated by a leading endocrinologist. She had been on medication for approximately a year with very little progress in alleviating the disease. The endocrinologist had indicated that she probably would have to have surgery to have the thyroid gland removed. But before she pursued that alternative she went to see Dora Kunz, a sensitive person who has the ability to see (in terms of energy flow) the patterns of people's interactions as they relate to their diseases (Weber, 1984). As my friend related to me the things Dora had told her, this is what I gleaned from it: That Dora could visualize her energy being diffused in every direction (in a slightly diminished intensity probably because of the medications she was taking to reduce the activity of the thyroid gland). Dora concluded that it was not relevant to tell my friend to curtail her activities in order to conserve her energy. The pattern of intense multidirectional energy expenditure was her way of life. The only thing Dora could suggest for my friend was that she make sure she took in enough energy to sustain her way of life.

To fill in some of the details of my friend's life, she was the oldest of nine children and was looked to for advice and assistance not only by her siblings but also by her parents. She was a member of a religious community of nuns and freely fulfilled her responsibilities to other members of the community during their frequent visits. She was a faculty member in a large urban university and enthusiastically carried more than her share of teaching responsibilities along with a larger-than-usual number of committee responsibilities. She could rarely say "No" to any request. She was a caring friend to many people—typically staying up half the night to bake a birthday cake or do some similar favor.

Dora's picture of her energy going in many directions was reflective of her life. And it was accurate that she was not taking in enough energy to sustain that way of life—not taking time to sleep or eat or rest. When I really began to think about it, her thyroid gland was trying to produce the energy she needed. The medical/surgical approach to diminish or delete the activity of the thyroid gland was just the opposite of what her system was trying to accomplish.

My friend did begin to pay more attention to her energy intake and did not have to have surgery and even was able to eliminate or greatly reduce the medications she was taking. *But I do not want to imply that simply balancing her energy intake-output did the trick.* I surmise that the transforming factor was the *insight* she gained regarding her own pattern of life. This is the understanding that Young (1976b) referred to as accelerating the evolution of consciousness. And perhaps, as has already been suggested, she discovered herself in this pattern, found peace in the congruity, and was able to move to a higher level of organization and harmony. Moss (1981) stated:

> We must attain higher energy states to begin to transmute the reality that appears unchangeable at our present energy level. Whether this occurs through the spontaneous awakening of energies or through a disease process is of little importance. (p. 101)

The pattern of a person that eventually manifests itself as disease is primary. The disease is a manifestation of the underlying pattern. This point is germane to Chinese medicine (Tiller, 1973) and has been illustrated in plants by Kirlian photography (Ostrander & Schroeder, 1971). Ravitz's early work correlating bioelectrical potentials with disease indicated that the change in the bioelectrical field preceded subjective and behavioral changes associated with illness (Ravitz, 1962).

Profiles of interactive patterns that correlate with disease states, especially coronary heart disease and cancer, have been described in the literature for at least a quarter of a century. My research, and that of my colleagues, has sought to elaborate the pattern of persons with these and other major medical problems as manifestations of the pattern of the whole (Jonsdottir, *in progress*; Lamendola & Newman, 1994; Moch, 1990; Newman & Moch, 1991). Themes for each category of participants have generally supported the profiles from previous research and are illustrative of the pattern of disease as pattern of the whole. These general profiles, however, are insufficient in addressing the individuality of the pattern demanded by the unitary-transformative paradigm of nursing science and practice. The unitary-transformative perspective becomes evident in the unique pattern of each individual person-environment trajectory.

DISEASE AS INTEGRATING FACTOR

It seems strange to say (strange because it's part of the revolutionary shift) but disease may be the way a person gets in touch with his or her pattern. Many of us have lived our lives in such a way that we have not become fully aware of ourselves or our own pattern. The pattern may then manifest itself in a more "unconscious" manner, in terms of changes that may be interpreted as maladaptive, or disease, but which may represent movement to a higher level of consciousness. Certain forms of psychosis may be an indication of a person's involvement in an important personal transformation (Pelletier, 1978). Physical disease may serve the same purpose—

even more so—since physical changes associated with internalization of stress may represent a person's inability to be fully aware of stress. Moss (1981) related that "what may unfold unconsciously at one level of consciousness and finally present as disease may now be perceived as an energetic shift which becomes an unfolding process" (p. 75). This relates to Moss's position that some of what is labeled disease might be considered stalled or overly rapid penetrations of higher energies. This is similar to Rogers' position that some of our diseases are manifestations of evolutionary emergence of higher energy states. According to Moss, our individual behaviors [diseases?] describe "what we don't dissolve into" (how we separate ourselves). It takes energy to maintain the me that is separate and this may translate into disease.

Disease may be considered an integrating factor (Stone, 1978), and as such, is important in the evolutionary development of the person. Evolution thrives on tension (Watson, 1978). Contrary to what one might think, disequilibrium is important in maintaining active exchange with the environment (Jantsch, 1980), and active exchange with the environment is essential for growth (Land, 1973). The tension characteristic of disease may provide an important disequilibriant in the growth process, and therefore, may be regarded as a facilitator of that process. We evolve by having our own equilibrium thrown off balance and then discovering how to attain a new state of balance, temporarily, and then moving on to another phase of disequilibrium. This is a natural process, according to Fuller (1975):

> "The forces of the field of energy . . . interoscillate through the symmetry of equilibrium to various asymmetries, never pausing at equilibrium. The vector equilibrium itself is only a refer-

> ential pattern of conceptual relationships at which nature never pauses" (p. 27).

Dossey (1982) agreed and viewed disease as a natural perturbation that offers human beings the chance to evolve to a new and higher level of complexity.

DISEASE AS AN EMERGENT PATTERN

For years Martha Rogers has considered various diseases as emergent patterns. More recently cultural historian William Irwin Thompson, systems theorist Will McWhinney, and musician David Dunn have declared the HIV/AIDS phenomenon as a signal of the emergence of a new culture. They regarded the loss of membranal integrity characteristic of AIDS as similar to the breaking down of boundaries at a global level, as seen in geographical changes and diminishing ideological differences. Thompson (1989) characterized the HIV not as an object but as a herald of the need to live together in symbiotic relationships:

> We may need to change our ideas of treatment to ones in which the immune system is "retuned" to new states of harmonic integration in which we learn to tolerate aliens by seeing the self as a cloud in a clouded sky and not as a lord in a walled-in fortress. (p. 99)

Within this theoretical context a study of the evolving patterns of persons with HIV/AIDS was conducted (Lamendola & Newman, 1994) and revealed patterns consistent with the theory of expanding consciousness. The men "moved from being separated, alienated individuals in search of their place and

connection in life to more meaningful, authentic relationships with self and others" (p. 9).

DISEASE AS EXPANDING CONSCIOUSNESS

The process of life is toward higher levels of consciousness. Sometimes this process is smooth, pleasant, harmonious; other times it is difficult, disharmonious, as in disease. Moss (1981) wrote:

> I believe that, when the new level of energy is attained, the forces that might have configurated disease at the old level no longer need operate. If it is not attained, then the disease probably perseveres and physical death may become the transformative door. In either case, transformation of consciousness has occurred, and to a deeper level of our Beingness this may be all that really matters. (p. 101)

The conclusions of Lerner and Remen (1985), based on their work with cancer patients, support this view:

> But what is most striking to me about many of these people with cancer has nothing to do with evidence of extended disease-free intervals or life expectancy. What amazes and touches me is that through this difficult life passage they have found inner resources of strength, wisdom, and insight that they often had not experienced before. They do not live with certainties of clear victories. They live with the knowledge that the cancer process may worsen or return at any time, and with the personal conviction that how they live may affect when or whether it does so. But the kind of life they develop is also the one that they would want to follow even if their efforts had no impact on the course of the disease. (p. 32)

Fryback (1993), too, found support for the meaningfulness of disease in people with cancer and AIDS. She found the study

participants allowing their lives to unfold in a satisfying, purposeful way.

When we begin to think of ourselves as centers of consciousness (patterns of energy) within an overall pattern of expanding consciousness, we can begin to see that what we sense of our lives is part of a much larger whole. First the pattern of consciousness that is the person; then broadening the focus, the pattern of consciousness that is the family and physical surroundings; then the pattern that is the community, the person's larger environmental affiliations, such as work or school; and ultimately the pattern of the world. It is this pattern of the whole that is the phenomenon of nursing's practice.

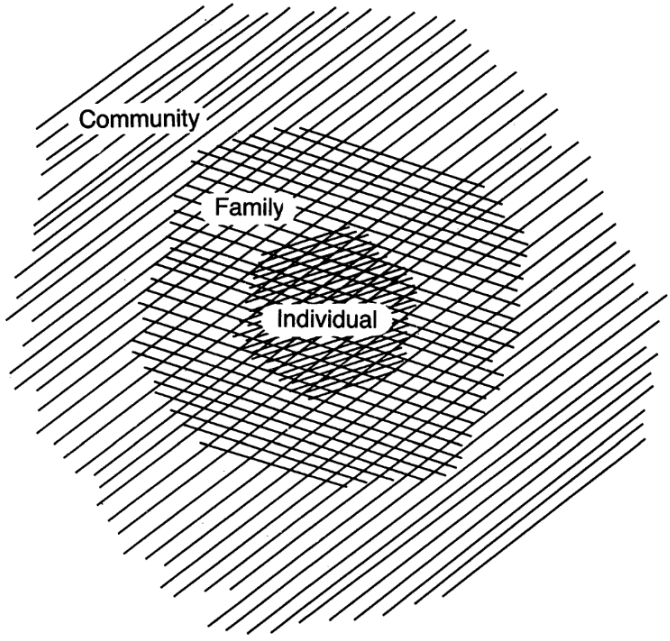

Figure 2.1 Individual-Family-Community as pattern of the whole.

EXTENDING THE PATTERN TO ENCOMPASS FAMILY AND COMMUNITY

We are not separate people with separate diseases. We are open energy systems constantly interacting and evolving with each other. The pattern manifested by a disease does not stop with one person but is part of the greater whole. In the process of considering the pattern of interaction of an individual with the environment, one inevitably considers the pattern of interaction of the family and the community.

A man in South Dakota shared how his father's experience with amyotrophic lateral sclerosis was a transforming process for an entire family. His father, an active man who had overcome polio and residual disability to become a successful businessman and politician, first fought the decline in his abilities brought on by the disease, then later began to accept these limitations. That acceptance was a turning point. The entire family became involved in assisting his father with his daily needs and the endless encounters with the medical system. There were changes in his father: "I saw Dad go from an aggressive, seemingly insensitive man to an accepting, aware, and tender person," and in his mother: "Part of his [Dad's] expanding consciousness, and that of the family, was the excitement and partial ownership he felt in my mother's expanding role and consciousness as a business woman. In three short years she took over the agency, passed each and every state exam and license, and was elected Businesswoman of the Year. You think he didn't play a part in that?" This six-year experience was one of loving intensity and uncertainty and transformation that involved the entire family.

People often ask how it is possible to apply the theory of expanding consciousness to situations in which a child comes

into the world with a developmental disability. This story of Aaron, who was severely disabled following fetal distress at birth, illustrates a pattern of expanding consciousness not only for his family but also for the community. It's referred to as "Aaron's legacy" (Tommet, 1992).

Aaron's parents, Jan and Tom, at first experienced the shock and sorrow of realizing that there was something wrong with their newborn child, who had frequent seizures. The first step was to understand what had happened to him and to find out who within the medical profession they could call on for help in this difficult situation. The first six months of Aaron's life was a constant struggle to deal with the complexity and uncertainty of his condition.

Jan was frustrated by Aaron's resistance to her attempts to cuddle him, but with the help of a rehabilitation specialist she began to understand Aaron's resistance to touch as overstimulation of his sensitive body. Jan spoke of each day as a constant struggle for survival:

> There was no joy in our lives. I felt like constantly treading water to keep our heads afloat.

There was the additional strain of finding someone to care for Aaron, so that Jan and Tom could receive some respite from the constant struggle and, eventually, so that Jan could return to work, something she felt she needed in order to restore some balance in her life.

The Developmental Achievement Center (DAC) was a source of hope and assistance in their desire to enhance the quality of Aaron's life. After the first year, all the critical support systems were in place, except that it was still difficult to

establish respite care. They had no extended family in the area and the alternatives they tried were unsatisfactory.

Jan and Tom began to reach out to others. At their suggestion, the DAC started a support group for families facing similar situations. With great fear, they decided to continue to have children. With the help of a high-risk specialist and a nurse for ongoing therapy and monitoring, Jan gave birth to a baby girl, Leah, when Aaron was 2½, and later to a third child, Evan, both of whom were a real joy to the family. Both infants related to Aaron by rolling over him, as he was no longer so sensitive to touch, and lying on him and doing all the physical touching. He was able to respond to the cuddling. He was learning to communicate his needs, and Jan and Tom were able to understand what he wanted. Both Leah and Evan were supportive of Aaron's learning.

Because of Jan's awareness of Aaron's response to Leah and Evan and of their response (in terms of curiosity) to him, Jan worked to establish a program at the public school that integrated children with and without disabilities. She wanted to create more understanding between the two and to prevent Aaron's being isolated from the mainstream of society. The program was established, and even though Aaron never had the chance to participate in it (he died at age 5½), Jan feels that "part of his legacy is that program." Here are Jan's concluding remarks:

> I think that Aaron taught our family a lot about this issue of belonging and being part of a community. Aaron's short life . . . in some ways he was much more powerful than me in being able to facilitate some changes just in attitudes by his presence. And that despite the tragedy and the sorrow of his situation, I value what he gave to us and sometimes I kind of

> miss his sense of spirit—which was a driving force for me . . . it was so intense and so severe that there almost was no choice. There is a choice—but there is almost like no choice because you have to do the best you can and more.

In the beginning of the interview, when Jan was asked to tell about the most meaningful experience in her life, she introduced the above story by saying it was "a very profound experience that changed my life dramatically. I think the reason it was probably a profound experience was the fact that it changed me and it changed my relationships with people. It changed my understanding of the world. The experience that I'm talking about was Aaron's birth, his whole life and his death, and . . . what's happened since his death, too, in terms of a legacy, his legacy. . . . What happened to me was a very deep, very intimate, very powerful experience."

Jan's experience illustrates graphically the pattern of the whole as it expanded from the individual to the family to the community. There were no separate parts.

The premise that illness in one family member is reflected in the pattern of family interaction was introduced in the fifties in psychiatry and may be extended within the theory of health as expanding consciousness to any family situation. There is no intent to imply causality. The pattern simply *is*. The disease simply is reflected in the pattern, a pattern of evolving consciousness of the family. Central to this view is the premise that disease is an integrative and transformative factor in the family system.

The pattern of the whole contains the individual as an open system interacting with the family as an open system interacting with the community as an open system. The previous assumptions apply also when focusing on the commu-