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The Nature and Prevalence of Healing and Wellness Initiatives in American Hospitals

Now is the time to address our nation's healthcare crisis and focus on healing and wellness. Our current healthcare system, which has a disease-focused, reactive model emphasizing '"curing" as opposed to "healing," has been shown to be woefully inadequate in addressing our nation's ever increasing healthcare needs. There is, however, a growing recognition that the healthcare delivery industry can, and must, play a major role in advancing a more proactive environment of healing and wellness; an environment that emphasizes a holistic, self-empowering model of true *health* care. The term "optimal healing environments" (OHE), was coined in 2004 by the Samueli Institute. The Institute defines healing as the process of recovery, repair, and return to wholeness, in contrast to curing, which is the eradication of disease (Jonas & Chez, 2004). An optimal healing environment, whether it be in a hospital, health clinic, or worksite, supports and stimulates healing and wellness through the following: developing healing intention, experiencing personal wholeness, cultivating healing relationships, practicing healthy lifestyles, applying collaborative medicine, creating healing organizations, and building healing spaces.

In 2006, to better understand the nature and prevalence of initiatives thought to contribute to wellness and healing in hospitals, the Samueli Institute piloted the *Survey of Healing Environments in Hospitals* with a sample of 125 hospitals in the upper Midwest region of the United States (Samueli Institute, 2006). Results suggest hospitals are developing and implementing a wide variety of initiatives related to all seven components in the OHE framework.

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Did You Know…?

The *Complementary and Alternative Medicine Survey* is the only national survey that collects data on the use of integrative healthcare programs and services in hospitals.

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Utilizing the Patient Activation Measure in Health Coaching

Wellness and healthcare professionals tend to agree, based on scientific documentation, that a large share of health care costs are preventable by lifestyle changes. This shared belief has contributed to an increasing number of health plans implementing health coaching programs to assist individuals in developing healthy lifestyles. By focusing on an individual's needs, knowledge, skills, and confidences, the health coach can personalize the interaction to the individual. This article will review the results of Medica Health Plan integrating the Patient Activation Measure ™ (PAM) into its Health and Wellness Coaching program to assist the health coach in personalizing the coaching to the individual.

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The seven components of OHE are developing healing intention, experiencing personal wholeness, cultivating healing relationships, practicing healthy lifestyles, applying collaborative medicine, creating healing organizations, and building healing spaces.

In 2007, in an effort to gather more general data and broaden our understanding of OHE initiatives in American hospitals, we added an OHE section to the American Hospital Association (AHA) *Complementary and Alternative Medicine Survey*. This biannual survey, conducted since 2005, is the only national survey that collects data on the use of integrative healthcare programs and services in hospitals. The *2007 Complementary and Alternative Medicine Survey* was sent to 6,439 AHA member and non-member community and military hospitals across the United States. The OHE section was organized around the OHE framework components and sought quantitative data about healing environment initiatives in hospitals.

Methods

The OHE section contained 34 statements addressing the seven components of an OHE. Respondents were asked to read each statement and indicate how true it was for their healthcare facility. Each answer choice was based on a Likert-type scale: 0 = "not applicable", 1 = "not at all true", 2 = "not very true", 3 = "somewhat true", and 4 = "very true." Since each of the seven OHE constructs, with the exception of Experiencing Personal Wholeness, was assessed by multiple statements, a construct score was computed by summing respondents' answers for each statement that made up each construct. The higher the score the more likely the respondent was to have chosen either "somewhat true" or "very true" for each statement. A minimal score was also computed for each construct so that only those respondents who had chosen either "somewhat true" or "very true" for a majority of or all the statements comprising that construct could be considered to have that OHE component in their hospital. The study also calculated the number of respondents obtaining the minimal score on all constructs combined, deeming them an "Overall OHE."

Additionally, we examined some key

Figure 2. Percentage of Positive Responses for OHE Constructs and Overall OHE

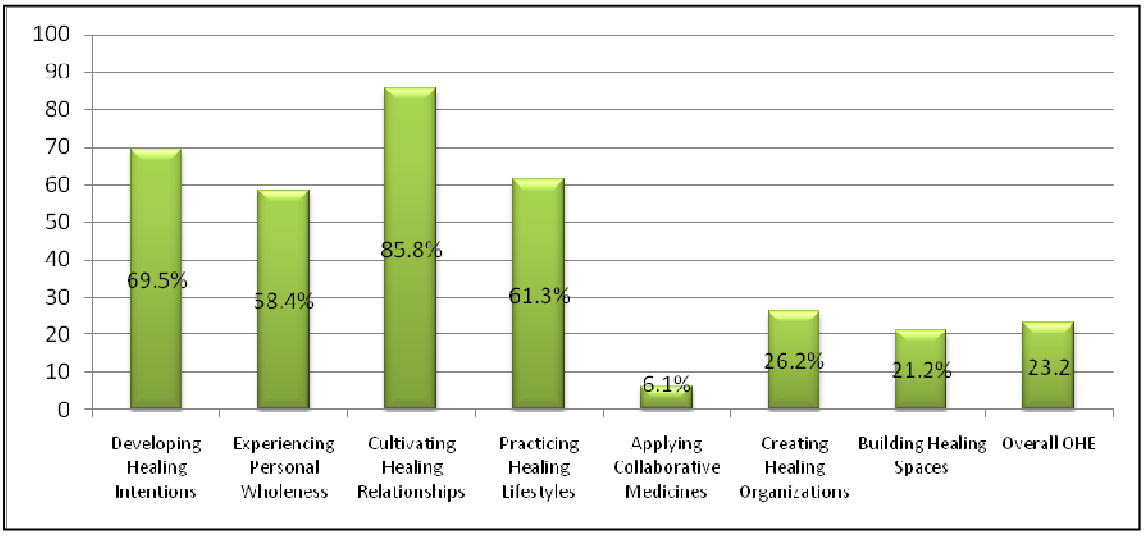

Table 1

Results for Individual OHE Constructs and Overall OHE (Mean (sd))			
Construct	Responses (n)	% Yes*	Means (sd)**
Developing Healing Intention	591	69.5	6.06 *(1.67)*
Experiencing Personal Wholeness	591	*58.4*	2.53 *(1.11)*
Cultivating Healing Relationships	587	*85.8*	13.60 *(2.54)*
Practicing Healthy Lifestyles	588	*61.3*	14.6 *(4.52)*
Applying Collaborative Medicine	586	*6.1*	4.33 *(2.54)*
Creating Healing Organizations	578	*26.2*	11.50 *(4.42)*
Building Healing Spaces	*588*	*21.2*	13.65 *(4.80)*
Overall OHE Score	***544***	***23.2***	**66.24** ***(16.07)***

*: % yes =number of respondents answering "somewhat true" or "very true" for all or a majority of statements within each construct.
**: scores ranged as follows: developing healing intention 0-8; experiencing personal wholeness 0-4; cultivating healing relationships 0-16; practicing healthy lifestyles 0-20; applying collaborative medicine 0-12; creating healing organizations 0-20; building healing spaces 0-24; overall OHE score 0-104.

demographics to assess whether they were related to the incidence of respondents reporting the statements were "somewhat true" or "very true" for their facility. Those demographics were:

- Bed size: 100 beds or less = 1, over 100 beds = 2
- Location: urban = 1, rural = 2
- Teaching status: non-teaching hospital = 1, teaching hospital = 2

T-tests were utilized to examine whether any significant differences existed between groups on scores for each OHE construct and their overall OHE score. Data were collected from 748 AHA hospitals.

Results

Figure 2 presents an overview of the percentage of respondents indicating "somewhat true" or "very true" for a majority or all statements within each of the OHE constructs, as well as an overall OHE score.

Finally, Figure 3 represents the differences between the overall OHE score for each demographic variable.

Discussion

2007 Complementary and Alternative Medicine Survey: Optimal Healing Environments Section was an effort to gather generalizable data and broaden our understanding of OHE initiatives in American hospitals. Overall, the results suggest that hospitals across the country are developing and implementing healing

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Hospitals seem to be incorporating the particular OHE elements that meet the particular health and wellness needs of their hospital and its patients and staff

and wellness initiatives that relate to all components of the OHE framework. Of the seven OHE components, four are being incorporated by *over half* of all responding hospitals. Further, 23.2% of responding hospitals indicated they had a majority of or all the seven OHE components in their hospitals. It is significant that almost a quarter of hospitals nationwide are attending in such a concentrated way to this group of elements that can support, stimulate, and optimize patient healing and wellness.

When comparing OHE components, the span for percentage of hospitals incorporating each component was wide. Scores ranged from a low of 6.1% of responding hospitals integrating the Applying Collaborative Medicine component, to a high of 85.8% integrating Cultivating Healing Relationships. This wide range seems to indicate that OHE's are not created in a "cookie-cutter" manner in which every hospital across the country uses the same mixture of elements. Rather, hospitals seem to be incorporating the particular OHE elements that meet the particular health and wellness needs of their hospital and its patients and staff.

By far, the most frequently incorporated OHE component is Cultivating Healing Relationships, used by 85.8% of respondents. This finding is consistent with our 2006 pilot OHE survey, which found healing relationships to be widely used in hospitals (Samueli Institute, 2006). The current finding suggests that hospitals nationwide realize the importance of healing relationships and are investing in their cultivation, not surprising given the growing body of evidence of the positive effects of the patient-provider relationship on healing (Gittell, et al., 2000; Stewart, Brown & Donner, 2000; Beach & Inui,

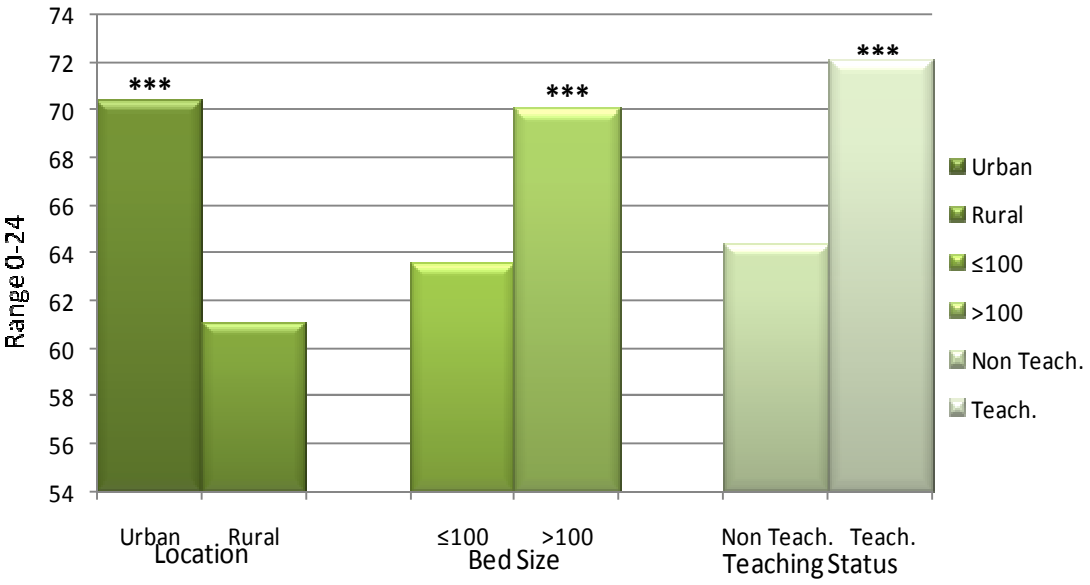
Table 2

Comparative Analysis Results of Hospital Demographic Variables for each OHE Construct and Overall OHE (Mean (sd), t-value)

Construct	**Location (Urban vs. Rural)**	**Bed Size (≤100 vs. >100)**	**Teaching Status (Teaching vs. Non-teaching)**
Developing Healing Intention	3.73***	-1.87	-2.22*
Experiencing Personal Wholeness	4.70***	*-3.46***	-3.44***
Cultivating Healing Relationships	3.91***	*-2.32**	-3.20**
Practicing Healthy Lifestyles	3.05**	*-3.86****	-2.75**
Applying Collaborative Medicine	5.92***	*-3.04***	-3.32***
Creating Healing Organizations	6.44***	*-4.51****	-5.81***
Building Healing Spaces	*6.73****	*-4.77****	-4.79***
Overall OHE Score	***6.93****	***-4.77****	**-4.79***

*p<.05; ** p<.01; ***p<.001

Figure 3. Overall OHE Score: Comparative Means for Demographic Variables (Range = 0-104)



2006; Frankel & Inui, 2006). Further, since the Institute of Medicine's (IOM's) groundbreaking *Crossing the Quality Chasm* report calling for patient-centered healthcare (The Committee on Quality of Healthcare in America, 2001), there has been a greater focus on putting the patient/ family-provider relationship at the center of care.

Developing Healing Intention is the second most popular OHE component among the surveyed hospitals, used by 69.5%. Perhaps the Healing Intention component is frequently used because as well as crucial, it is also simple and inexpensive. Developing healing intentions does not require sophisticated equipment nor major architectural redesigns; healing intentions can be set into motion by patients, family members, and/or providers through a brief pre-surgical prayer for healing or a bedside conversation about the patient's hopes for recovery. Also contributing to the frequency of this OHE component might be that the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) now requires hospitals to conduct a patient spiritual assessment (JCAHO, 2008), which would be a natural time for hospital staff to discuss with patients their beliefs and hopes for healing and recovery.

Practicing Healthy Lifestyles is also a prevalent component, used by 61.3% of hospitals. Perhaps the breadth of research linking lifestyle to a variety of chronic illnesses (Oster, et al., 1999) and lifestyle management to health care savings (Govil, et al., 2009) makes it popular. Notably, each of five types of healthy lifestyle programs (exercise/fitness, nutrition counseling, weight, addiction, and stress management) are offered to staff by 65% to 82.5% of hospitals, suggesting that hospitals across the country

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Urban hospitals and teaching hospitals were significantly more likely than rural hospitals and non-teaching hospitals to attend to OHE components.

recognize investing in staff wellness can be a cost-effective business strategy.

Comparing OHE elements demographically also provides interesting findings. For each OHE component, as well as overall OHE, urban hospitals and teaching hospitals were significantly more likely than rural hospitals and non-teaching hospitals to attend to these components. Similarly, larger hospitals were significantly more likely than smaller hospitals to have each individual OHE component (except for the construct of Developing Healing Intention which was only marginally significant) and an overall OHE. What is it about larger, urban, and/or teaching hospitals that makes them more conducive to incorporating OHEs? Do larger hospitals have greater resources? Perhaps urban hospitals have greater access to a bigger pool of skilled "non-Western" health practitioners to integrate into their hospitals. Teaching hospitals, historically research-focused, may be more interested in OHE components as evidence is building showing the positive effects of OHE components. These are questions to explore and answer as we continue to gather information about the nature and prevalence of hospital-based OHE initiatives.

Conclusion

These rich findings show the survey to be a valuable tool for collecting information about hospital-based health and wellness initiatives. The survey results provide descriptive data that give an informative picture of the types and frequencies of initiatives being undertaken in hospitals today. In the future, it would be beneficial to also gather data that can help us understand the effect of optimal healing environments on hospital business case outcomes, such as patient and staff satisfaction, patient loyalty, quality of care, safety, and return on investment (ROI).

In October 2009, a follow-up survey addressing the seven OHE components was sent out to a similar sample of over 6,000 AHA community and military hospitals in the United States. This survey, *2009 Complementary and Alternative Medicine Survey: Optimal Healing Environments Section*, gathers almost identical data on optimal healing environments and will be used to look for trends in the adoption of OHE components.

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The PAM is designed to determine the individual's level of knowledge, skills, and confidence in respect to managing his or her health.

The PAM is designed to determine the individual's level of knowledge, skills and confidence in respect to managing his or her health (Hibbard et al., 2004). The individual is assigned an "activation scale" based on responses to a 13-item scale. Evidence shows individuals go through four levels to be fully competent managers of their health (Hibbard et al., 2009).

Level 1: The individual tends to be overwhelmed and unprepared to play an active role in his or her own health.

Level 2: The individual lacks knowledge and confidence for self-management.

Level 3: The individual is beginning to take action, but lacks confidence and skill to support behaviors.

Level 4: The individual has adopted many of the behaviors to support his or her health, but may not be able to maintain them in the face of life stressors.

By using this tool, the coach can elicit the individual's current level of activation and guide them in developing their own agenda. Addressing the individual's whole life in this way is an effective method of coaching for lifestyle changes (Whitworth, 2007). To start the process, the member completes the PAM after a coaching session to document changes in his or her activation level. Increases in the individual's level of activation can improve various health-related behaviors ranging from preventive care to exercise and diet, and medication adherence (Hibbard 2007). Pre- and post-coaching PAM scores also allow a program to capture changes in the individual's overall confidence in self-management behaviors.

By measuring the individual's level of activation the coach can tailor the level and style of coaching to make each session relevant and meaningful to that individual. For example, the coaching style and information that an individual needs at Level 4 would be overwhelming for those at a Level 1.

The following are examples of individuals at the four levels of activation. These individuals have unique needs and require very different approaches to coaching. Compare the differences between the various levels and notice how each individual's needs, skills, and confidence vary.

PAM Level One:

Bill is a 40-year-old man who was told by his doctor five years ago that he has diabetes and ulcerative colitis. His doctor and a diabetes educator have recommended weight loss, exercise, monitoring of his blood sugars twice daily, and medication. Since Bill has not managed his diabetes well, his doctor wants him to come in for checkups every three months. Bill often will stretch his doctor's appointments out five to six months since he does not like to be told what he is doing wrong. Bill reports rarely checking his blood sugars (due to his aversion to needles). He acknowledges his doctor told him to take his medication for his diabetes twice daily, but typically just takes it once daily since it is easier to remember one dose.

Bill is a classic Level 1, but the majority of the advice and information given to him to self manage his health care needs is for someone at a much

higher level. The result is Bill continues to poorly manage his health and does not understand the need for him to play an active role in his health.

The coaching approach to help Bill allows him to determine his own agenda and take small progressive steps to help build his confidence and find some success in managing his health. Bill's first goal was to keep his appointments with his doctor; he was coached on how to ask his doctor questions regarding when he should take his medication. Bill has multiple health concerns to be addressed, but coaching acknowledges his level of comfort and allows him to succeed without being overwhelmed by the changes he needs to make.

PAM Level Two:

David is a 45-year-old man who realizes he needs to lose weight and improve his exercise habits. He was told he has high blood pressure, but does not remember the numbers for his last blood pressure readings. David acknowledges he needs to change his eating habits, but is not sure where to start or how to find helpful information. He does not have a regular exercise routine and reported not having the time or money to join a health club.

At a Level 2 in activation David lacks the knowledge and confidence that he can make changes in his health. During the initial coaching session David was coached on ways to increase his physical activity without joining a health club. David realized he could take short walks in the mornings before work and could start parking his car in the back of the parking lot to get a few extra steps in. When discussing his eating habits David acknowledged his evening snacking and felt confident he could avoid snacking after 7 p.m. at least three days a week. David also requested information regarding blood pressure readings. He was provided information on what were normal and abnormal blood pressure readings.

David was allowed to develop his own program of walking and made the decisions on diet changes. Allowing David to set his own agenda with achievable goals builds his confidence and creates an opportunity for him to develop his self management skills.

PAM Level 3:

Linda is a 52-year-old attorney trying to manage her weight and stay on a regular exercise program for the past several years. She has lost weight in the past by going on several different diet plans and had some success, but finds that once she goes off the diet plan the weight comes back. She has a treadmill and elliptical trainer at home which she uses, but has difficulty maintaining any regular routine or consistency in her exercise.

At an activation Level 3 Linda has taken action to lose weight and maintain an exercise routine. She has experienced some success, but has not been able to maintain the weight loss. Linda lacks the confidence and skills to maintain her healthy behaviors. Linda noted that when she makes changes to improve her diet and exercise habits something would come up that would throw her off. This would cause her to discontinue the exercise and resort back to unhealthy eating habits.

During the coaching sessions Linda realized she needed to develop a plan

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Allowing the patient to set his or her own agenda with achievable goals builds confidence and creates an opportunity for the patient to develop self management skills.

Marshall Feller, D.C.

to maintain a healthy diet and an exercise program. In addition, the reason she had difficulty maintaining a routine was her failure to plan the day and her schedule. Because Linda was self employed with an adaptable schedule, she realized she had to work to control her schedule rather than it controlling her. Linda began to organize her work hours in a more structured format creating specific times to meet with clients and work on cases. This allowed Linda to maintain a regular routine for meals and exercise. Linda also discovered her work improved and that more free time was available for her family. Linda has begun to lose weight and she feels more confident in her weight maintenance.

PAM Level 4:

Bruce is a 42-year-old who exercises five to six times a week, eats a low fat diet, and has at least five servings of fruits and vegetables a day. Bruce has a background in health care and is very much aware of the need to stay current with preventive exams and checkups for early detection of health problems. Bruce's job keeps him on the road several days of the week, which does make maintaining healthy eating and exercise habits difficult.

Being at the fourth level of activation, Bruce is a very good self manager of his healthcare needs. Bruce's needs are markedly different than what Bill requires at a Level 1. Bruce seeks information to expand his current level of knowledge and is seeking ways to maintain his health when his work schedule gets hectic. Coaching Bruce on ways to deal with life stressors and managing his work life balance is what Bruce requires to maintain his healthy lifestyle.

Determining the needs and activation level of the individual allows the health coach to personalize the coaching to the individual. By providing coaching that addresses the needs, skills, and confidence levels of their members Medica's Health and Wellness Coaching Program has achieved success in the following areas.

$139 per participant per month savings in health care expenditures

95% of our members report satisfaction with the program

99% of our members feel their coach gave them the support they need

Members self-reporting on their own experience with the program indicate the following:

66% report quality of life increases

40% report productivity increase

59% report increase in exercise

51% report increase in fruit/vegetable intake

PAM's coaching successes are being carried over to other areas of Medica's wellness program. Next year, Medica will combine the 13-item Patient Activation Measure into its health risk assessment. Incorporating the PAM into to the health risk assessment will allow the online wellness programs to be personalized to the individual's level of activation.

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Medica is a health insurance company headquartered in Minneapolis and active in the Upper Midwest. With nearly 1.6 million members, the non-profit company provides health care coverage in the employer, individual, Medicaid, Medicare, and Medicare Part D markets in Minnesota and a growing number of counties in North Dakota, South Dakota, and Wisconsin. Medica also offers national network coverage to employers who have employees outside the Medica regional network.

Facing Pollyanna: When "Positivity" Hurts—Finding a Balance in Psychoeducational Programs

Especially today, people are feeling worried, uncertain, and unsettled. At the same time, there's an upside as more families seek a return to enduring values by reevaluating the way they live, paying more attention to their health and wellbeing, and placing more weight on what really matters. In the process they are actively seeking ways to reduce stress and upgrade the quality of their lives through a variety of practices and techniques.

As a result, practical and scientifically driven methods that help individuals deal with stress and wellness are incredibly timely. Significant evidence pinpoints the role stress plays in almost every disease and illness known to man. Even our genes respond—favorably or unfavorably—to how we deal with the hurry and worry of everyday life. The upshot is that disarmingly simple research-based strategies offer individuals a reliable shortcut to accomplishing their health and lifestyle goals.

Ironically, though, one of the foremost roadblocks on the path to enlightenment is the cult-like status of the positive attitude. While pop psychology has opened the door to greater awareness of skills and strategies to enhance well-being, erroneous information about the danger of negative emotions has unintended consequences. While not everyone is affected, those who are suffer in a variety of ways. Suppression carries quite a high price tag and can physically affect all of us; yet nowhere is the fallout more immediate than in individuals facing a chronic illness where it can have immunological consequences.

Ironically, though, one of the foremost roadblocks on the path to enlightenment is the cult-like status of the positive attitude.

Consider this example: In a study of more than 1,000 people over a 40-year period, researchers at John Hopkins University in Baltimore, Maryland, discovered students who

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had a “limited expression of tension or anxiety” were twice as likely to die by age 55 as their peers who were either able to express anxiety or experienced little tension. No one is advocating we exploit nervous tension, but there are serious medical advantages to identifying our feelings, and then dealing with them. Unfortunately, in our programs we often see individuals who happen to believe negative thoughts and emotions “don’t help and may likely hurt.” Most wonder how “feeling their feelings” square with media recommendations—and friends’ and family’s encouragement—to adopt a cheerful, chin-up stance, often under the mistaken impression that negative thoughts or emotions, in and of themselves, are harmful to our mental and physical health. Untangling this common misconception offers distinct health benefits.

Even our most well-read patients are typically unaware that a positive attitude actually refers to embracing and experiencing the full range of human emotions, including the more challenging ones.

So we go a step further, not only defining “positive attitude,” but also citing the clear and measurable physiological benefits that can occur from the cognitive shift alone. Even our most well-read patients are typically unaware that a positive attitude actually refers to embracing and experiencing the full range of human emotions, including the more challenging ones. We explain this means neither denying nor indulging “negative” emotional states but working through them, eventually transcending them, as we move toward becoming authentically hopeful, joyful, or confident. Most are pleasantly surprised to discover this rules out adopting a rigidly cheerful demeanor or an uncompromising Pollyanna attitude as a healthy coping strategy.

Roger E. Dafter, Ph.D., the Associate Director of the Mind/Body Medicine Group at the UCLA School of Medicine, finds the idea that negative emotions are bad for the immune system and that positive emotions are beneficial for the immune system to be “simplistic, inadequate, and unsubstantiated.” He reports that research indicates emotions are actually necessary information, which ultimately help the process of fighting disease and healing.

There’s more. According to Pennsylvania State University psychologist Alicia A. Grandey, a variety of physical illnesses have been linked with suppressing emotions. Researchers such as Jeanne Achterberg and Lydia Temoshok demonstrated that suppressed anger and seeing oneself as a victim can negatively affect immunity. One recent investigation discovered a link between inhibited anger and an increase in pain severity. Armed with an accurate definition and a bit of practice, clients can learn to interpret feelings as important messages. It is liberating and empowering and very different from venting, raging, or hiding under the covers for weeks at a time.

Yet knowing all this even I was surprised when the authors of a leading 10-year study on coping style and cancer found that neither depression nor the holy grail of cancer jargon, “fighting spirit,” had any significant effect on survival—but feelings of helplessness and hopelessness did—and negatively so. Helplessness cripples our capacity for self-protection, rendering us vulnerable to the vagaries of circumstance and paralyzing our ability to respond emotionally and immunologically. That is not to say a chin-up stance does not help one get

out from under the covers and actively engage in conquering helplessness and hopelessness. But a nuanced understanding can lead to skill-building that can transform both the physical and psychological recovery processes, leading to change in genetic expression.

On the other hand, suppressing unwanted thoughts and feelings can consume valuable physical and mental resources that could be better used in creative problem solving or developing positive coping strategies. Multiple studies indicate writing about negative or traumatic events is more effective in improving working memory than trivial writing. We can only guess at the mechanism, but it may be sitting on top of smoldering emotions swallows up precious energy resources that become available once we recognize and resolve inner conflict.

At least one study shows exercises that help us identify feelings can reduce our risk of cardiac problems. Like learning a new language, some feelings can be so disguised or buried that we have to look for physical clues. Unconsciously denying negative feelings results in physiological arousal that can be measured by biofeedback, EMG, EEG, temperature, and moisture. Clients may not consciously feel disturbed by low levels of depression or anxiety, but their cold hands, back pain, or headache may signal otherwise. Getting curious about their physical symptoms can open the door to identifying and exploring emotions—which can lead to releasing and resolving them.

A watershed study from the Centers for Disease Control sheds light on what may be going on here. The ACE Study found that adverse childhood experiences are a stronger predictor of serious chronic illness in adulthood than smoking history, cholesterol, or obesity. While the impact of the study lies in its size and the strength of its findings, the beauty of it lies in its totally unexpected clinical significance. A company on the New York Stock Exchange specializing in neural net analysis, and trying to move into the medical field, offered, as a gift, two years of follow-up on 120,0000 participants who had undergone a comprehensive medical evaluation using the new ACE-based questionnaire. I felt a chill run up my spine as one of the lead authors, Vincent Felitti, MD, laid the results before me: There was a 35% drop in doctor's office visits, an 11% drop in emergency room visits, and a 3% drop in hospitalizations compared to the year before. What did they believe accounted for the result? Felitti replied, "That's hard to answer definitely. But I can tell you what all of us associated with this work believe. We were asking, and people were telling us the worst secrets of their lives, and they were still accepted as human beings." Despite the astounding results, a peculiar difficulty arose. Newspapers and some media were reluctant to publish the questionnaire for fear of upsetting people. [Who would think our cultural bias toward the positive would impact sensational news items!] The participants responded themselves. Below is an amalgam of just two of the many letters Dr. Felitti received:

I have read the questionnaire over and over. I have been thinking a lot about it. I had a difficult childhood very similar to what Christina Crawford described in her book Mommie Dearest*. I feel that if I had this*

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Suppressing unwanted thoughts and feelings can consume valuable physical and mental resources that could be better used in creative problem solving or developing positive coping strategies.

questionnaire in front of me years ago I would have come forward to get help and would not have blamed myself for every bad situation that happened to me. As it was, I suffered for years. I hope that you do publish the questionnaire because I know that you would help a lot of hurting people that otherwise would never talk about their difficult childhood. The mind is very powerful. I was told every day that I was worthless and would never accomplish anything in life. If the questionnaire had been put in front of me it would have shown me that the people in the medical profession knew about the sad things that happen to some people. I am 53 years old now and it has only been about 10 years ago that I started allowing myself to think that it was OK for me to enjoy life. I am seeing a psychologist, taking antidepressants and have joined a theatre group. I still have a long way to go, but I can see a big difference in my life. I am setting boundaries and standing up for my rights. How many (more) lives can be saved by this program (questionnaire)?

For our purposes though, the tantalizing implication is we're only as healthy as the secrets we share.

For our purposes, though, the tantalizing implication is we're only as healthy as the secrets we share. This, in and of itself, is not necessarily new information. Twenty years ago investigations revealed that upheavals "kept secret were more likely to result in health problems than those that could be spoken about more openly." What is new, are the variety of immune markers and physical health measures that track positive changes following an emotional disclosure and are likewise associated with significant drops in physician visits. Science writer Henry Dreher captures the power of disclosure under the subheading "Truth or Dare: The Health Effects of Opening Up" in his book Mind-Body Unity. A leading expert on the physical effects of confession, James Pennebaker, PhD, interviewed polygraph instructors and learned

> …of a peculiar but telling sequence of events that typically occurred when individuals guilty of a crime were given a polygraph test. When people are initially hooked up . . . whether guilty or not—their autonomic nervous systems are racing, with elevated heart rate, breathing rate, blood pressure, and skin conductance. . . . When a confession is induced . . . in most instances he or she is required to take one more polygraphs to ensure that the confession was truthful, and it is here that the peculiarity occurs. Although at that very moment the person's life is in a shambles, remarkably he or she is often found to be physiologically very relaxed. The person's heart rate has slowed, breathing has slowed, skin conductance has normalized, and blood pressure has lowered. Often the suspect warmly thanks the polygraph instructor before he or she is carted off to jail.

For clinicians working in health care settings psychoeducational programs can address the unique needs of this underserved population—once Pollyanna is put in her place—with near miraculous results.

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Yoga for Older Adults

The older adult population is growing rapidly in the United States. Nearly 1 in 8 Americans is 65 years of age or older (U.S. Census Bureau, 2008). One in five Americans will be age 65 or older by 2030 and the rise in the older adult population is expected to double from 2008 to 2050. Similarly, the 85 and older cohort is expected to triple from 2008 to 2050 (U.S. Census Bureau, 2008).

Public health professionals and gerontologists are examining ways to reduce health risks for older adults as this population continues to grow. Falls are a major health concern in the older

adult population causing significant morbidity and mortality, and contributing to functional decline, depression, social isolation, and nursing home admission (Ferris, 2008). Additionally, falls lead to increased frequencies of broken bones, severe bruises, and head injuries. One-third of community-dwelling adults over age 64 fall annually and those who fall once are two to three times more likely to fall again (Ferris, 2008; Stevens & Sogolow, 2008). Economically, the direct medical costs for injuries related to falls in 2000 totaled $19 billion (Stevens & Sogolow, 2008). Although, the prevalence of falls increases with age, falling is not a normal part of aging. Exercise intervention, home modifications, and multi-faceted interventions reduce the number of falls in older adults (Stevens & Sogolow, 2008).

Balance does not necessarily decrease with age; however, the risk of developing balance problems increases with age.

Balance does not necessarily decrease with age; however, the risk of developing balance problems increases with age. Balance problems are often attributed to infectious or degenerative diseases of the brain, the sum of a lifetime of bodily injuries, or limited physical activity (Tinetti & Speechley, 1989). Yoga, an effective gentle therapy for older adults, can be used to improve and maintain balance in this population (Bonura, 2008). An increasing number of retirement communities and assisted living communities are offering gentle yoga (a slower moving yoga focused on relaxation and breathing) or chair yoga classes for their residents (Quilty, 2010).

Chair yoga is a modified style of yoga in which participants are seated in straight back chairs and perform postures with modification based upon individual physical limitations. This form of exercise has become popular for older adults who have difficulty standing for long periods of time, bending forward to place their hands on the floor, being on their knees, or performing poses on their back (Bennett, 2007; Quilty, 2010). Chair yoga allows older adults to regularly practice yoga even if they have limitations such as using a cane, walker, or wheelchair.

Many yoga therapists believe in addition to improved balance, yoga can help improve older adults' flexibility, ability to breathe, sense of calm, and circulation, as well as ease any musculoskeletal/joint pain (Bennett, 2007; Kraftsow, 2010; Bonura, 2008). Health professionals are supportive of yoga for seniors but, at the same time, caution seniors to be careful if they have blood pressure issues (Bennett, 2007; Kraftsow, 2010; Quilty, 2010). In a recent study, Eggleston & Ehlman (2010) interviewed 20 nurses (RN and NP) and several other health professionals, and found that 65% (*n* = 13) of health care professionals were unaware of the hundreds of training hours required for yoga therapists to practice.

The growth of alternative medicine, such as yoga for older adults, is evidenced in the literature. A program entitled *Safe Steps, Falls Prevention for Seniors* used yoga to improve balance, strength, and flexibility (Home Safety Council, 2004). Yoga was found to be a therapeutic practice enhancing the physical, psychological, and spiritual wellbeing of older adults in nursing homes and residential care settings (Bennett, 2007).

Crews (2005) developed a program entitled *Yoga Basics for Older Adults*

for active seniors. Crews incorporates three components in this program: movement, breath, and meditation, allowing participants ample time to move deliberately into and out of each pose, as well as time to make adjustments with the pose. In Crews's (2005) program designed for seniors, participants listen to the messages coming from their bodies, and adjust the pace and intensity accordingly.

Flegel (2007) analyzed yoga adherence data from a six-month study involving 135 generally healthy seniors 65-85 years of age. Participants were randomly grouped in one of three groups: a) an Iyengar Yoga class group with home practice, b) an exercise class with home exercise, c) or a wait-list control group. Among the participant completers of the two active interventions, the average yoga class attendance was 77% and yoga practice at home occurred 64% of all days. For the exercise and home exercise group, the class attendance was 69% and home exercise occurred 54% of all days. The researchers reported the yoga class with home practice had a positive effect on quality of life.

The *Silver Yoga Programme* (Chen, 2007), developed specifically for older adults, incorporates warm-up and cool down aspects. The *Silver Yoga Programme* is designed for reduced body flexibility experienced by many older adults. Program participants found the program appropriate for older women, but further evaluation is needed to determine its efficacy with other groups.

Bonura (2008) developed yoga programs for individuals with limited mobility and programs to promote pelvic floor health. Bonura identified yoga as an activity that improves older adults' psychological health. Older adults practicing yoga observed the following improvements: decrease in anger, decrease in anxiety, decrease in depression, increase in well-being, increase in general self-efficacy, and increase in self-efficacy for daily living. Yoga may be helpful in complementing other forms of medical services that older adults receive and can be offered at a low-cost to large groups of older adults.

Easy Does It® Yoga, developed by Christensen in the 1960s, helps individuals with limited mobility (including elderly individuals) practice yoga in a chair or bed (American Yoga Association, 2010). Easy Does It Yoga is a combination of breathing, meditation, and physical postures that allow individuals to improve their overall quality of life. Research on the Easy Does It Yoga program has shown it to be effective for decreasing somatic and psychological complaints; decreasing anxiety symptoms; improving self-esteem; and experiencing positive physical changes. Additional research has shown this program to be effective for decreasing blood pressure over time as well. The Easy Does It Yoga program is one of the oldest yoga therapy programs for older adults in the United States.

Beneficial effects on balance were found in a yoga program specifically designed for fall prevention in the senior population (Brown, Koziol, & Lotz, 2008). The program incorporated improving "strength and flexibility in the torso, hips, and lower extremities; movement outside the base of support . . . stepping; and

The researchers reported the yoga class with home practice had a positive effect on quality of life.

reaching" (Brown, et al., 2008, p. 455). The researchers point to a need for future studies to isolate older adults who could most benefit from yoga programs.

A public Midwestern university conducted a study to measure improvements in balance and well-being after an eight-week yoga class for older adults. Under the direction of university faulty, university students and community members collaborated to offer yoga classes for older adults at two care settings. In addition to the yoga classes, the older adults participated in an eight-week computer class. A repeated-measures crossover design was utilized, which offers equivalence among subjects exposed to different conditions (Polit & Beck, 2004). The first group attended yoga classes twice a week for eight weeks and then attended computer skills classes twice a week for eight weeks. The second group attended computer skills classes for eight weeks and then attended yoga classes biweekly for eight weeks. Study participants were at least 60 years old and resided at one of the two care settings in the study.

Data collection took place at three points in time; week one, week nine (crossover), and week 16. The following data collection tools were used in the study:

- Demographic Information/Health History
- Balance (Berg Balance Scale)
- Should Flexibility (Back Scratch Test)
- Life Satisfaction (Diener's Life Satisfaction Scale)
- Positive and Negative Affect Scale (PANAS)
- Short Form 36 (Quality of Life)

To encourage home practice, participants received an instructional DVD, *Yoga for Well-Being*, to use outside of yoga classes. *Yoga for Well-Being* was filmed and produced through the university and led by a certified yoga instructor. The video has four sections: Beginning Practice (morning), Continuing Practice (afternoon), Yoga for Evening and Restful Sleep, and Yoga for Comfort. The video also includes a legal disclaimer and introduction to explain the video, and to encourage the participants to use the video in a safe way.

Over 90% (*n*=28) of participants in this program overwhelming reported positive feelings regarding both the yoga and computer instruction courses. . .

Over 90% (*n*=28) of participants in this program overwhelming reported positive feelings regarding both the yoga and computer instruction courses; however, regular consistent participation of classes at times was difficult to achieve. There was an insufficient sample size to find significant differences among individuals regarding the physical health measures of resting heart rate, blood pressure, balance, height, weight, shoulder flexibility, and well-being. Participants reported higher levels of well-being over time through both the yoga and computer programs, respectively. Additionally, overall perceived flexibility was reported to be higher over time for 87% (*n*=27) of participants.

Although the participant sample size was small and the attrition rate was high in this study, the researchers gained valuable insights for future yoga programs for older adults. First, to understand the full impact of the intervention, yoga research studies for older adults should extend beyond eight weeks. Second, a larger sample

size allows for attrition and will likely show statistically significant improvements in older adults' blood pressure, resting heart rate, well-being, and flexibility measures. Additionally, yoga therapists and other professionals working with older adults should consider cultivating community partnerships to provide programs for seniors. In the program described above, university faculty and students collected data for this project as well as taught the computer classes to the residents. As well, the local library provided meeting space and computers for the computer classes for the residents. Developing new partnerships and cultivating current community partners has the potential to open doors to new programming that may improve the quality of life for older adults. As the body of literature regarding yoga for older adults continues to grow, individuals working with older adults are urged to develop yoga programs for older adults. The benefits are likely to go beyond improving balance, but have the potential to improve overall quality of life.

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Submission Guidelines for *Wellness Management*

Wellness Management, the best practices new wellness insights publication of the National Wellness Institute is looking for original work. Articles might be wellness-related research summaries, detailed "how-to's" on program creation and implementation, or new ideas in wellness.

Articles should be no longer than 2,000 words and **must** adhere to the following criteria to be considered:

1. Evidence-based (even if it is something you have personally observed, please back up statements with proof or citations).

2. Include citations in APA format with a "Reference" section at the end of the document.

3. An author(s) biography and curriculum vitae. If there is more than one author, both/all biographies/vitas must be included.

4. An author(s) photograph. If there is more than one author, both/all photographs must be included. Photographs should be sent in a separate file in .jpg format

5. Articles that promote a specific product will not be accepted.

6. Articles written with an underlying marketing bent will not be accepted.

7. Due to space limitations, charts and graphs should be limited.

8**. All files names must be in the following format: <author last name>-<title key word>-<Winter2011>**

. Once selections are made, notice will be given. Due to the volume of submissions, interim notice is not possible.

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