

# Use of Letter Writing as a Means of Integrating an Altered Body Image: A Case Study

Patrice Rancour, MS, RN, CS, and Kathryn Brauer, MSN, RN, CNOR, USAFNC

**Purpose/Objectives:** To describe the use of letter writing as a technique to assist patients in adjusting to an altered body image after dramatic cancer treatment.

**Data Sources:** Published articles and books.

**Data Synthesis:** Gestalt therapy, psychosynthesis, and journaling techniques evolve into a technique that can assist patients who are challenged to accept altered body parts.

**Conclusions:** Described in a case study presentation, letter writing was found to assist female patients with recurrent breast cancer in adjusting to reconstruction of lost breasts.

**Implications for Nursing:** Nurses can use letter writing as a means of assisting patients through the grief process associated with body image alterations.

## Key Points . . .

- ▶ Patients who undergo dramatic changes in physical appearance after cancer treatment will grieve for the lost or altered body part or its function.
- ▶ Psychosocial rehabilitation and reintegration are important components of a holistic approach to care.
- ▶ Letter writing, a technique in which patients “communicate” with lost or altered body parts, can evoke a healing response during the adjustment period.

## Literature Review

An impressive number of psychotherapy outcome studies in medical settings have determined that patients who receive psychotherapy in addition to surgery or medical treatment fare significantly better psychologically and emotionally than patients who rely on medical treatments alone (Ferrell & Coyle, 2001; Holland & Rowland, 1990). The therapeutic technique of journaling used with verbal therapy also is well documented as a tool to stimulate a healing response (Day, 2001; Jordan & L’Abate, 1995; McGihon, 1996; Pennebaker, 1993; Rosenberg, 1990; Torrem, 1993).

Numerous benefits have been cited for the additional use of journaling or, more specifically, letter writing for patients undergoing intrusive medical or surgical techniques.

- Patients become active participants in their treatment and assume personal responsibility for change. Writing is an active statement of externalizing an internal experience and becomes a prelude to proactive problem solving by patients (McGihon, 1996).

*Patrice Rancour, MS, RN, CS, is a psychiatric and mental health clinical nurse specialist at the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute in Columbus, OH; Kathryn Brauer, MSN, RN, CNOR, is a flight commander in the surgical suite of the U.S. Air Force Nurse Corps at the U.S. Air Force Academy Hospital in Colorado Springs, CO. The views expressed in this article are those of the authors and do not reflect the official policy or position of the U.S. Air Force, Department of Defense, or the U.S. government. (Submitted June 2002. Accepted for publication January 25, 2003.)*

Digital Object Identifier: 10.1188/03.ONF.841-846

Despite the emergence of microsurgery and other less invasive surgeries, many patients still undergo radical operations that alter body parts’ structure and function. As a result, they may grieve the losses associated with such drastic changes (e.g., altered reproductive or elimination processes, missing limbs, sensory and motor alterations, other stigma-producing anatomic alterations). Grief is the normal healing response to such losses. Because grief is not pathologic, its facilitation originates from a wellness conceptual framework.

Numerous one-on-one interventions already exist to assist grief work and promote adaptation to an altered body image. These include helping patients look at altered sites, sharing bibliotherapies with pictures of patients having undergone similar surgeries now engaged in daily living activities (Sabolich, 1995), and encouraging the use of expressive arts such as painting pictures of themselves before and after treatment with attendant debriefing. In addition, community building can help patients feel less isolated. Encouragement to join groups or other support activities offered by organizations such as the Wellness Community (Benjamin, 1995) can inspire hope that “life after cancer” does exist. The American Cancer Society’s “Look Good, Feel Better” program and one-on-one programs also are useful in helping patients feel more comfortable with their new bodies.

Ultimately, the ideal outcome for patients is to use their health situations as an opportunity for growth, especially psychospiritual growth. This article describes the process of letter writing as one way healthcare professionals can assist patients who must grieve the loss of body parts and function so that they can move past the role of patients to their daily lives. If these situations are handled therapeutically, patients can be helped to not only cope with but also transcend the illness and its treatment.

- Writing complements one-on-one therapy (Jordan & L'Abate, 1995) because it helps therapists obtain critical patient information more quickly and gives patients a feeling of being cared for between sessions (McGihon). In addition, patients remain centered in the grief work at hand, and letter writing can be an economical way of continuing work between sessions (Jordan & L'Abate).
- Patients who are reluctant or embarrassed to speak openly in one-on-one interactions find that they can use writing to communicate sensitive issues. This includes suicidal ideation or other serious symptoms (McGihon).
- Self-reliance, self-mastery, and insight are enhanced. Journaling as a learned tool can be used later by patients to help cope with future crises (Day, 2001; Jordan & L'Abate).
- A journal provides a map of the therapeutic process and reveals the hidden opportunities an illness can provide. These often are painful learning experiences that patients often describe later as "soul making" experiences (Day).

Researchers hypothesize that journaling evokes a healing response through mind-body interaction. Energy used to suppress painful experiences drains the immune system of the energy required for physical healing. As journaling releases this energy, it becomes available to a struggling immune system (Day, 2001). Day also believes that written dialogue is an opportunity to make contact with another way of knowing, which taps a deeper wisdom that typically is not accessed through logical, linear methods.

## The Therapeutic Process

As a healing strategy, letter writing can facilitate the integration of an altered body image. Although it can be part of an ongoing series of counseling sessions with a healthcare provider, letter writing also can be incorporated into any therapeutic alliance with a patient facing medically induced body alterations. For example, an outpatient can be counseled to use the technique during a series of clinic visits.

The process begins with identification of the body part that will be lost or changed. Ideally, this kind of work should start prior to surgical intervention to help facilitate rehabilitation. Once the patient has expressed his or her feelings about the upcoming treatment, he or she is instructed to write a letter (as homework) to the affected body part, describing his or her reactions to its impending loss. This is done without censorship on the patient's part. Often, feelings of victimization, anger, fear, and anxiety are reiterated as the patient tries to articulate his or her innermost feelings.

When the patient returns for the next session, he or she is asked to read the letter out loud to the healthcare provider. This creates an additional opportunity for catharsis. At the end of the session, the patient is given another homework assignment. This time, the threatened part or function "writes" back to the patient. Initially, this may seem strange or awkward to the patient; however, the patient should be encouraged to try identifying with the point of view of the lost or altered body part and writing a response back to the whole person. This reminds the patient on a subconscious level that although he or she possesses this particular body part or function, the whole person consists of more than any individual body part. This activity is designed to help people transcend the limits of strictly physical self-identification (Shinoda-Bolen, 1996) and lays the groundwork for future psychospiritual work.

At the next meeting, the patient is encouraged to read the letter from the body part to the therapist. This way, an active dialogue is set up between the patient and the removed or altered body part. This letter writing between the patient and the affected body part continues until the patient has diverged from his or her previous physical sense of self and is forming a new, more holistic identity. Patients reaching this point will begin to express increasing comfort with their appearance and confidence in their abilities to take care of themselves and return to daily life activities.

Letter writing softens the immediacy of other forms of experiential work for people who find those approaches too threatening, such as the Gestalt approach of using "the empty chair" technique (Perls, 1969). This technique involves the patient imagining the affected body part in a nearby chair and speaking with it as if it were a detached entity. This point of view can help the patient form a separate identity and evoke an entirely new self-concept capable of shifting the patient's relationship with the body part. The privacy of letter writing provides a "safe" means for patients to achieve the goals of their grief work.

Barriers to the use of letter writing as an adjunctive technique to facilitate grief work include patient illiteracy or patient resistance to its use. However, the authors have found that most patients who are introduced to the use of letter writing find it helpful and go on to use it voluntarily as a means of coping.

## Case Study

The following case study describes an application of the letter writing technique. As the patient progresses through her treatment, her letters are augmented by the nurse therapist's and her own observations. The patient also views her newly acquired point of view as her survival of the crisis.

### Nurse Therapist's Point of View

Kathryn is a 44-year-old Caucasian woman with recurrent breast cancer. Her prior treatment consisted of a lumpectomy with node dissection, radiation, and chemotherapy. She is extremely angry that after her first extensive treatment, she is being asked to submit to treatment all over again with a more aggressive surgery, mastectomy. Because she is a single woman still engaged actively in dating, this presents a further complication to her sense of self with implications for handling issues ranging from communication ("When do I actually tell a prospective partner?") to physical intimacy ("Who will want me like this?").

Kathryn's anger impedes her ability to make urgent treatment choices that she verbalizes are against her will. Her deep feelings about facing the loss of her breast are challenged by the necessity of moving along quickly with these choices and implementing them. This is compounded by her intense sense of injustice about her situation. She needs her therapist to acknowledge and legitimize her feelings and ensure that she does not feel discounted in the rush to treatment.

Kathryn chooses a skin-sparing mastectomy with an immediate latissimus dorsi reconstruction. She will have progressive saline implant instillations until a permanent breast implant can be inserted. At that time, her other breast will be cosmetically altered to achieve some symmetry. After healing is complete, a nipple will be grafted onto the recon-

structed breast. A positive aspect of this treatment plan is that the process occurs over a period of time and will give the patient time to adjust to an altered body image. However, because the process takes so long, her experience of illness also will linger.

### Patient's Point of View

I think it is important to understand the intense emotional pain I felt so you can appreciate how much the letter writing affected my healing process. When my surgeon told me the results of the breast biopsy, the world suddenly changed. Previously, I had been treated with breast conservation therapy; therefore, there was only one option left. That option was one I wanted no part of. There was no way I was going to have a mastectomy! I would rather die than have my breast cut off. I felt my world was over. What was the point of going on? No one would want me after I was mutilated.

At the same time all of this emotional chaos was taking place, I had to decide on treatment options. Whether to choose reconstruction, now or later, what type, where to have it done, and who was going to do it were the decisions I faced as I approached what I perceived to be my wit's end. As an operating room nurse, I am around surgeons all day long. I have heard doctors talk for years and knew in my heart I needed a mastectomy. Dying from untreated breast cancer was not a responsible choice. I knew I needed surgery, but how was I going to live the rest of my life feeling as I did?

I did not like feeling the way I did. I sought counseling during my first experience with cancer and decided I should do so again. I knew I was not mentally ill, but I wanted to talk to someone who knew what to say and was comfortable talking about death, body image, and the like without discounting my feelings. I had a difficult time finding the best help for myself. Two months after my recurrence was diagnosed and three weeks before my surgery, I asked for another consultation. By the time the nurse therapist saw me, I was a "basket case." This began to change when she allowed me to grieve and express my sorrow. Crying was allowed and so were hugs. I trusted her. When she asked me to write a good-bye letter to my left breast, I did so without any reservations. After all, I finally felt I was being understood.

## The Letters

A series of letters that Kathryn wrote to and from her breast as part of the grief work designed to help her integrate her new body image accompanies this article. Readers can observe the movement through the process reflected in and facilitated by the letter-writing technique. These homework assignments between therapy sessions provided a way for the therapeutic work to continue between sessions. Figure 1 contains the first letter written as part of this therapeutic process.

### Nurse Therapist's Point of View

The powerlessness and rage over the impending loss in the first letter shows that Kathryn's experience threatened her self-concept to the point of suicidal ideation. Assessment for lethality at this point certainly is indicated. Nurses are reminded to pick up on statements like these and refrain from promising to keep them in confidence if they believe patients may act on them. Asking questions like, "Are you feeling so down that you might hurt yourself?," or "Do you

I'm writing this letter because my worst nightmare has come true. Cancer has invaded once again. For some unknown reason, it has picked you, my left breast. I must tell you that you have always been my favorite breast. This is probably true because I'm left-handed (hence left is the best reasoning coming into play). I'd rather die than lose you. Unfortunately, our society won't let me do that. They hang onto life, and people have to suffer. Everyone says I should receive the treatment, but they don't understand the hell we've been through. I've let them assault you with a knife twice. They've zapped you with radiation. Even with that, you are still a beautiful breast. If I don't let them treat you, the cancer will erode through the skin that covers you, and it will metastasize to our lungs, brain, and bones. Then you will not be a beautiful breast anymore. If I jump off the deep end, they'll lock us up with keys, locks, and chemicals. Yes, we could kill ourselves, but how would we? A gun? No. We may not be successful, and you know I'm not going to do anything illegal. So they've got us cornered. We have to accept treatment. I want to explain this to you so you won't think I'm giving you up without a fight. People say to me "it's just a breast." You are more than just a breast. You are a part of me I don't want to lose. I like my body the way it is. You are one of my two size 34B breasts, not too big and not too small—just right. Remember when we were fourteen years old? We were invited to a pool party. You guys weren't as big as you are now, so Mom bought us a bathing suit with ruffles on the top to "help us out."

This is totally unfair. I thought we narrowly escaped that damn demon, cancer, the first time with breast conservation. Now we have NO choice. NO choice, can you believe it? Why us? What did we do to deserve this? My heart hurts so bad at the thought of this. I hate this for you. I'm sorry, so very sorry I have to lose you. I'll hate signing the consent form. I don't want to sign it. I will miss you forever and ever. Cancer takes its toll. You are not just a breast. You have protected my heart my whole life. Thank you for that.

### Figure 1. Patient's First Letter to the Cancerous Body Part

have a plan for how you would harm yourself?" will help nurses ascertain whether patients need to be in a more protective environment and whether more intensive mental health work is indicated and an appropriate referral is made.

Discriminating between clinical depression and a complicated grief response also is critical. The nurse therapist may have difficulty determining the difference. In this case, a mental health referral may help, especially because many vegetative symptoms of depression (e.g., sleep and appetite disturbances, depressed affective states, immobilization, social withdrawal, all lasting for at least two weeks) are common side effects of cancer and its treatment. Clinical depression hosts a constellation of vegetative symptoms, and complicated grief can mimic depression but is highly responsive to therapeutic techniques such as letter writing. If letter writing is done in a timely manner, a patient can experience consistent movement through the grief process. Depression requires active treatment, perhaps with antidepressant medication. Complicated grief requires active facilitation of what is essentially a stalled grief response (Schneider, 1980). This differential diagnosis is beyond the scope of this article, and the reader can find further elaboration in Schneider (1980). Kathryn's fears about mutilation are common among patients facing cancer treatment. Seeing treatment as something to assist long-term survival rather than focusing on what is lost is an inherent goal of effective grief work. Nonetheless, the painfulness of the loss and how it is experienced by the patient should be acknowledged and

not trivialized with remarks such as, “But you know your hair will grow back” to patients receiving chemotherapy. Until such pain is acknowledged, patients are likely to direct their anger toward healthcare personnel who they may perceive as insensitive and uncaring.

Kathryn’s first letter also emphasizes that cancer recurrence is completely different from a new diagnosis scenario. Unlike the first time, she understands what is being asked of her.

### Patient’s Point of View

I took my “homework” assignments very seriously. I even wrote them on stationery with angels in the background. After writing the first letter, I felt a profound sense of relief because I finally was able to express all of my horrific feelings without being told to “get over it.” The nurse therapist accepted my negative thoughts and said they were okay. The first assignment also included writing a letter to welcome my newly reconstructed breast. I was very apprehensive about how the new breast would feel, not how it would feel to my touch, but how it would feel as a part of me. I already had planned several weeks before my surgery that I was not going to look at the new breast for quite a long time. I decided I had to have the surgery, but I did not have to look if I did not want to, and that also was fine with the therapist.

The next assignment consisted of my cancerous breast writing a good-bye letter (see Figure 2). To me, this assignment was an acknowledgement that someone really understood and could comprehend the tremendous sense of loss I was experiencing. Following my surgery, I recall waking up, looking down, and touching my chest. The new breast felt like it belonged with the rest of me. It did not feel strange. It did not feel like it was hung on my chest like a picture. It was fitting in with the rest of me. Maybe I could do this! With the help of my nurse therapist, along with the oncology staff nurse’s therapeutic conversation, I was ready to look at my new breast on the third postoperative day, much sooner than I originally intended. At discharge, I was given my next assignment (see Figure 3). I was to write another letter to my new breast telling it how I felt about it now that it had been created. It would be due the following week at my first postoperative visit. As you can see from the letter, my skepticism is gone and my sense of humor has surfaced again. Also, I am accepting the long process involved with breast reconstruction.

---

November 2000

Words cannot express the sorrow I am feeling for you. I know this is a very big setback for you, and it has hit you hard. I am proud of you for taking such wonderful care of me during our first bout with cancer. You fought hard for me, and I know it was not easy for you to find the nurturing care we both needed. I know you will be very upset for some time, on Tuesday as you go to the operating room and as you recover from surgery. This is as it should be. We have suffered a serious assault. Do not allow anyone to discount your feelings. You do not have to be happy about this and try to hide your feelings. I will miss you. I heard you mention you are not going to look at your new breast for some time. I know why. You are afraid it will not look like me. You can be afraid, and you don’t have to look. I am scared for you, too. I hate what you are going through. I wonder when the suffering will end. I am just as sorry as you are to have cancer in me. I will miss you forever and cry a million tears for you.

### Figure 2. Cancerous Body Part’s Letter to Patient

---

With every serious illness, there are many changes and losses to adapt to, and you represent both. Now, don’t get me wrong. I’m very thankful my gifted surgeons were able to create you. I’m even somewhat comforted, relieved, and able to accept you more because of the newest techniques today that allow skin to be spared. I’m grateful you are now part of my anatomy, because I would not want to experience a chest without a breast. I will share with you that I’m apprehensive about what you will look like. Therefore, I won’t be looking at you for a long time. Don’t take it personally though; it’s a coping mechanism. I think they call it denial. I think we’ll have to take one step at a time. That’s the best I can offer you right now.

### Figure 3. Patient’s Letter to the Reconstructed Body Part After Hospital Discharge

#### Nurse Therapist’s Point of View

As the letters continue after the surgery, the “voice” of the breast represents a compassionate point of view that Kathryn finally is able to access as she looks at the problem from a different perspective (see Figure 4). The voice of the breast introduces the experience of deep forgiveness into Kathryn’s process. Often, anger and resentment interfere with patients’ ability to move forward. Normalizing the anger by acknowledging it, and then moving on to suggest that what their bodies need right now is love and compassion rather than anger, helps remind patients that, while they have bodies, they are not solely their bodies. This new self-identification is assisted by the letter-writing dialogue and helps increase the likelihood that Kathryn will respond to her pain, rather than from her pain. When this shift happens, patients feel more self-empowered, more in control, and less victimized. This is the foundation of psychospiritual growth. As a result of giving herself permission to let go of the cancerous breast, Kathryn was able to move forward to accept a new body part. Further evidence of Kathryn’s healing is that she was able to look at the altered body part earlier than she had expected. When patients feel too immobilized to proceed, expressing confidence in their innate abilities to move on when they are ready is imperative. This way, patients are provided a safe place to explore their feelings without experiencing pressure to be different from who they are. A wellness perspective allows nurses to point out what is whole and well with patients, rather than what is broken or pathologic with them. “Although everything is not fixed, everything is not broken” is certainly an applicable wellness maxim in this situation.

---

December 2000

You’ve been on board for two weeks now. I can’t believe I’m telling you this, but I think you just may work out. Everyone says you look great. It took me a few days to look at you. I wasn’t sure what you would look like, and, since I’m not accepting this cancer thing very gracefully, I decided to wait until I was ready to deal with looking at you. Actually, I was rather surprised at the overall result. Don’t tell anyone, because I’ll deny it, but you are pretty perky! I’ll be even happier when Dr. V. finishes his matched set.

### Figure 4. Patient’s Letter to Reconstructed Body Part Two Weeks After Surgery

**Patient’s Point of View**

The next letter was written nearly nine months following my original surgery (see Figure 5). I learned to be patient and not to “go off the deep end” until I had a reason. The progress I am making toward accepting what has happened to me is interesting. When initially diagnosed, I could not stand the thought of having numerous surgical scars. In the letter, I mention I can live with the scars and accept them as a part of me. The nurse therapist visited me the day after my surgery and was there for the “unveiling.” Lo and behold, I had a matched set. Finally things were getting better. It had been a long time since I felt this good about myself. I found a happiness I never thought I would experience again. Four months later, I wrote a final letter just before my last procedure, areola and nipple reconstruction (see Figure 6). Looking back, it commemorates the entire journey. I believe letter writing helped me move through the grieving process by allowing me to deal with issues that would have paralyzed me. It also was an opportunity to look back on the progress I made and declare my victory.

**Nurse Therapist’s Point of View**

Kathryn’s perception of the surgery shifts from being a mutilation to being “the answer.” She begins to see the surgery as something to promote her healing, not as something designed to further assault her. This is another indication that her grief work is progressing.

August 2001

I’ve waited a long time for this day to arrive, nine months to be exact. If you were wondering why I call you “Matched Set,” it is my nickname for how I envision my breasts to look after this surgery.

It is very important to me for both of you to look alike. I hope I’m not being unrealistic. I have been very patient since my first surgery. I understand how breast reconstruction surgery is a step-by-step process. The first surgery creates the breast “mound.” It’s no secret that I’m not satisfied with my breast mound, as it is today. I’m tired of being lopsided. It is a mound and it is hard to the touch. I feel it is missing the shape and softness of a natural breast, and it is quite a contrast to my right one.

I have been told the goal of breast reconstruction is to look normal in a bra. I want to look normal without one. I realize scars can’t be erased. I’m willing to live with those. I don’t like asymmetry. When I saw the photo album of reconstructed breasts in the plastic surgeon’s office, I wasn’t impressed with the results. When I asked why the women didn’t have more surgery to correct their defects, I was told it was a personal choice. I couldn’t believe it. I’m hoping the permanent implant will have a better result than the saline implant. I decided to have the right side augmented to help with symmetry. It’s not that I wasn’t satisfied with my original size, but as I faced my first surgery, my concern was how my new breast would feel, and I was worried about potential defects as a result of the latissimus dorsi flap. Well, my reconstructed breast feels like it belongs to me, and I don’t have any defects from the flap. So, I’m putting all my faith in my surgeon and his surgical skills. I will be very upset if I can’t get symmetry. I feel that it could be possible because there are more options if the surgeon can manipulate the size of both breasts. I’m not upset now, because I’m looking at this surgery as the answer. If it isn’t, the nurse therapist will be there Tuesday morning, and, together, we can formulate a plan.

P.S. I’m hoping you guys turn out to be a set of world-class boobs, after all we have been through.

**Figure 5. Patient’s Letter to Altered Body Part After Further Reconstruction**

It was a LONG, LONG haul. I can look back at how difficult having breast cancer a second time has been. Quite a few people have mentioned they admire me for getting through it. It wasn’t easy. As a matter of fact, I do believe this has been the toughest challenge of my existence. During this cancer treatment, this is the first time I’m actually looking forward to having surgery tomorrow. Not only is this the last procedure of the entire breast cancer treatment, it also completes my restoration. That is why I am calling you the “Icing on the Cake.”

I believe I’ll have a set of world-class boobs tomorrow! I’m also seriously considering going to Mardi Gras! All kidding aside, those comments just confirm that I’m very comfortable with my new body image. I also reconfirmed a lesson I learned the first time I had cancer. It’s the one when you realize you made it. If you don’t know what I’m talking about, it’s almost like putting the horse before the cart, but not really. You actually come across people who need you to shine the light for them. You are able to do just that. Then you realize you are better because you can put yourself aside and help them with their needs.

This happened to me this fall when I helped two friends cope with newly diagnosed breast cancer. They both said, “If you can do it, so can I.” Also, being asked to circulate in the operating room for a coworker’s 13-year-old daughter having a breast biopsy tomorrow morning is an honor. Especially when the mother said she could think of no one better to offer support to her daughter.

I won’t kid you or myself for that matter. It is tough some days, coping with all of the changes brought about by breast cancer treatments. Believe me, there are lots of them. Now, I know I’m going to make it. Don’t worry. You’ll fit in just fine!

**Figure 6. Patient’s Letter to Reconstructed Body Part Prior to Final Reconstructive Surgery**

During Kathryn’s last therapy sessions, she began to discuss her need to use her painful illness and treatment experience to help others. This is indicative of grief work being brought to resolution. This discussion has a redemptive quality, and it reminds us that great suffering can be borne in a meaningful way. Kathryn has learned to transcend her sole physical self-concept and perceive herself in other ways. Therapists state that this is the transformative power of healing (Frankl, 1963).

**Conclusion**

Letter writing is a technique that complements ongoing counseling for medical and surgical patients. Therapists can assist patients to accept altered body images following invasive traumatic surgeries or other medical treatments. By incorporating letter writing, the patients’ grief processes can be facilitated and grieving becomes a natural part of the rehabilitation process rather than an impediment.

Nurses in a variety of care settings can include letter writing as part of the care plan for patients experiencing an altered body image. Many nurses are skilled in therapeutic communication and have the ability to guide patients through the process. Although advanced preparation in mental health nursing is advantageous, nurse therapists do not need to have this training for patients to benefit from this technique. Nurses wishing to learn more about the use of such techniques are encouraged to find a mentor, such as a mental health clinical nurse specialist. In addition, continuing education in the form of extended reading and attending coursework designed to

Downloaded on 05-21-2024. Single-user license only. Copyright 2024 by the Oncology Nursing Society. For permission to post online, reprint, adapt, or reuse, please email pubpermissions@ons.org. ONS reserves all rights.

refine such skills can enhance nurse therapists' self-confidence and competence.

Implications for nursing education suggest that these mental health techniques can be integrated throughout medical-surgical courses to assist students who are taking care of the whole patient and not just the affected site. Merely telling students to "provide for the emotional well-being or the spiritual care of the patient" is not enough. These kinds of concrete and practical strategies can be incorporated easily into their clinical work with immediately visible results. The use of these techniques can be self-reinforcing and rewarding for practitioners.

Future research may identify how such techniques can reduce length of stay and complication rates for recovering pa-

tients, and outcome studies should examine the effects of these therapeutic strategies on the length of rehabilitation, rates of morbidity, and adherence to treatment plans.

As Dass, Matousek, and Roeder (2000) instruct, curing is a return to the way things used to be, and healing is using the current situation to bring us closer to God. Although not all patients will be cured, healthcare professionals can work with all of them to make healing possible.

*The authors wish to thank Jeannie Stewart, research librarian at the Wright-Patterson Air Force Base in Dayton, OH, for her invaluable assistance.*

**Author Contact:** Patrice Rancour, MS, RN, CS, can be reached at rancour.1@osu.edu, with copy to editor at rose\_mary@earthlink.net.

## References

- Benjamin, H. (1995). *The wellness community guide to fighting for recovery from cancer*. New York: Tarcher-Putnam.
- Dass, R., Matousek, M., & Roeder, M. (2000). *Still here: Embracing aging, changing, and dying*. New York: Riverhead Books.
- Day, A.L. (2001). The journal as a guide for the healing journey. *Nursing Clinics of North America*, 36, 131-142.
- Ferrell, B., & Coyle, N. (2001). *Textbook of palliative nursing*. New York: Oxford University Press.
- Frankl, V. (1963). *Man's search for meaning: An introduction to logotherapy*. New York: Washington Square Press.
- Holland, J., & Rowland, J. (1990). *Handbook of psychooncology*. New York: Oxford University Press.
- Jordan, K.B., & L'Abate, L. (1995). Programmed writing and therapy with symbiotically enmeshed patients. *American Journal of Psychotherapy*, 49, 225-236.
- McGihon, N.N. (1996). Writing as a therapeutic modality. *Journal of Psychosocial Nursing and Mental Health Services*, 34(6), 31-35.
- Pennebaker, J.W. (1993). Putting stress into words: Health, linguistic, and therapeutic implications. *Behavior Research and Therapy*, 31, 539-548.
- Perls, F. (1969). *Gestalt therapy verbatim*. New York: Real People Press.
- Rosenberg, L. (1990). The use of therapeutic correspondence: Creative approaches in psychotherapy. *Journal of Psychosocial Nursing*, 28(11), 29-33.
- Sabolich, J. (1995). *You're not alone*. Oklahoma City: Sabolich Prosthetic and Research Institute.
- Schneider, J. (1980). Clinically significant differences between grief, pathological grief and depression. *Patient Counseling and Health Education*, 2, 267-275.
- Shinoda-Bolen, J. (1996). *Close to the bone: Life-threatening illness and the search for meaning*. New York: Scribner.
- Torem, M.S. (1993). Therapeutic writing as a form of ego-state therapy. *American Journal of Clinical Hypnosis*, 35, 267-276. \_\_\_\_\_