Self-care follows from compassionate care – chronic pain patients’ experience of integrative rehabilitation

Maria Arman PhD (Associate Professor) and Johanna Hök PhD (Lecturer)
Department of Neurobiology Care Science and Society, Karolinska Institutet, Huddinge, Sweden

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The long-term outcome of any intervention for people suffering from chronic pain relies on the patient’s ability for self-care. This study explores patient experiences of self-care in relation to a rehabilitation programme at an anthroposophic clinic. In a qualitative interview study with a hermeneutic approach, individual interviews were conducted, recorded, transcribed verbatim and analysed. Interviews were conducted with ten women who were taking part in a year-long rehabilitation programme for chronic pain and overlapping illness. The women told stories of suffering with a focus on lives that were not functioning well. In this context, pain is like secondary. For many, the experience of loving care at the clinic became a turning point, a chance to be vulnerable, to be recognised, to reflect and to begin life anew. Signs of self-care could then be witnessed. The women described a process whereby they regained contact with their bodies and their fellow human beings; they were able to identify their needs and when to stand up for them. Everyday life at the clinic is guided by universal aspects of love, life and meanings. The care gives patients glimpses of a move towards community in contrast to past isolation, towards love in contrast to past alienation, and towards joy and inspiration in contrast to past suffering. Through receiving caritative and compassionate care, these women were able to identify their needs as a first step towards self-care. In the context of chronic pain, self-care needs to be more than advice, education and training. Health can be attained when the sufferer experiences what it is to be cared for. This study supports the potential of a caritative caring culture to help patients participate in a compassionate community both with others and with the self. This forms the basis for the reawakening of their natural self-care ability.

Keywords: self-care, caring science, patients, chronic pain, rehabilitation, integrative, complementary alternative medicine, anthroposophic care, suffering, health, compassion.

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Introduction

This article explores the concept of self-care using examples from patients with chronic pain who were receiving integrative health care at an anthroposophic hospital. Earlier studies of this integrative healthcare context (1, 2) have shown promising results on patients’ long-term health. While it is still debatable what kind of care that may improve these patients’ health, this study explores the role of self-care as part of a healthcare intervention for this group of patients.

Background

Self-care, as viewed in this article, is a contemporary term, which relates to a person’s view of and strategies for improving their own health. Everyday use of the term self-care is very flexible and encompasses home remedies, use of medicines, physical exercise, lifestyle issues and spiritual practice.

With regard to both the research question and context, Bauman et al. (3) write that, for patients with chronic conditions, it is important for practitioners to reduce and eliminate barriers to patient self-care. Their model includes a question guide that caregivers can use to identify patient attitudes towards self-care. In another review of chronic pain and self-management, Paterson et al. (4) have identified partnership as being essential to overcoming barriers against self-management. Written action plans and flexibility are recommended, with patients included in decision-making about their self-management. Allison (5) goes a step further by applying Orem’s concept of self-care in nurse caregiving with regard to patient activity and rest. Helping patients to participate in healthy activity, to sleep properly and to relieve stress through various aspects of health care is, accordingly, an example of a nursing action that enhances patient self-care.
Can the concept of patient self-care be integrated and understood within a wider caring science perspective and become useful for the conceptual and clinical development of rehabilitation and integrative care? When used as a complement to conventional care for long-term conditions, Thorne et al. (6) describe the use of integrative therapies as pragmatic self-care alongside other caring components. Crawford (7) has also pointed to the fact that chronic pain affects the whole person, and thus, integrative therapies offer one way to activate self-care. In a similar way, studies from other integrative care projects have described patient experiences of empowering self-help strategies (8). Earlier studies in anthroposophic care (9, 10) have also suggested that the holistic approach includes a caring attitude towards patients, which is delivered in a caritative and compassionate manner that is consistent with the Nordic caring tradition (11).

Within the nursing discipline, Dorothea Orem has explored the relevance of patient self-care with an emphasis on always strengthening the patient’s own ability to act. In ‘Self-care deficit theory of nursing’, she (12, 13) focuses on patients’ lack of ability to care for themselves as the underlying motive of nursing care. In short, self-care, according to Orem, is ‘the practice of activities that maturing or mature persons initiate and perform, within time frames on their own behalf in the interest of maintaining life, healthful functioning, continuing personal development and wellbeing by meeting known requisites for functional and developmental regulations’ (12 pp. 244). Nursing activities are described as helping methods and include acting for or doing for another, guiding and directing, providing physical or psychological support, and maintaining an environment that supports personal development and teaching (12, 14). Orem’s theory has had and still has wide recognition among researchers and clinicians worldwide. Biggs’ (15) paper on state-of-the-art nursing theory 1999–2007 lists 41 dissertations and 32 analytical articles that adopt self-care theory from various fields of health care.

According to the Nordic tradition in caring science, caring for others has its roots in a caritative attitude where human love, compassion and mercy are essential (11, 16). To care for another is both natural and professional; caring is at the core of all healthcare professions and is often cited in connection with nursing care. The main idea of caring is to alleviate human suffering and to safeguard life and health (17). Human suffering can be recognised and alleviated in a relationship where the caregiver sees the patient as a unique human being. Caring must disclose the path the patient should take to the goal, not carry her there, Eriksson writes. However, one must not forget that human beings need other humans. Sometimes this process includes being cared for by others, even though the ability for self-care remains (18). This openness towards the patient as a suffering human being forms a universal core concept in caring science, a concept that should be applied in caring encounters with the unique, whole and holy patient.

Anthroposophic health care is an integrative form of health care with a holistic approach that is used worldwide (1, 10, 19). In Sweden, one private hospital combines conventional and anthroposophic health care for rehabilitation and internal medicine as well as in outpatient care. The theory behind anthroposophic care rests on offering patients a variety of medical, therapeutic and caring activities for body, soul and spirit. Patient satisfaction has been high in previous reports, and a long-term increase in self-measured health has been reported even among patients with diagnoses of severe chronic conditions such as cancer and chronic pain (1, 20). A recent study found that, after anthroposophic health care, patients (2) had reduced their intake of prescribed pain medication significantly, compared with a matched group of patients with chronic pain.

The context for this study is a hospital in Sweden that offers integrative anthroposophic care for rehabilitation and internal medicine. The patients in this study participated in a rehabilitation programme at the clinic, which was paid for by their county council after GP referral. The 1-year programme was developed for people with chronic pain including fibromyalgia. The programme began with 3 weeks of inpatient care where a set of individually selected anthroposophic therapies for example massage, baths, eurhythm, artistic exercises and counselling were introduced alongside routines for nursing care, dining, social interaction with other patients and rest. In addition, short presentations on alternative thinking about pain, stress, suffering and therapy were offered on some evenings. The inpatient stay was followed by day care therapy on a weekly basis over two ten-week periods. The patients received the same types of integrative therapy during the day care visits.

The majority of patients with chronic pain as well as the majority of patients seeking integrative health care are young or in middle age, well-educated and with good social positions. A recurrent question regarding their rehabilitation is consequently their long-term health and self-care as well as whether there is a trajectory in self-care practice among this group of patients.

The aim of this analysis was to explore patients’ experiences of self-care and to track their progress in self-care.

Method

The analysis was conducted with a phenomenologic hermeneutic approach and attitude. According to the thinking of Gadamer (21), the structure of inner meaning can be reached by questioning the data and by testing pre-understanding related to data. In the language of hermeneutic experience, traditions, content and meaning are
fused into insight and new questioning. The analysis of data was conducted with a method used by Lindseth and Norberg (22), and carried out in three steps (see further description below).

Sample
The study included interviews with ten women who were participating in the 1-year rehabilitation programme for chronic pain in an anthroposophic clinic (described above). The participants were selected based on their willingness to participate. Of 18 patients in the rehabilitation programme, 10 volunteered to participate in this interview study. There was no obvious difference between those interviewed and those who refrained except that the only man in the programme chose not to participate in the interviews. The researchers considered saturation to be achieved after the tenth interview.

Since chronic pain has a significant overlap with other symptoms such as fibromyalgia, burnout, fatigue, stress and anxiety, these symptoms and diagnoses were taken into account (see Table 1).

Data collection
Individual interviews were conducted by one researcher (the first author) using an interview guide with the opening question: Can you tell me what your pain illness has meant to you? The questions that followed concerned experiences from earlier healthcare visits as well as the ongoing rehabilitation programme. The interviews were conducted either at the clinic (8) or in the participant’s home (4) and lasted 35‒80 minutes. The recorded files were transcribed verbatim by a professional typist.

Data analysis and interpretation
Inspired by Lindseth and Norberg phenomenologic hermeneutics (22), the analysis was carried out in three steps. In the first step, the entire transcripts were read to allow for an intuitive first understanding. The intuitive understanding was written down as the starting point for the structural thematic analysis. Initial assumptions and questions therefore emerged in relation to the reading of data and are not described here. During the second step, the thematic analysis, the researchers attempted to view the text as neutrally as possible to condense and abstract the content. Meaning units were identified and sorted, and preliminary themes were underlined.

In the third step of analysis, an interpreted comprehensive understanding took place in which the different parts were merged together. The data, the initial understanding and the thematic pictures were then interpreted in a process leading towards a new whole. A mind map (see Table 2) was used as a tool during this part of the analysis, which was guided by exploring signs of self-care related to four successive meta-levels: the individual, the contextual, the cultural and the universal.

Research ethics
The research project was approved by the Research Ethics Committee in Stockholm, Sweden (2014/5:2). Ethical principles, informed consent, usefulness in relation to risks, integrity, nonmalfeasance and respect for human dignity were considered.

Findings of the thematic analysis
The findings are illustrated by direct quotes from the interviews. These are taken from all participants but are not attributed to any specific interviewee. The presentation follows the narrative order of the women’s stories, beginning with the story of suffering, followed by the turning points to signs of self-care.

The story of suffering
The women are in the midst of lives that are not functioning well. Life is hindered by physical symptoms and

<table>
<thead>
<tr>
<th>Age</th>
<th>Social status</th>
<th>Education</th>
<th>Self-described illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>43        Divorced, two children moved out</td>
<td>Factory work</td>
<td>Fibromyalgia</td>
</tr>
<tr>
<td>2.</td>
<td>59        Divorced, one son at home</td>
<td>Assistant nurse, taxi driver</td>
<td>Fatigue, muscle pain</td>
</tr>
<tr>
<td>3.</td>
<td>59        Widow, no children</td>
<td>Assistant nurse</td>
<td>Stress, depression and pain</td>
</tr>
<tr>
<td>4.</td>
<td>42        Married, two children at home</td>
<td>Entrepreneur, personal training</td>
<td>Burnout, stress, pain</td>
</tr>
<tr>
<td>5.</td>
<td>50        Cohabiter, one child moved out</td>
<td>Assistant nurse, chiropractor, acupuncturist</td>
<td>Pain in the neck, shoulders and fatigue</td>
</tr>
<tr>
<td>6.</td>
<td>50        Married, three children moved out</td>
<td>Preschool teacher, entrepreneur</td>
<td>General pain and fatigue</td>
</tr>
<tr>
<td>7.</td>
<td>54        Divorced, two children moved out</td>
<td>Preschool teacher</td>
<td>Fibromyalgia</td>
</tr>
<tr>
<td>8.</td>
<td>30        Cohabiter, no children</td>
<td>Health educator, office worker</td>
<td>Fibromyalgia, IBS and depression</td>
</tr>
<tr>
<td>9.</td>
<td>57        Divorced, two children moved out</td>
<td>Cook, child minder</td>
<td>Fatigue and pain</td>
</tr>
<tr>
<td>10.</td>
<td>45        Married, one child with ill health</td>
<td>Health educator, entrepreneur</td>
<td>Burnout, stress, fatigue and pain</td>
</tr>
</tbody>
</table>
tiredness; for many, social relationships are not working. Pain and physical symptoms are, however, not the central issue in these women’s stories. It is, rather, the consequences of pain that are in focus including the inability to maintain relationships. The illness is felt to cause an inherent sensitivity to stimuli and people. This in turn brings loneliness and isolation:

I have reduced my life to encompass only myself and my son these days. I can’t take responsibility for anyone else, I don’t have the energy to take responsibility for other people.

A general sense of suffering permeates many of the stories, with oversensitivity to the everyday demands and duties of life. The women describe themselves as exhausted, lacking energy and being moody without being clinically depressed. A focus on the most basic needs in life becomes necessary for survival. This sensitivity has become worse with the pain:

I devote 100% of my energy only to be able to keep the health I have today, not to become worse. That’s how I feel. Every day. . . One day at a time.

The women talk about demanding lives and a level of suffering that is on the edge of what they can take. Their reasoning traps them in a circle without an exit, and they feel stuck in a passive mode of being. As they see it, their experience of pain is related to their life situation including, for example, negative social relations both within the family and work life:

What frightens me is that I can’t see that I could have done anything differently. The equation was what it was. I had to work to survive, although I worked as little as possible. I couldn’t stop helping my children, and we needed to do that job on the house. It was an impossible equation.

Some women describe being in a state of resignation. This includes deep feelings of resentment with unspoken thoughts of suicide. The situation leaves no space for joy or hope. Many women attribute their suffering to a psychological pattern of always putting everyone else’s needs before their own. Most of them worked in caregiving professions. They knew the importance of taking care of oneself but had not been able to apply this knowledge to their own lives:

So, you see, I am aware of how to be and take care of myself, but I haven’t succeeded.

Their previous experience of health care was extensive but coloured overall by a sense that help was fragmented and short term. They associated it with struggle and distrust. There was an unspoken belief that the rehabilitation at the anthroposophic clinic would end the story of suffering and thereby become a turning point in their lives.

Turning point through care

With the experience of care at the anthroposophic clinic, the possibility for introspection arises. The women describe how the staff at the clinic encourages them to contemplate and look inside themselves:

Yes, my body and mind had been separated for very long. What did I do with all difficulties? Well, I used to put it in my back pack. And the back pack became larger and larger. I am still as lonely, but I can. . .

Suffering and vulnerability, previously put aside or denied, are given voice as a result of the care received at the clinic. Some women cry when speaking about their memory of receiving care and attention from a loving caregiver. An inviting atmosphere, with no demands, breaks their isolation:

It was really difficult to let go of everything. To be taken care of. So that was good. I think it is not until now as we speak . . . (cries) it was really, then I could let go of everything. I had full trust and it was like I had no skin. And it was so great to get there (to the clinic) and be seen and cared for. I could concentrate fully on building a shield around me, as
they say. To be conscious of my own sensitivity and really take responsibility for it.

These descriptions of caregivers contrast with previous negative experiences of healthcare practices and practitioners, where the women felt invalidated or rejected. The actual experience of a caring environment seems to awaken a joy for life as well as the will and strength to engage with their own health.

Through art and movement therapies, the women discover the aspects of life that they need to open up. The aesthetic and natural environment at and around the clinic encourages them to slow down, see new things and live life in a more natural way:

I realise now, that at home I was often really stressed without even noticing. I thought I was really good at taking care of myself but . . . . No, now I have learnt.

During the first week, many say that they slowed down reluctantly. They describe how they began to live in a different way, not driven by their fears as in the past.

The process of opening up can be interpreted as a difficult but necessary turning point in the women’s journey to increased health. They begin to see their own situation in a larger context and to take responsibility for their own development. The turning point is the first step towards the alleviation of suffering through an authentic and natural life that includes a sense of self-dignity and self-care. The women have been recognised for themselves, their suffering has been understood, and their longing for a life of joy and love has been acknowledged.

**Signs of self-care**

The care given to the women breaks new ground. The women describe how the caregivers at the clinic make them feel worthy, whole and suffering human beings. Their story of suffering is confirmed, and as a result, the women feel confirmed in their illness and suffering. The women also talk about the caregivers and the environment at the clinic in terms of a humanity they have been longing for. It is this sympathy and compassion that is central in their narratives; the therapies can be interpreted as means by which this humanity is expressed:

The way they received and welcomed me. Their friendliness, their view of the human being. I think that is like the real me, I can feel that. For many years, I think I have lived in a world where I haven’t belonged. I appreciate that they see the entire me.

In the women’s experiences of treatment at the clinic, suffering and health can meet and interact through caring activities. From the start of their stay at the clinic, the women describe how their own lives and taking responsibility for themselves as a whole lie at the centre of their care. The care and the caring environment direct the women’s attention back to their own lives and bodies as well as their needs:

I got here and I was hospitalised, that was the best that ever happened to me. They saw that I had had a rough time. I got a lot of therapy sessions, much more than everybody else. That was exactly what I needed. . . . Then I understood that everything I had gone through was in my body.

When the women get in contact with themselves and are able to identify their own needs, they also seem to acknowledge what they need in life. For example, the rhythm of the rehabilitation programme is an inspiration for a new view of the balance between activity and rest. They learn to understand and accept how much they can take and when to rest. This can be viewed as part of accepting an illness that severely hampers their ability to be active for long periods of time.

Difficulties in asking for help can be interpreted as one part of the relational problem in the women’s narratives. There is an implicit relationship between their experience of their health problems and the difficulty of living and interacting with others. The encounter with a natural life and the love and friendliness they meet in the rehabilitation care programme show them new paths to take towards self-compassion and self-care. This seems to change the women’s view of themselves as well as the opportunities available to them. They are deeply touched and reflect about their situation:

The gap . . . (cries) that I do what I’m used to, not to see or listen to myself but rather let things be the same way as when I grew up . . . .

The environment at the clinic is described as natural and inspires the women to reflect on how they live their lives. This is experienced as a reminder of a simpler life, close to nature and other humans, without television, the internet and so on. Some women emphasise the serenity of the environment and the fact that that none of the caregivers seems stressed. The caregivers are thereby seen as carriers of an ideal that the women know about and agree with but have forgotten in their present lives. They give this natural environment credit for enabling them to regain contact with the self:

I was getting back on track. I felt that my body and mind had been really far from each other. But they got closer again without TV and radio. I could just be with myself.

The women’s stories suggest that they find new ways of thinking, being and living their lives. They are inspired to change and develop their ways of taking care of themselves and their lives. The environment seems to inspire the women to think and behave in a way that leads implicitly to an enhanced awareness of their own needs.

A recurring reflection concerns the possibilities, the tools and the potential to continue the path towards improved health even after leaving the clinic. The loving
The women describe in detail how they would like to apply certain aspects of the anthroposophic lifestyle to their everyday lives. Examples include the importance of regular meals and sleep, and the balance between activity and rest. They want to continue with the different therapies at home, and they want to eat healthy organic food. Among these women, the experience of a turning point seems to go hand in hand with an increased trust in their own ability to take care of themselves, to initiate appropriate self-care means and thereby to create a functioning life for themselves. The care they have received makes them reconnect with themselves and their bodies, and gives them a sense of homecoming.

Interpretive comprehensive understanding

The analysis suggests that the women have been able to overcome some of the barriers to self-care practice. This can be inferred from universal, cultural, contextual and individual levels (see also the mind map in Table 2). The women experience being cared for while living a healthy life, with their individual and unique qualities including weaknesses and strengths. Individual suffering is transcended by new perspectives on life, new experiences and ideas given in a caring environment that represents a new context. Being in natural, simple and aesthetically pleasing surroundings is an important part of the caring. Opening up to relationships and communion with others plays a significant role in any experience of health. Being invited to join a caring culture in community with caregivers and fellow patients at the clinic supports a shift in self-image. Being greeted and recognised as a fellow human being, and being confirmed with love open up possibilities for transforming their health. Everyday life in the anthroposophic caring culture is built on ideas guided by the universal aspects of meaning, love, life and death. This indicates reorientation and relief from suffering on the individual level, which opens a sight line towards trust in the good life. The principles of self-care continue to be integrated after the clinical rehabilitation has ended. Dependence on certain individuals, physical space and time is transcended by the capacity for living life in health. Caregiving is able to offer glimpses of a move towards community in contrast to past isolation, towards love in contrast to past alienation, and towards joy and inspiration in contrast to past suffering. Through a caritative and confirming care, these women are enabled to identify their own needs as a first step to developing self-care.

Discussion – from caring to self-caring

In these women’s stories, life is demanding and causes suffering, whereas their own needs are ignored and a sense of meaning is hidden. There are few signs of joy, longing or dreams. From the perspective of suffering theory (23, 24), this absence of meaning and purpose is the worst kind of suffering. This is supported by the fact that many of these women have had thoughts about suicide. These women often had professions within the caregiving sector; their jobs were related to physical activity and health. Interestingly, their knowledge about health did not lead to their own health. From a scientific caring perspective, striving for health can be counter-productive if reduced to activity and acts. When health is reduced to doing that is separate from being, efforts to achieve health solely through the body lead to increased alienation and suffering. Eriksson (25) relates the state of doing to problems, whereas the state of being is more closely related to the inner need for purpose in life. From this perspective, there is no point in paying attention to the physical body through exercise if a person has neglected his or her needs for inner purpose and social connection. The suffering described by the women in this study shows signs of alienation both from themselves and their social context. This alienation becomes particularly clear in the vivid descriptions of confirmatory gestures from caregivers in the rehabilitation programme. Acts of compassion are the ethical key to love and therefore to the heart of caring (26, 27). The women repeatedly emphasise the love they have received from the caregivers and the support they have received from the entire environment at and around the clinic.

The women describe the social interactions in the caring environment as encouraging them to ‘become more like themselves’. Caring scientists Rehnsfeldt and Eriksson (28) point to how caring encounters can help patients to develop an understanding of life and reconciliation with oneself. In this way, suffering can be alleviated and health improves as a person engages in life and social interaction. Råholm and Eriksson (29) point to love as an ontological prerequisite for existence, and to compassion as a visible sign of love in caring acts.

If a caring environment can support a suffering human being and, in this way, enable him or her to care of him or herself, and to create health through doing, being and becoming (25), like was experienced by the women in this study, there is a potential for improved health and better life situation for persons with widespread chronic pain. The findings of this study suggest that complex symptoms of disease, such as those suffered by the women in this study, may point to a need for an extended perspective on life, health and self-care. The development of such perspectives on life and related health care demand a view the goes beyond acts of
advice, information or education. Suffering human beings want to take care of their own health but need to find ways to do this with help from a caring, supportive environment and community, where self-care becomes part of the experience of a how to live a meaningful, whole and good life.

A person’s journey from passive suffering towards active care and concern for his or her own health may include a transformation from an individual to a more universal perspective on life. Health care inspired by a universal perspective is shaped with awareness of the human need for deep contact and communion with people, nature and existence. The phenomenological philosopher Løgstrup (30) has argued that ‘naturally lived experiences of life’ can be seen as expressions of the universal or ontological essence of human beings. Humanity’s deepest desire is, according to Eriksson (31), the quest for life and love. The anthroposophic integrative caring culture studied here rests on a philosophy building on the idea of the human being as a unity of body, soul and spirit. Spiritual aspects, synonymous with universal aspects, are integrated in the view of health care and are reflected in the women’s experiences of rehabilitation. The caring environment is, by its common culture, experienced as coherent and independent of the individual caregiver. These women’s stories suggest that the respect and honour for existential issues and the human being, intrinsic to anthroposophic health care, may lay a foundation for a tender and compassionate healthcare environment (10, 19).

Implications

Caregivers may understand their significance in the development of patient self-care as that of a role model who demonstrates how to lead a good and natural life. In this way, the caregiver may offer a universal sense of togetherness, in a ‘human-to-human compassionate natural caritative relationship’. This can be understood as a caring act for people in a deep state of suffering that goes beyond individual relationships. In holistic caring, one tries to let individual, contextual, cultural and universal aspects work together when searching for key aspects to support a patient’s ability to achieve health by self-care.

This study provides a new perspective on self-care that transcends previous ideas on self-care such as Orem’s idea that nursing care should constitute helping and learning. On the other hand, we may be talking about the same world, life and patients. Perhaps Orem is saying something important when she emphasises that health is promoted through patient self-care (12). The present study, perhaps, adds another piece of the puzzle in this discourse with its confirmation of the importance of loving care and a natural life context for the development of self-care.

Self-care has to be much more than advice, education and training for people with complex suffering. The journey to health begins when the sufferer experiences what it is to be cared for.

The findings of this study give clinical support for the potential of a caritative and caring culture to help patients participate in a compassionate relationship both with others and with the self. This forms the basis for a reawakening of their natural self-care ability.

Contextual reflections

A general objection to research in integrative care is that patients who choose this treatment are somehow special and therefore able to take better advantage of this approach. On the contrary, one should rather say that patients seeking integrative care have higher demands and expectations of health care and are more difficult to satisfy (1).

It is important to take conscious account of gender aspects. Women are overrepresented in both integrative health care and in conventional rehabilitation for chronic pain. A majority of the patients (90%) in all integrative healthcare environments are women, as is the case in this anthroposophic hospital. The gender differences in integrative health care can be understood from the perspective of women’s and men’s conceptions of illness. Ahlsen (32) et al. found women more likely to actively try to transcend their identity and life condition to reach health, whereas men appeared to be actively seeking a solution to pain within a medical context. The results of this study support the findings of Ahlsen (32) with the choice of integrative care and a number of self-care strategies representing both internal and external relations in managing illness and the quest for health.

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Author contributions

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