

Anthroposophic Nursing in Aotearoa New Zealand:
How do Anthroposophically Educated
Registered Nurses Use the Anthroposophic Paradigm to
Inform Their Practice?
An Interpretative Descriptive Approach

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Abstract

This study explores the way registered nurses who have completed further education in anthroposophic nursing apply this knowledge to patient care in Aotearoa New Zealand. Anthroposophic medicine and healthcare are based on anthroposophy, a spiritual philosophy of human existence first articulated by the Austrian philosopher Rudolf Steiner at the start of the 20th century. Healthcare extended with anthroposophic foundations focuses on a holistic, multidisciplinary and person-centred approach which considers the person's physical, emotional, and spiritual needs. In Europe, anthroposophic healthcare and medicine are integrative health practices offered in hospital and community settings renowned for holistically supporting and benefiting patients with various health conditions.

A qualitative research design (interpretative description [ID]) was used to investigate the research question and aims. Eleven (11) semistructured interviews were conducted to gain insight into how registered nurses inform their practice with anthroposophic concepts and foundations. Eligible participants had completed an internationally accredited education pathway to anthroposophic nursing in Aotearoa New Zealand and held a current annual practising certificate (APC). Six (6) of the 11 participants had completed the requirements to become anthroposophic nurse specialists (ANS).

I analysed the data using the four steps of Morse's (1994) cognitive processing framework. Three key themes were identified: "Our way of being," expressions of anthroposophic nursing practice, and negotiating place: nursing with anthroposophic foundations in Aotearoa New Zealand.

The findings of this study contribute to a better understanding and awareness of anthroposophic nursing as a person-centred, holistic approach to care. With its emphasis on spiritually integrated caring interventions, participants articulated the anthroposophic paradigm as embodied knowledge that informed practice, nurtured patient/nurse relationships, and underpinned holistic person-centred nursing care.

Anthroposophic concepts motivated inner development as part of the nurses' self-reflection and spiritual growth and fostered embodied knowledge.

This study provides new insights into the challenges and opportunities faced by registered anthroposophic nurses working in healthcare structures unfamiliar with the foundations of this integrative approach. The findings will facilitate improved understanding of the relevance of practice guided by anthroposophic foundations and concepts related to the bicultural health context in Aotearoa New Zealand, and contribute to evolving recommendations for providing person-centred and holistic care which is inclusive of spirituality. These results augment the current literature, expanding knowledge of the ontological and epistemological significance of anthroposophic nursing as a caring culture in nonanthroposophic healthcare settings. Future empirical research to strengthen the development of anthroposophic nursing in Aotearoa New Zealand, should include investigating and validating the utilisation of the 12 Nursing Gestures model in various clinical settings.

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

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Ethics approval

Ethics approval was obtained from the Auckland University of Technology Ethics Committee (AUTEK), reference number 20/74, on May 12, 2020 (Appendix B).

Chapter 1 Background and Introduction

*The healthy social life is found
When in the mirror of each human soul
The whole community is shaped,
And when in the community
Lives the strength of each human soul.*

Rudolf Steiner (*Fundamental Social Law*)

1.1 Introduction

This chapter centres on the historical context for the emergence of anthroposophy, its disciplinary branching and the development of anthroposophic healthcare as an integrated and holistic approach to health. I introduce the emergence of anthroposophic nursing in Europe and its subsequent developments. In the second section, the focus turns to the positioning of anthroposophic nursing in Aotearoa New Zealand, providing distinct and localised insights into the teaching and current position of anthroposophic healthcare and nursing in Aotearoa New Zealand. The objective of this section is to underscore the significance of this research within the local cultural and professional context. It outlines the influences of the health structures as these relate to the nursing workforce and specifically to the positioning of anthroposophic nursing in Aotearoa New Zealand. In addition, I outline the structure of the thesis, clarify the purpose of this study, and provide an overview of the forthcoming chapters.

1.1.1 Anthroposophy: History and Introduction

Anthroposophy, first introduced at the start of the 20th century by Rudolf Steiner (1861–1925), sees human beings as informed by spiritual insights. Steiner, a literary and Goetheanistic philosophical scholar, examined how spiritual insights enhance and expand human consciousness. Contrary to common assumptions, Steiner developed his philosophy of human existence and development without introducing novel spiritual and esoteric views. What he achieved, however, was the articulation and presentation of previously described influences of spiritual essence working within the human entity. One can find various elements of the anthroposophic paradigm in other

worldviews, especially those that acknowledge human existence and perception beyond the obvious physical manifestations (Bergdolt, 2008; Durie, 1985, 1994; Gale, 2014).

Table 1 outlines a historical timeline for the development of various disciplines that have extended their approach with anthroposophic insights and principles. This comprehensive approach confirms anthroposophy’s innate, all-encompassing (holistic) reach extending throughout human existence. It is this breadth and depth that make anthroposophy a rich and complex field of study, offering numerous avenues for exploration and understanding.

Table 1

A Timeline of the Developments of Anthroposophically Oriented Disciplines

<p>1919-1925 Foundational years</p>	<p>1919–First Independent Waldorf School (Freie Waldorfschule) opened 1920–Several lectures and anthroposophic courses provided for physicians 1921–First anthroposophic hospital in Arlesheim, Switzerland 1921–Beginnings of anthroposophic nursing and development of rhythmical massage/touch therapy 1921–Beginnings of eurythmy (movement therapy) 1921–Weleda (anthroposophic medicine manufacturer) founded 1924–Beginnings of anthroposophic curative education and social therapy for individuals with developmental disabilities 1923–Medical section established within the School of Spiritual Science at the Goetheanum in Dornach, Switzerland 1925–Steiner & Wegman publish <i>Fundamentals of Therapy: An Extension of the Art of Healing Through Spiritual Knowledge</i>.</p>
<p>1925-2000 Further developments</p>	<p>1933–New Zealand Anthroposophic Society established in Hawke’s Bay 1939–Camphill movement founded in Scotland 1944-1960–Foundational developments in education, curative education (Höhepa Trust), agriculture, and medicine in Aotearoa New Zealand (see Turbott, 2013) 1950–First Waldorf School (Taikura) established in Hastings, Aotearoa New Zealand 1960s-1990s–Various hospitals founded, integrating anthroposophic medical (AM) concepts with conventional medicine/therapies (Germany, Italy, Sweden, Switzerland, United Kingdom)</p>

	<p>1976–Inclusion of AM as a “special therapy system” in the German Medicine Act</p> <p>1983–University Witten/Herdecke, Germany, founded as part of an integrated AM hospital</p> <p>1990–New Zealand Association of Anthroposophical Doctors established</p> <p>1993–Anthroposophic Nurses Association New Zealand (ANANZ) established</p> <p>1998–First group of nurses graduate in anthroposophic nursing from Taikura, (Hastings, Aotearoa New Zealand)</p>
<p>2000–present Increased integration of AM and research</p>	<p>Training/education in anthroposophic medicine (AM), nursing, and therapies expands to Africa, the Americas, Asia, Australia, and Eastern Europe</p> <p>International coordination and consensus statements on best practice, training/education, and research developed</p> <p>AM training/education included in various universities—AM professorships created (Brazil, Germany, Netherlands, and Switzerland)</p> <p>Increasing numbers of studies and publications on AM and anthroposophic nursing</p> <p>2000–International Forum for Anthroposophic Nursing (IFAN) established as part of IKAM (International Coordination of AM)</p> <p>2004–11 Anthroposophic nursing graduates (from Taruna College, Aotearoa New Zealand)</p> <p>2008–10 Anthroposophic nursing graduates from Taruna College in Aotearoa New Zealand</p> <p>2009–Vademecum (Latin: Handbook) on External Applications (an IFAN project) was published (Vademecum, n.d.-g)</p> <p>2009–Certification of first Anthroposophic Nurse Specialists (ANS) in Aotearoa New Zealand, Germany, and Switzerland. Seven (7) RNs achieve ANS status in Aotearoa New Zealand</p> <p>2012–12 Anthroposophic nursing graduates (from Taruna College, Aotearoa New Zealand)</p> <p>2015–14 Anthroposophic nursing graduates (from Taruna College, Aotearoa New Zealand)</p> <p>2022–13 Anthroposophic nursing graduate (from Taruna College, Aotearoa New Zealand)</p>

Note. Adapted from *WHO Benchmarks for anthroposophic medicine*, by World Health Organization (WHO), 2023.

Waldorf education (also known as Steiner education/schools) was the first social movement underpinned by anthroposophy (see **Table 1**). Steiner’s concept of a three-fold human being comprising body, soul, and spirit (1919b) served as the foundation

for developing the Waldorf curriculum to support early and middle childhood and adolescence holistically (Cohen & Bresnihan, 2019). Various other professional groups (in medicine, agriculture, architecture, and literary and performing arts) approached Steiner, intending to integrate anthroposophic concepts into existing paradigms. The seamless integration of spiritual science into knowledge areas such as anthroposophic medicine (AM), curative and artistic eurythmy, music, art therapy, and biodynamic agriculture followed. A deeper understanding of the human soul from a natural scientific and spiritual perspective led to a worldwide movement with its main centre at the Goetheanum in Dornach (School of Spiritual Science, n.d.), Switzerland.

Anthroposophic insights and perspectives on the human being as existing in relation to the world and universe signalled a shift away from the purely scientific (biomedical) perspectives on health that were present in the time after the First World War. While Steiner's lectures offered indications and spiritual insights into how spiritual science (see Glossary) can enhance and extend conventional approaches to health and illness, they did not result in a prescriptive manual of "new" therapies. The publication of *The Fundamentals of Therapy: An Extension of the Art of Healing Through Spiritual-Scientific Knowledge* (Steiner & Wegman, 1925/1983) presented the foundations for the development of the AM paradigm. Ita Wegman, who had trained in Swedish massage and later became a medical practitioner, played a significant role in developing AM and established Switzerland's first anthroposophic hospital (Arlesheim Klinik) in 1921. At that time, her collaborative work with the caring profession was the impetus for the first AN group (Zeylmans van Emmichoven, 1995). Wegman also became the first leader of the medical section established in the School of Spiritual Science in 1923. The school has grown into a worldwide interdisciplinary collaborative network influencing health in the areas of cultural, social, political, and economic interests (Glöckler, 2020; Glöckler & Heine, 2010). In their text, Steiner and Wegman (1925/1983) provided fundamental insights into the core elements and archetypal pictures of human nature and anatomy, and their potential imbalances. Despite the authors' presentation of typical case studies in Chapters XIX and XX ("Typical Cases of Illness" and "Typical Therapeutic Substances"; Steiner & Wegman, 1925/1983), interventions in AM emphasise active participatory engagement with the

patient/person, their biography, and their social environment. To expand, the premise in AM is that while common ailments have common indications for treatment, each individual may respond differently to therapies and interventions; therefore, complex holistic considerations and assessments are crucial. Furthermore, Steiner and Wegman never positioned their work in opposition to conventional medicine; in fact, they elucidated that the AM approach was a spiritual extension of the former.

On the other hand, to all that can be known about the human being with the scientific methods that are recognised today, we add further knowledge, whose discoveries are made by different methods. And out of this deeper knowledge of the World and Man, we find ourselves compelled to work for an extension of the art of medicine. (Steiner & Wegman, 1925/1983, p.1)

1.1.2 The Development of Anthroposophic Medicine (AM)

The timeline in **Table 1** illustrates the global growth of anthroposophically orientated disciplines and underscores their interdisciplinary nature. According to the last updates by the European Federation of Patients' Associations for Anthroposophic Medicine (EFPAM, 2024), there are practising anthroposophic physicians in over 60 countries worldwide. The International Federation of Anthroposophic Medical Associations (IVAA) represents national AM associations from 40 countries on five continents (IVAA, n.d.). This number excludes physicians not represented by a national AM body.

Although no detailed numbers are available on how many anthroposophical health professionals practice worldwide, an estimated 4,000+ work within the European member states (EFPAM, 2024). The 24 anthroposophic hospitals across Europe (EFPAM, 2024) employ some of these professionals. However, AM has also had a solid historical presence in primary healthcare (Ritchie, 2001) and other community organisations such as the Camphill Foundation (Camphill Foundation UK & Ireland, 2023). Various communities worldwide rely on primary healthcare (PHC) centres for anthroposophic healthcare and medicine, for instance, in the United Kingdom (Anthroposophic Medicine UK, n.d.) and Aotearoa New Zealand (Weleda NZ, 2024b).

In Germany alone, 6 million patients access anthroposophic medicine annually (EFPAM, 2024), illustrating AM's widespread integration into conventional/mainstream health structures. In Aotearoa New Zealand, there are only estimates on the prevalence of AM use and, in fact, the last data captured for the use of any complementary and alternative medicine (CAM) is from 2007 (Liu et al., 2021).

Eight European countries teach AM in university-level medical schools, with university chairs in AM in Germany and Switzerland (EFPAM, 2024). The recently published WHO *Benchmarks for Training in Anthroposophic Medicine* (2023) provides an international standard with curriculum requirements for all practising anthroposophic disciplines.

According to the International Forum for Anthroposophic Nursing (IFAN), AN is practised in 16 countries and on all continents (IFAN, n.d.-a, para 3). The International Council for Anthroposophic Nursing Associations (ICANA) presently has 10 member associations worldwide, including the Anthroposophic Nursing Association New Zealand (ANANZ) (IFAN, n.d.-b). The IFAN is also the overarching professional body that regulates professional training for anthroposophic nurses (AN) and anthroposophic nurse specialists (ANS; IFAN, 2022). As part of IFAN, the Quality of Anthroposophic Nursing Bureau (QAN, n.d.-c) oversees the updating of training guidelines and the accreditation process for training programmes (IFAN, 2014).

The Weleda website provides access to a list of anthroposophic health professionals in Aotearoa New Zealand (Weleda, 2024b). In the listed PHC clinics with multiple general practitioners (GPs), at least one is trained in AM. These clinics may also employ ANs/ANSs or refer to self-employed ANs/ANSs. The anthroposophically trained health professionals may refer patients to other allied professionals (art therapists, eurythmists, etc.) within each region according to patient need or request. At the time of writing, the site listed nine GPs, 17 ANs/ANSs, nine art therapists, four counsellors/psychotherapists, 11 eurythmists, five educators trained in child development, two massage therapists, and one music therapist (Weleda, May 5, 2024).

Alongside the AM-led hospitals in Europe and integrated clinical wards in some conventionally managed clinics (Rutert et al., 2021), the EFPAM (2024) has documented 120 outpatient centres in 14 European member states. In Aotearoa New Zealand, patients self-fund AM medicines and products, but in some European states, national health insurance covers these costs (EFPAM, 2024).

1.1.3 Cultural and Political Factors

A transition to a freer and more accepting society in Europe was occurring at the end of the 19th century (Bergdolt, 2008). Industrial changes greatly influenced these philosophical shifts and were expressed through various art forms. For example, the development of more communal architecture fostered a sense of support to self-manage creative and professional autonomy, especially in the working class within European society. The notion of “freedom” from the restraints of the 19th century led to a push to challenge existing structures related to health and education. This resulted in the emergence and acceptance of a more conscious human mind (as evident in the various art expressions at the beginning of the 20th century). Alongside these developments, the establishment of the science-based biomedical healthcare model strengthened significantly after the First World War, influenced by scientific discoveries such as penicillin therapy (Bergdolt, 2008).

Steiner’s lectures on observing human *beingness* and presence in this world from a multilayered perspective grounded in spiritual science attracted diverse professional groups ready to expand educational, agricultural, artistic, and spiritual disciplines. Anthroposophy emerged during a time of progressive biomedical advances and, conversely, the disappearance of energy healing.

As discussed by Kaptchuk (1996), similar tensions were present in various alternative healing practices grounded in vitalism developed in the 19th century and into the 20th century. Klassen et al. (2022) further asserted that the increasing professionalisation of biomedicine occurred alongside the disempowering of healing based on spirituality and vitalistic foundations, leading to distinct separations between religion, law, and science. Therefore, anthroposophy evolved in this cultural space of tensions between

opposing viewpoints as a freeing philosophy aimed at extracting the best from both worlds (paradigms).

1.2 Anthroposophic Medicine: An Integrative Holistic Approach

To effectively situate this research, it is crucial to offer background information on the overall concept of integration and its significance within the realm of anthroposophic healthcare. Integration in healthcare signifies a collaborative approach that promotes mutual understanding and acknowledgement between practitioners from different disciplines in a single health structure. This approach encompasses the holistic well-being of individuals, including their physical, mental, and spiritual aspects as well as their surrounding community. Leach et al. (2018) proposed the following definition:

Integrative healthcare is a client-centred model of care provided by a team of biomedical, allied and complementary health professionals who work collaboratively and respectfully to deliver accessible, holistic, evidence-based, personalised, coordinated care that emphasises disease prevention and health, healing and wellness promotion. (p. 55)

For the health consumer, the inclusion of the term “integrative” signals that conventional/mainstream health services embrace and even promote a range of integrated therapeutic modalities. Health professionals may have dual training or be open to collaborating with allied and complementary health professionals. The overall message is that integration acknowledges diverse health beliefs and treatment options while providing services that are mindful of holistic person-centred values.

AM extends the conventional/mainstream healthcare approach and is referred to as an integrative and holistic practice (Medical Section at the Goetheanum, n.d.). More concisely, anthroposophic scholars and researchers have defined AM as “an integrative, multi-modal treatment system based on a holistic understanding of man and nature and disease and treatment” (Kienle et al., 2013, p. 20).

In the European health environment, AM has established its status as an acknowledged integrative practice (EFPAM, 2024). Although often listed as a CAM approach (EUROCAM, 2014), researchers have argued that AM is not a CAM modality

(Arman et al., 2008). However, given the interdisciplinary nature of the anthroposophic healthcare approach (which involves doctors, nurses, midwives, music and art therapists, movement or eurythmy therapists, speech therapists, and teachers), it is not surprising that policymakers, health providers, and health researchers frequently include it in the plethora of CAM modalities.

The conflicting and confusing uses of terminology in different modalities are common and evident in the ongoing debate among scholars about the need for more consistency and clarity in defining various approaches alongside the conventional/mainstream (Ng et al., 2023). Ng et al. (2023) have argued that the lack of consistency in the use of terms at international and national levels is affecting ongoing research in and acceptance of complementary, alternative, and integrative medicine (CAIM¹). Nevertheless, health professionals must grasp these subtle terminological nuances, particularly when health recipients seek cooperation or receive referrals between CAM practitioners and conventional health services. Misunderstandings, insufficient knowledge about the evidence, and potential interactions could all lead to adverse health outcomes for the health consumer.

This ontological minefield of terminology and definitions for health approaches also has implications for the professional positioning of nurses working within integrative or CAM modalities. Star (2023) has asserted that the complex terminology around the practice of CAM, holistic, and integrative nursing “adds fuel to the fire to those who do not take the specialisms seriously within nursing” (p. 156).

Another important term in the context of complementary and integrative health approaches is “traditional medicine.” In some countries, traditional medicine is part of the health culture and is integrated and acknowledged as part of the health system. While Ng et al. (2023) have argued that traditional medicine sits outside their definition of CAIM based on its origins in regional cultures, others (Lee et al., 2022; von Schoen-Angerer et al., 2023; WHO, 2019) have used the more inclusive categorisation

¹ Author’s note: Ng et al. decided to include integrative practices in their study and used the abbreviation CAIM as an extended version of CAM.

of traditional, complementary and integrative healthcare (TCIH). A pertinent aspect of the positioning of traditional healing and medicine, rather than the need to allocate positions and categories, is governmental health providers' role in fostering equality and the right to access care embedded in cultural values. While it may be helpful to collectively define therapeutic approaches not situated in the conventional biomedical healthcare system, traditional medicine and healing occupy relevant and undervalued spaces in most contemporary societies with histories of colonial structures. In Aotearoa New Zealand, Indigenous healing practices are significant cultural practices within the worldview of Te Ao Māori (Ahuriri-Driscoll et al., 2008; Mark et al., 2017; WHO, 2013) and health professionals are educated to recognise and respond to Indigenous and diverse cultural needs. At a policy and government level, support for rongoā Māori (traditional healing) can be traced back to 1991 (Ministry of Health [MoH], 2021). However, recent research (Eggleton et al., 2021; MoH, 2021) illustrates that integration and access to traditional healing for Indigenous people have been flawed because of legislative and structural issues.

Nevertheless, while there has been progress in recognising and validating rongoā Māori as a traditional healing pathway through the establishment of the Te Kāhui Rongoā Trust in 2011 and the implementation of tikanga-a-rongoā practice standards in 2014, no national representation for CAM or traditional and complementary medicine (T&CM, see WHO, 2013) exists in Aotearoa New Zealand at present. The last detailed data on the use of CAM was published by the Ministerial Advisory Committee on Complementary and Alternative Health (MACCAH) in 2004, despite WHO (2019) reporting that “up to 20% access a T & CM practitioner or use T & CM in some form” in NZ (p. 173).

Overall, most health systems are wary about CAM integration due to issues such as cost (Fjær et al., 2020) and the longstanding challenge of the prevailing medical paradigm (Gale, 2014; Saks, 2015; Shuval et al., 2012). Other factors include the need to educate the public on CAM and the legal implications for health professionals (Shorofi & Arbon, 2017; van der Heijden et al., 2022). In Aotearoa New Zealand, alongside traditional healing, some therapeutic approaches (osteopathy, chiropractic,

and acupuncture) captured under the definition of CAM receive subsidised funding on referrals following an accident via the mainstream government system administered by the Accident Compensation Corporation (ACC; Liu et al., 2021).

An integrative whole-system approach like AM extends the premise of scientific foundations, and this is evident in its practice applications from a structural perspective in areas such as integrated hospital care, therapy centres in the community, and multimodal treatment and assessment systems.

1.3 Anthroposophic Nursing: Extending the Conventional Paradigm of Care

Anthroposophic nursing stands alongside the renewal movements inspired by Rudolf Steiner for education, agriculture, nutrition, economics, social sciences, art, religion and especially medicine.

(Heine, 2018a)

As noted previously in this chapter, the first group of nurses trained under the guidance of Ita Wegman at the Arlesheim Klinik (Switzerland) in 1923 marked the beginning of the AN movement. Ita Wegman established the first anthroposophic nursing school at Sonnenhof/Arlesheim on May 2, 1925 (Ita Wegman Institute, 2023). Today, anthroposophic nurses (ANs) are represented in national (for example, ANANZ—Anthroposophic Nursing Association NZ) and international professional nursing forums (IFAN—International Forum for Anthroposophic Nursing; ICANA—International Council of Anthroposophic Nursing Associations) and other anthroposophically orientated interprofessional networks (for example, IVAA [International Federation of Anthroposophical Medical Associations]). According to IVAA (2011), “Nursing plays a central role in anthroposophic medicine” and is “not simply an ‘add-on’...rather applied in a methodical way and...an essential part of the treatment process” (p. 17).

In Europe, various education programmes are offered, including conventional nursing education alongside training in anthroposophic nursing (Gemeinschaftskrankenhaus

Herdecke, 2023), and additional postgraduate education in anthroposophic nursing after completion of the conventional 3-year registered nurse (RN) qualification.

In Aotearoa New Zealand, Taruna College offers the part-time, IFAN-accredited Foundation Course in Anthroposophic Nursing (FCAN) for RNs. The curriculum includes structured foundational content on anthroposophic concepts and frameworks with clinical case studies and fieldwork. Knowledge in botany and the preparation and application of external nursing therapies/applications (compresses, hydrotherapy, rhythmical body oiling and massage) is included, as well as an understanding of various adjunct anthroposophic therapies (art, music, movement [eurythmy] and speech therapy). The inner personal journey plays a significant and impactful part in this learning, encompassing biographical study and reflective work. Alongside this, the participants are required to critically explore existing nursing research and complete robust academic assignments illustrating the complexity of anthroposophic clinical interventions/applications. More specific details about the curriculum are provided in the upcoming section.

1.3.1 Anthroposophic Presence in Aotearoa New Zealand

Emergence of Anthroposophy in Aotearoa New Zealand

In addition to the timeline in **Table 1**, this section highlights some historical evidence showing that anthroposophy appeared in Aotearoa New Zealand at the start of the 20th century, as evident in the formation of the Anthroposophic Society in Havelock North in 1933 (Turbott, 2013). According to Steiner Education Aotearoa (2019), 18 Waldorf education facilities are currently operating, including preschools, kindergartens, and primary and secondary schools. The main centres for anthroposophic activities are in Auckland (Höhepa Auckland, [n.d.] and the Waldorf schools in Ellerslie [Michael Park School, 2021] and Titirangi [Titirangi Rudolf Steiner School, 2019]); Taruna College [2015a], and Weleda [2024a] in Havelock North, Waldorf education at Hastings Taikura Rudolf Steiner School [n.d.] and curative education & community living at Höhepa Trust Hawke's Bay [2024]); Wellington (Raphael House Rudolf Steiner School, [2019]); and Christchurch (Höhepa Canterbury [n.d.] and Christchurch Rudolf Steiner School [n.d.]). Waldorf schools and

kindergartens at other locations in Aotearoa New Zealand have small therapeutic circles and activities. Grassroots developments, often initiated by establishing a Waldorf kindergarten or a health clinic, are hallmarks of anthroposophic communal growth and are focal points for further education within the local community (for example, seasonal festivals, farmers' markets, or cultural activities).

The Health System in Aotearoa New Zealand

My research question *How do anthroposophically educated registered nurses use the anthroposophic paradigm to inform their practice?* relates to the health system and is situated in the context of health care delivery in Aotearoa New Zealand. The following sections provide an overview of the historical influences and changes that have impacted the positioning of nurses and nursing care. Aotearoa New Zealand has a relatively short history as a nation (New Zealand Parliament Pāremata Aotearoa, 2007), which has affected the development of systemic structures.

Aotearoa New Zealand's historical systems and structures were modelled after the British Westminster tradition (Ministry for Culture and Heritage, 2024). As in other colonised nations, European immigrants introduced colonial rules and claimed dominance over the existing Indigenous society (Pool, 2015). Colonial legislation and regulation had a devastating impact on the Indigenous population (Cram et al., 2019), and despite a partnership treaty, Te Tiriti o Waitangi, an agreement of shared governance between both the Crown and Māori (Orange, 2021), the effects of colonisation, especially on health, are still seen today (Brown & Bryder, 2023; Cram et al., 2019; Robson et al., 2015). Over the past 30 years, increased research has established the long-lasting and undeniable impacts of this intergenerational trauma which is reflected in contemporary society (Blakely & Simmers, 2011; Pōmare & De Boer, 1988; Robson & Harris [Eds], 2007). There is clear evidence of Māori being disproportionately represented in negative health statistics (Robson et al., 2015).

An active approach to creating change emerged in the mid-1980s through various governmental inquiries (Came et al., 2020; New Zealand. Royal Commission on Social Policy, 1988). One outcome of these inquiries was the introduction of cultural safety, a concept developed by Irihapeti Ramsden, a Māori nurse academic (Papps & Ramsden,

1996; Ramsden, 2002) that emerged out of *Kawa Whakaruruhau* (Hunter et al., 2021; Ramsden, 1990), ensuring the safety of Māori. The Nursing Council of New Zealand (NCNZ) incorporated the framework of cultural safety into the RN competencies in 1992 (Ramsden, 2015).

Further, Mason Durie, a Māori psychiatrist, published *Te Whare Tapa Whā* (Durie, 1985, 1994), the first Indigenous health model in Aotearoa New Zealand based on traditional cultural values and beliefs. While these changes in the health system and increased recognition of the impacts of colonisation have had some effect, more needs to be done to see improved equity in the health system (Brown & Bryder, 2023). Building on this seminal work by Ramsden and Durie, in 2024, the NCNZ further reviewed the competencies for registered nurses and enrolled nurses in New Zealand. One focus of the revised standards of competence for all nurses (implemented in January 2025) is a requirement for all nurses to combat racism and provide culturally safe care. This includes recognising the power imbalance between the nurse and the recipient of care and nurses must reflect on their own culture to understand the impact of that culture on care provided for all people (NCNZ, 2024). Therefore, any nursing care provided must be aligned with these foundational principles and ensure ethical practice supported by an understanding of historic impacts.

The health reforms initiated in 2022 focused on reducing health inequalities and easing health service delivery by improving efficiency and effectiveness (Te Whatu Ora, 2022). Under the previous health system, 20 district health boards were tasked with delivering and funding healthcare services in their designated regions. In 2022, Te Whatu Ora Health New Zealand (now Health NZ) was established as the single organisation managing hospital and secondary services nationwide, while four new regional divisions are responsible for planning and allocating funding for PHC service delivery, including community-based services (Te Whatu Ora, 2023b). While some healthcare services are free, including most hospital visits, healthcare after an accident, and for children and young people under 13 years of age, other PHC services and prescriptions incur a partial cost for the patient. PHCs also encourage their patients to formally enrol with a health provider because GP and nurse consultations

are cheaper for registered patients. Funding for the PHC services is associated with the number of patients enrolled (Healthify Te Puna Waiora, 2022). Publicly funded secondary care services (hospitals) have waiting lists for minor or nonacute surgery. Voluntary private health insurance schemes may, depending on the contributions paid, subsidise or pay for surgical and nonsurgical interventions in private hospitals.

As noted earlier, the health system underwent significant restructuring in 2022, and the Labour government (at the time) introduced a co-governance model between Māori and non-Māori. The purpose of the newly established Māori Health Authority Te Aka Whai Ora was, in the first instance, to work alongside Health NZ to improve services and achieve equitable health outcomes for Māori (Te Whatu Ora, 2024a). After all these modifications to the health system, the general election in October 2023 resulted in a change of government from a Labour-led to a National-led coalition which made it a priority to undo several recent health reforms. One of these changes was to disestablish the co-governance arrangement with Te Aka Whai Ora (Māori Health Authority; Pae Ora [Disestablishment of Māori Health Authority] Amendment Act, 2024; Pae Ora [Healthy Futures] Act 2022).

Since the establishment of a more formalised health system in Aotearoa New Zealand in the first part of the 20th century, the recurring alterations in healthcare structures have been an ongoing challenge. While there were multiple access points to healthcare before the turn of the 20th century, “the Social Security Act in 1938 marked the introduction of a comprehensive health system” (French et al., 2001, p. 32), providing free care for all citizens. It included free hospital treatment, medicines, and subsidised medical care, except for PHC services. GPs remained independent but were subsidised by the government on a fee-for-service basis. Other services like dental care and optometry still required private payment. By 1947, Aotearoa New Zealand had adopted a predominantly tax-funded healthcare system that offered most services at no cost. However, over the next 35 years, it became increasingly evident that service delivery was becoming more fragmented, leading to further changes in the healthcare system.

Since the 1980s, various attempts to improve health for Māori have resulted in systemic changes without a shift in health culture and a successful approach to address inequities. The WAI 2575 inquiry in 2016 (MoH, 2024) presented compelling evidence of inherently racist health structures in Aotearoa New Zealand that perpetuate and continue to undermine equitable health outcomes for Māori. Researchers have underscored these findings by scrutinising current health policies in relation to Te Tiriti o Waitangi principles (Came et al., 2020, 2024; Kidd et al., 2021; Rae et al., 2023). Working within health structures designed to provide care for people with various needs, including marginalised groups, shapes and influences the role of health professionals. Deficits and shortfalls in equitable healthcare delivery also highlight the importance of culturally safe practices when caring for those affected by colonisation. Whether another structural change will achieve better and more equitable health outcomes or a more significant shift in health culture is needed (Reid, 2021) is a question many health professionals are currently considering.

However, alongside the progressive and heightened awareness of the need to consistently work with culturally safe and responsive models of care in Aotearoa New Zealand (NCNZ, 2011; New Zealand Nurses Organisation [NZNO], 2018), research has shown a lack of holistic approaches in practice (McBride-Henry et al., 2022; Reweti et al., 2023). The lack of integration of spirituality or wairua in healthcare provision is particularly noticeable and has been discussed in contemporary research (Christian, 2020; Egan et al., 2017; Egan & Blank, 2021; Rae et al., 2023). While it is pertinent to grasp the meanings of the facets of *holisticism* or *holism* as these are defined and used in conventional health, the Indigenous perspective on holism encapsulates a less compartmentalised and more interwoven view. Holism encompasses all that is life (Te Ao Māori) and is inseparable from living within the natural world (Papatuanuku). Further to that, planetary (cosmic) influences, life beyond the earthly existence, and the meaning of spiritual connections through genealogy (whakapapa) are additional elements that arguably go beyond the often reductionistic presentation of holism in the mainstream health context (Mead, 2016; Pihama et al., 2023; Wehipeihana et al., 2022).

Moreover, while all Indigenous Māori health models embrace holistic foundations to health and well-being (hauora) as core non-negotiable elements, the application of these models by non-Indigenous healthcare services is frequently contested and questioned by Māori recipients of care (Pene et al., 2022, 2023; Reweti et al., 2023; Wilson et al., 2018). Feedback from Māori healthcare recipients must be considered crucial when auditing existing structures and modes of healthcare delivery. Despite the claims that Indigenous care models are used and integrated with conventional holistic care models in Aotearoa New Zealand, practice does not illustrate a comprehensive understanding of holism. With this in mind, nurses are required to evaluate their care based on conventional/mainstream practice and challenge interventions and interactions with health recipients that are labelled as holistic. Social and cultural aspects can influence perceptions of holistic nursing care, which are expressed and interpreted in various forms. Working from the anthroposophic paradigm might prompt non-Māori nurses to question their understanding of holistic care.

1.3.2 Education Pathway to Anthroposophic Nursing in Aotearoa New Zealand

Taruna College (2015b) in Aotearoa New Zealand is the only education provider offering face-to-face foundation courses in anthroposophic nursing in the Southern Hemisphere. Over the past 25 years, it has provided a range of foundational courses on holistic health and home care, focusing on improving health education and self-management in the community.

Education guidelines for anthroposophic training programmes to qualify as an AN or ANS are developed and designed by QAN, which is part of IFAN (n.d.-c), the overarching professional body for national associations. In 1998, seven founding members—all anthroposophically trained nurses—established the ANANZ (**Table 1**).

To date, anthroposophic nursing has not been part of contemporary health service structures in Aotearoa New Zealand. Although integration is observed in specific care domains such as Māori health, end-of-life care, residential care, disability services, and mental health, it is typically instigated by ANs/ANSs practising in these clinical areas

(Freeman Rock, 2014). Another way of practising anthroposophic nursing is through self-employment, often in collaboration or association with other regional anthroposophic services and therapists.

In Aotearoa New Zealand, the first group of nurses graduated in anthroposophic nursing in 1998 and, since 2002, RNs have been able to access training courses through Taruna College in Hawke’s Bay. **Table 2** shows the number of nurses graduating since 1998. At present, there are 11 active ANSs in Aotearoa New Zealand; one ANS has passed away, and one lives in Australia (D. Bednarek, personal communication, May 28, 2024).

Table 2

Anthroposophically Trained Nurses Since 1998

1998 pre-Taruna held at Taikura (Hastings)	24 graduates
2004 Taruna College	11 graduates
2008 Taruna College	10 graduates
2012 Taruna College	12 graduates
2015 Taruna College	14 graduates
2022 Taruna College	13 graduates
Total	84

Note. From personal communication with C. Wilson, November 4, 2023.

Anthroposophic nursing training providers must meet international guidelines (IFAN, 2014) and training benchmarks (WHO, 2023). The last audit for the Foundation Course in Anthroposophic Nursing at Taruna College occurred on March 20, 2022, as part of QAN’s regular assessment of education providers. The auditor highly recommended the course to IFAN, and IFAN ratified the audit outcome in September 2023 (D. Bednarek, personal communication, May 28, 2024).

The curriculum is delivered face-to-face in block courses (four seminars, 20 days in total) over 12 months. All anthroposophic nursing foundation courses require completion of a minimum of 365 learning units (1 unit = 45 minutes; IFAN, 2022; WHO,

2023). As per the Anthroposophic Nursing Association of New Zealand and Taruna College *Handbook* (2019) and in alignment with the *Handbook of Certification of Anthroposophic Nurse Specialist, Version 5* (IFAN, 2022, pp. 3-7), the foundation course in Aotearoa New Zealand focuses on the following four core modules:

Module 1—Anthroposophic Foundations of Nursing and Diagnosis: three- and four-fold concepts (spiritual physiology/anatomy) and their integration; life processes; biographical and planetary influences on human life; the 12 senses; 12 Nursing Gestures; understanding life, health, and illness in the context of anthroposophic foundations/philosophy

Module 2—Nursing Interventions: includes education in external anthroposophic therapies (EAT) like rhythmical einreibung (RE), according to Wegman and Hauschka (Hauschka, 1990); compresses and hydrotherapy; use of plant and metal substances; nursing across the lifespan-opportunities (interventions for acute and long-term conditions); therapeutic dialogue

Module 3—Healing Impulse in the Interdisciplinary Therapy Team: anthroposophic medicine/pharmacological processes; introducing anthroposophic medicines and understanding pharmacological processes; artistic therapy (sculpture, painting, music, movement and eurythmy)

Module 4—Personal and Professional Development: supporting inner (personal) development; sustainability and salutogenesis in life and work; therapeutic practice in context

An adult learning approach is used, offering a variety of learning modes, for example, face-to-face classroom lectures, observation, journalling, biographical reflection on one's own life journey, small group work, artistic experiences (therapeutic artwork with reflection and links to case studies/clinical presentations), and clinical practice.

The participants must undertake individual self-directed study and complete formative and summative assessments. All assessment points and self-directed learning are compulsory and assessed against IFAN learning outcomes (IFAN, 2022, pp. 3-7).

Theoretical and practical knowledge about the three- and four-fold concepts, combined with case studies and plant observations during anthroposophic nursing education, offer new and expanded insights and learnings about holistic conceptions of human existence. The concepts of illness in the light of meaningful encounters linked to biographical milestones help build new ontological and epistemological foundations. These foundations serve as the basis for all interventions by ANs/ANSs. They acknowledge the interconnectedness between an individual's spiritual essence, daily experiences, biography, and their health journey.

1.3.3 Anthroposophic Caring: Warmth, Rhythm, and Substance

The philosophical foundations of anthroposophic nursing centre around a holistic perspective of human beings, incorporating observations and evaluations guided by the principles of the three- and four-fold human nature. A comprehensive understanding of the elements of warmth (van der Star, 2020; van Bentheim et al., 1987), rhythm (Camps, 2020; van Bentheim et al., 1987), and substance (Heine, 2020a) provide additional support for these theoretical concepts as they inform the use of external nursing applications (see Chapter 2).

Anthroposophy can be approached from two perspectives. At its core are the esoteric insights Steiner outlined and presented to the world; however, anthroposophy's practice-related perspective is the more well-known and has developed and evolved through inquiries and collaborations with professionals in various fields since its inception. For nurses, this is reflected in their practice interventions and nourished as an inner quality that characterises the therapeutic dialogue between the nurse and the patient. While the outward actions find expression in the assessment skills and draw attention to the upper senses (see Chapter 2, **Table 5**; for example, applying a warm compress or preparing a footbath at a specific time every day), the lower senses (see Chapter 2, **Table 5**) are influenced by gestures like acknowledgement or respect. Those

inner qualities can only be finetuned and fostered by the nurse through spiritual attention and practice.

Anthroposophic nursing is presented not only as a distinct caring philosophy marked by various therapeutic interventions (external nursing applications, also known as EAT) that extend conventional nursing actions but is also described as a cultural task (Heine, 2020c) and as an art of caring (Sustick, 2017) that expands its ontology into environmental (Arman et al., 2008) and social responsibilities (IFAN, 2021). The theoretical model of practice is juxtaposed with an internalised model of caring practice (Andermo et al., 2017; Ben-Arye, 2021; Ranheim et al., 2010), which emanates from the nurse's inner spiritual work. The following sections offer examples of how theory is joined with practical realities.

Nursing therapies make use of substances along with touch and warmth, working with the skin as the body's primary sensory organ, which is part of the nerve-sense system. The anthroposophic external applications (Fingado, 2012; Heine, 2022; Mühlenpfordt et al., 2022; Mühlenpfordt & Seifert, 2022; van der Star, 2020) are essential parts of therapeutic nursing interventions (see Chapter 2) and create connections to the natural world through the use of plant, animal, and mineral material.

Applying a substance through touch has advantages compared to the oral ingestion of remedies and medicines. This approach is considered less invasive, enabling the body to respond. When a remedy/medicine is ingested, the bypassing of a more conscious engagement with the substance occurs. Steiner described the nerve-sense system's effect on healing the etheric and physical bodies (Steiner, 1920b; Steiner & Wegman, 1925/1983).

All anthroposophic nursing therapies emphasise the combination of warmth and rhythm as healing and therapeutic elements connecting back to the three-fold concepts of anthroposophy. The ego-body has a particular affiliation with warmth. Nursing interventions must consider using warmth alongside specific substances, especially for conditions influenced by a weakened ego-body. Warmth, as an influential element of transformation, determines changes in seasons and solid or

liquid structures, and van der Bie (2003b) concluded that “warmth forms the bridge between the visible world of manifestation and the invisible world of dynamic qualitative processes” (p. 208). For nurses, stimulating or regulating warmth is an essential diagnostic and practical component when working with external applications. The esoteric considerations of warmth rest with the individual nurse’s inner path to spirituality and empathy; both can be nurtured through meditative exercises (Heine, 2020c).

The quality of rhythm, whether inner (body functions, asleep/awake) or outer (frequency, time of day), has a structuring, reaffirming quality and emphasises the three-fold middle. Breathing as the archetype for all rhythmic phenomena (for example, rhythm expressed via touch or sound which is palpable or audible to the senses) aids the presence of regularity, certainty, and safety in therapeutic encounters.

In anthroposophic nursing, the term “substance” can include a variety of ingredients derived from herbs, minerals, and animals. Substance and rhythm combined, along with the specific setting (such as attention, touch, or environment), the medium used (such as water or oil), and the temperature, will determine the effectiveness of the external application (Heine, 2020a).

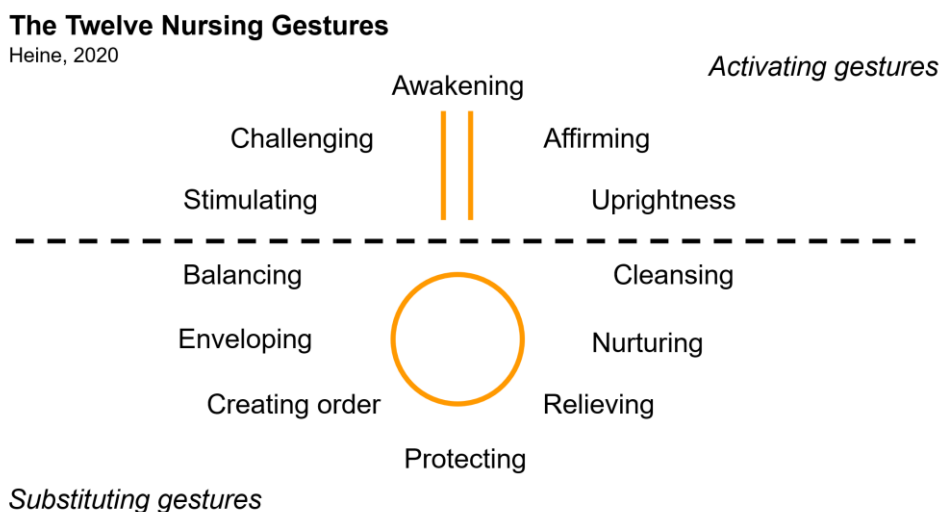
1.3.4 The 12 Nursing Gestures: A Model of Care

The 12 Nursing Gestures model was developed through a process that involved phenomenological observations derived from daily nursing practice, case studies, and group discussions within the framework of anthroposophic anthropology. These collaboratively discovered inner attitudes were articulated as empathetic intentions and initiated the development of the 12 Nursing Gestures model (Heine, 2020d). Continued exploration of these collected terms followed this initial process.

The development of the 12 Nursing Gestures was influenced by the aim to illuminate the way inner attitude and outward expression of nursing activity can be expressed/made visible (Heine, 2008). The model (see **Figure 1**) depicts two groups of gestures—activating and substituting—each containing further subcategories (Heine, 2020d, pp. 130-131).

Figure 1

The 12 Nursing Gestures



Note. From *The concept of Nursing Gestures as a model for nursing care*, by R. Heine, 2020d, in R. Heine (Ed.), *Anthroposophic nursing practice. Foundations and indications for everyday caregiving* (Chapter VII, pp.121-200). Copyright 2020 by Rolf Heine. Reprinted with permission (see Appendix A).

The anthroposophic nursing interventions described in Chapter 2 illustrate an external, visible side of nursing care. Although anthroposophic anthropology underpins these tasks, anyone interested in holistic care informed by the anthroposophic health paradigm can acquire and practice them (Vademecum, n.d.-g). The role of the AN/ANS is shaped by cultivating a conscious and nurtured inner attitude enriched with archetypal imagery (Riehm, 2022). These archetypes then infuse the observable and pragmatic with a spiritual gaze or gesture. The term gesture encompasses a more profound meaning concerning the manner and attitude in which the nurse performs a specific action. According to Heine (2018b), “[by] gestures we do not mean the intentions or actions of the person providing nursing care or therapy. Rather, the term denotes a specific power [inner intention] that is at work in our relationship...” (para. 7). The quality surrounding a gesture could be summed up as a merging of various aspects, namely, “action and attitude, deed and expression... [the gestures] are archetypes of nursing care (Heine, 2020d, p. 121). In anthroposophic care, nurses are asked to reflect on the external nursing activity/task and the “inner attitude or nursing

ethos” (Heine, 2008, p. 1), with the guiding question in mind: “How can inner attitude become activity? How can something which I inwardly strive to achieve with the patient become visible activity?” (Heine, 2008, p. 1).

The two straight lines shown in **Figure 1** symbolise the five activating gestures, reflecting uprightness, self-reliance, the ability to speak and think for oneself, and the capacity to manage challenges. “Stimulating gestures must always wait for the patient’s ability to react” (Heine, 2020d, p. 131).

Substituting gestures represent nursing gestures that assist the patient OR, depending on the patient, the nurse completing the action on their behalf (Heine, 2020d; Kramer et al., 2022). The practical expression of each gesture transferred to a patient can be related to and articulated through each of the elements of the four-fold conception of the human organisation—physical, etheric, astral, and “I” or ego (Kramer et al., 2022).

The 12 Nursing Gestures model offers guidance and connection to macrocosmic influences (Heine, 2008, 2020d). The qualities of the zodiac combined with the nursing moods/attitudes to the seven planets are core drivers for each gesture but do not represent a fixed structure. Each life stage and health condition requires a new approach to integrating this model into care as the nurse begins the therapeutic dialogue with each new patient, who is a different individual. **Table 7** in Chapter 6 uses interview data to illustrate how ANs/ANSs use caring language and work with an understanding of the 12 Nursing Gestures.

1.4 Rationale and Purpose of this Research

This research project originated from my deep interest in anthroposophic nurses’ work and influences on the health landscape in Aotearoa New Zealand. A more formalised idea for the study emerged from discussions held at nursing conferences during the last decade. These mostly revolved around anthroposophic nurses’ perspectives of their practice and the way ANs/ANSs contextualise and work with the anthroposophic foundations in Aotearoa New Zealand. In addition, the research has sought to explore barriers, facilitators, and challenges experienced by ANs/ANSs.

Over the years, my ongoing involvement with the ANANZ Education Committee has deepened my understanding of anthroposophic nurses' positioning and implications in the health context of Aotearoa New Zealand. Health structures and models of care are complex and the expression and practice of anthroposophic caring might not fit all health environments for various reasons. The question of how anthroposophic nurses integrate their knowledge working in health structures that are less familiar with this paradigm has implications for their practice. However, ongoing research such as this study, and commitment to holistic nursing practices are essential for supporting the whole human being in contemporary healthcare.

Despite the nursing profession's claim to work with holistic foundations in providing nursing care for the individual, their family and whānau (wider family group), there is clear evidence of persistent gaps and shortfalls in nursing care in Aotearoa New Zealand (Christian, 2020; Clendon, 2013; Egan et al., 2017). Indigenous health beliefs have historically been threatened and almost extinguished by processes of colonisation; it is paramount that holistic practices inform healthcare and require health professionals to be actively involved in exploring the meaning of holism as part of self-exploration/development.

With this research, my priority was to initiate thinking that recognises change and enables practice shifts to improve future nursing care. Secondly, I wanted to explore how RNs who have completed education in anthroposophic nursing contextualise and work with these concepts.

The possibility of expanding care based on anthroposophic anthropology has been observed and documented in past literature and research by anthroposophic and nonanthroposophic scholars and nurses (Andermo et al., 2017; Arman et al., 2008, 2011; Kramer et al., 2022). In Aotearoa New Zealand, feedback from anthroposophic nursing colleagues and outcomes from a pilot study (Te Huia, 2018; see Appendix C) showed that integrating AN into conventional, nonanthroposophic health services/systems can be challenging. I aimed to capture AN's/ANS's experiences that illustrate the capacity and validity of this way of nursing in the local context.

Anecdotally, ANs/ANSs have supported various communities and individuals over the

past 3 decades in Aotearoa New Zealand (Therkleson, 2005; Turbott, 2013); however, there is limited research data to substantiate this.

This study aims to explore the perceptions of RNs who have completed anthroposophic nursing education and illuminate the ways they contextualise and apply this knowledge to their clinical practice. It delves into their practical experience but also aims to expose facilitators and barriers. An overarching purpose is to bring more attention to and recognition of anthroposophic nursing in Aotearoa New Zealand and spotlight its potential for integration with conventional/mainstream health services.

In the first instance, I intend to improve the understanding of health and nursing care delivery underpinned by the anthroposophic human picture (anthroposophic anthropology). I believe it is also relevant in the international context of anthroposophic healthcare to capture the variations in receptiveness to anthroposophic nursing, depending on each nation's sociocultural, economic, and political context. Health structures, societal characteristics, and complex funding systems affect how nurses position themselves as health professionals, navigate their respective health environments, and articulate their practice.

1.5 Research Aim and Question

The following sections outline the aims of the study and present the research question, followed by a brief introduction to the study's design, my position, and my journey as an RN who has incorporated anthroposophic insights into her practice. I have included a reflective account to clarify these motivators and their influencing factors. Equally important is to expose and recognise the potential bias I bring to this qualitative research.

The aim of this research inquiry is to gain a better understanding of how nurses educated in anthroposophic healthcare incorporate these principles into their practice. The study's objectives were:

- to investigate and explore anthroposophic nurses' perceptions of their practice

- to examine how the application of the anthroposophic paradigm is contextualised within the healthcare system in Aotearoa New Zealand
- to identify the barriers and facilitators registered nurses trained in anthroposophic principles encounter

Guided by these aspects, I formulated the following research question:

How do anthroposophically educated registered nurses inform their practice using the anthroposophic paradigm?

1.6 Design of the Study

Although research evaluating AM and the use of anthroposophic therapies has been growing, minimal attempts have been made outside anthroposophic hospitals or PHC clinics to explore how anthroposophic nurses integrate the knowledge of anthroposophic foundations into their clinical practice.

My intention is to explore the way nurses' practice is influenced after completion of anthroposophic nursing education and the application of this knowledge to their clinical thinking and decision-making. Understanding the influence of the conventional health culture on nursing values and beliefs rooted in the anthroposophic paradigm was crucial, given the lack of awareness about anthroposophic medicine and nursing in Aotearoa New Zealand. When approaching the study design, I knew I was especially interested in studying practice implications as experienced by ANs/ANSs, which inevitably led to the choice of a qualitative constructivist research design (Creswell & Poth, 2018; Crotty, 1998). Positioning oneself within the research process influences the research design and illustrates paradigmatic alliance translated into a "basic set of beliefs that guides action" (Guba, 1990, p. 17). Interpretive description (ID) is aligned with a constructivist and naturalistic orientation to inquiry. These interpretative paradigms encompass ontological, epistemological, and methodological understandings and embrace the nature and process of inquiry. They are core beliefs that inform and shape behaviour or action (Crotty, 1998; Flick, 2018).

While I initially explored several qualitative approaches (see Chapter 3), the choice of ID (Thorne, 2016) was attractive because it reflects the constructivist epistemology that underpins this study. A constructivist perspective views knowledge as a product of human interaction and experiences rather than a defined, objective reality (Crotty, 1998; Denicolo et al., 2016). Emphasis is placed on the role of experiences and social interactions that shape understanding of the world and cannot be or become a fixed orientation but represent ever-changing experiences that inform perspectives. In this research, the constructivist approach shaped each interview by posing open-ended questions that allowed for a range of factors to be considered (Creswell & Poth, 2018), for example, the participant's background or their motivation to become an anthroposophic nurse and focused on the specific cultural and social context in Aotearoa New Zealand.

ID was developed in response to situating research inquiries within a discipline versus adhering to 'methodological eclecticism' (Thorne, 2016, p.36) that serves mainly to develop theory rather than addressing real-life clinical applications. This step into a new methodological space, however, was underscored by the intention to strengthen qualitative research "by aligning it with the epistemological underpinnings of the applied disciplines for which it is being used" (Thorne, 2016, p.39).

The flexibility of ID and its grounding in nursing values (Thorne, 2016) aligned well with the philosophical and theoretical concepts of anthroposophic nursing and Steiner and Wegman's (1925/1983) assertion of AM as a practice-driven and oriented discipline. While anthroposophy or anthroposophically oriented spiritual science serves as the foundation for various disciplines, the onus to apply and further develop anthroposophic principles and concepts rests with each respective health profession. This intent reflects a non-stagnant and ever-evolving process that demands ongoing inquiry and is constructed and driven by practice observations.

For both ID and anthroposophic nursing, the motivating factors for research are professional practice-situated experiences that shape ongoing inquiry and, therefore, development of the profession. At the nexus of a constructivist, ID and anthroposophically oriented approach to inquiry rests the interest in the human

experience that further shapes and informs professional perspective and caring interventions.

My professional allegiance to conventional nursing, expanded by anthroposophic foundations, required a methodological approach situated in conventional nursing practice with the flexibility to include the theoretical concepts of anthroposophy (Heusser, 2016). The focus on practice in this study also implied a varied interpretation of practice moments and encounters, which Thorne has asserted is manifest as one of the critical characteristics of her methodology; theory alone does not account for an a priori understanding of the phenomenon researched (Thorne, 2016). ID emphasises and validates the ever-evolving dialogue of experiences between the researcher and the researched, underscoring practice experiences as the defining factors in the development of new knowledge.

One may argue that ID's relative novelty (Hunt, 2009) could present a challenge or limitation to study design; however, multiple studies using ID within nursing and other allied health disciplines provide reassurance of the robust nature of the methodology (for example, Bright et al., 2013; Nkulu Kalengayi, 2012; Slomp et al., 2018; Smith et al., 2013).

My initial plan was to work with Braun and Clark's thematic analysis (2006, 2022). However, after some consideration, discussion with my supervisors, and an email exchange with Sally Thorne (see Chapter 4 & Appendix D), I decided that using the four phases (comprehending, synthesising, theorising, and recontextualising) of Morse's cognitive processing framework (1994) to support the data analysis was more fitting given my methodological approach.

1.7 Positionality as a Researcher and Anthroposophic Nurse Specialist

My journey with anthroposophy began after I immigrated to Aotearoa New Zealand in 1993. Although I had qualified as a RN in my homeland, Germany, in 1987, I worked in conventional healthcare settings in Germany and Switzerland and only discovered Waldorf education during those initial years of nursing in Aotearoa New Zealand. My focus as a new graduate in Germany was on acute care. Working in different intensive

care units, I developed a strong affinity for assisting individuals and their families during critical situations. During these times, I often noticed that I felt a sense of loss when we had exhausted all avenues of clinical intervention and were unable to save or restore someone's ability to live independently. Conversely, more substantial issues came to the forefront after life was preserved, such as overcoming the past and incorporating the new experience and potential disability in the future. I frequently noticed that I was searching for *something else* that would add more fulfilment to my nursing career and strengthen my ethical grasp of the art of nursing.

I have been interested in herbal medicine and folk healing since early childhood. This interest was rooted in my upbringing and connected to my mother. Her initial response to ailments was using home remedies and being with us during times of unwellness before consulting the doctor. At that time, however, I had no intention of exploring this interest in natural healing approaches as a possibility for furthering my nursing career.

After travelling, working in Switzerland as an occupational health nurse, and starting a family, my partner and I and our 1½-year-old son emigrated to New Zealand. Here, I became acquainted with Waldorf education and delved more into various branches of anthroposophy. One day, a mother at the Waldorf Kindergarten brought up anthroposophic nursing and asked me if I had heard of it. I was intrigued, to say the least!

After reading more about anthroposophic healthcare, I returned to Germany, worked at an anthroposophic clinic, and enrolled in a nursing course there. I returned to New Zealand in 2000 with a completed qualification and was eager to work as an anthroposophic nurse, initially focusing on the Waikato Waldorf School community. I juggled being a parent at the Waldorf School and offering consultations as a qualified anthroposophic nurse; through this, I became aware of the barriers and challenges when working from anthroposophic foundations within the conventional/mainstream health system in Aotearoa New Zealand.

I established a small private practice as an anthroposophic nurse while working part-time as a RN in various conventional healthcare settings—in the hospital and in the community. Interest was undoubtedly present among those familiar with anthroposophy, but I also drew in clients searching for a health professional offering therapies that provided additional health support alongside the conventional/mainstream approach.

In 2006, a not-for-profit organisation invited me to be part of establishing a health retreat (called The Monastery) offering women with a history of depression, stress, and anxiety a 5-day stay. During my time there, it became even more apparent that health structures/systems unfamiliar with anthroposophic healthcare struggle to recognise and value its benefits. A small pilot study I conducted in 2009 confirmed this and illustrated how improving self-management and resilience with anthroposophic nursing therapies achieved lasting results. Some women spoke of these benefits up to 6 months after their stay at the retreat. Reporting on these insights and presenting case study notes was part of my achieving the anthroposophic nurse specialist requirements in 2009.

Working for The Monastery, I began my postgraduate journey in 2010, focusing on nursing in PHC, with the long-term goal of completing a master's qualification which was achieved on December 12, 2015.

As I delved deeper into postgraduate studies and started my career as an educator, I became more aware of paradigmatic challenges and gender roles in nursing, and their impacts on the healthcare workforce. Additionally, I gained a greater understanding of the role and importance of nursing advocacy in postcolonial health systems and the responsibility for nurses to engage in it. My professional journey over the years has continued to reaffirm for me the value of becoming familiar with the principles of the anthroposophic paradigm and further advancing my existing conventional nursing knowledge. Teaching nursing students at the undergraduate and postgraduate levels since 2011 has additionally fuelled my motivation to explore anthroposophic nursing, as it has brought attention to areas of the nursing curriculum that would benefit from

improvements, for example, an increased understanding of what constitutes a holistic practice.

I observed and reflected on my voice during the research process, especially during the interviews, when moving from being a facilitator within a familiar worldview and concept to a researcher who listened to the narratives and experiences of peers. Despite my deliberate attempts to include notetaking, reflective writing, and discussions with my supervisors, my understanding of anthroposophic nursing remains undeniably subjective. Shifting between being knowledgeable about a subject and adopting a researcher's role presented challenges and potentially introduced subjectivity and bias into the findings of this study.

1.8 Thesis Structure

Chapter 2 offers a brief insight into anthroposophic foundations and concepts. The three- and four-fold concepts are explained as they relate to health practice. This is accompanied by a description of Steiner's articulation of the 12 senses and, lastly, some context that illustrates the relationship between salutogenesis and anthroposophic healthcare.

Chapter 3 presents an overview of the existing literature on anthroposophic nursing. The findings from the empirical and grey literature are discussed in relation to three themes: integrated care grounded in anthroposophy, patient experiences of anthroposophic care, and anthroposophically extended practice and education.

Chapter 4 outlines my methodological approach informed by my epistemological stance. My rationale for using the qualitative methodology of interpretive description (ID) is discussed. Additionally, I describe participant recruitment, sampling, data collection, and how the data was analysed. The COVID-19 pandemic considerations are discussed as these affected the data collection.

Chapter 5 begins with an introduction to the participants and their motivations for expanding their professional practice with anthroposophic nursing. I then present the study's findings under three key themes: "Our way of being", understanding of the

question of identity, expressions of anthroposophic nursing in practice, and negotiating place—nursing with anthroposophic foundations in Aotearoa New Zealand.

Theme 1 captures the participants' nursing identities and how they perceive their roles as anthroposophic nurses. It provides further detailed examples to illustrate how the anthroposophic paradigm supports nursing practice by applying frameworks and concepts. This theme also introduces the participants' ways of being ANs/ANSs in relationships with patients, nursing colleagues and allied health professionals.

Theme 2 presents visible and invisible gestures, traits, and facets of AN practice and illustrates the complex dimensions of anthroposophic nursing through participants' elaborations on the planning and rationales for their nursing care.

Finally, Theme 3 reports on the participants' understandings of the influences of the cultural and bicultural contexts of anthroposophic nursing in Aotearoa New Zealand. It highlights the challenges and barriers to anthroposophic nursing within contemporary healthcare structures.

Chapter 6 starts with a summary of the findings, positioned within a theoretical framework of two fundamental dynamics. The first fundamental dynamic relates to rethinking existing knowledge of human existence during health and ill health prompted by anthroposophic concepts. This intentional process stimulates a journey that expands and transforms our understanding of nature, human existence, and interpretations of the universe. The second fundamental dynamic is the emphasis in anthroposophic nursing on human interaction. The findings are then discussed and compared with the existing research on anthroposophic nursing and recontextualised within the health context of Aotearoa New Zealand.

Chapter 7 summarises the results and provides concluding statements and recommendations for future studies. After highlighting the study's outcomes, I present the strengths and limitations, followed by recommendations focused on practice—

oriented implications, education, and future research studies relevant to the national and international context of anthroposophic nursing.

1.9 Chapter Summary

This chapter began with an introduction to anthroposophy, its origin, and a timeline of the historic makers relevant to anthroposophic medicine and healthcare. I then introduced the complex foundational paradigmatic concepts and frameworks of anthroposophy and how these relate to nursing. While possibly reductionist, this introduction to the epistemological foundations of anthroposophy and the links to health practice was necessary to underscore this study's rationale and aims.

I then addressed the debate surrounding the incorporation of AM under the broad category of complementary medicine and therapies, acknowledging its frequent mention in this context. This section highlighted AM's place alongside conventional/mainstream approaches as an integrative whole-system healing approach. Anthroposophic healthcare is, by nature and origin, a collaborative and interprofessional approach to health that seeks to aid recovery from illness and disease using salutogenic strategies alongside other conventional therapies.

Before presenting the education programme for anthroposophic nurses in Aotearoa New Zealand, I provided a brief history of the health system and its features to emphasise the current gaps in this research area. In this chapter, I have also covered the research study's aim, rationale, and purpose, along with an initial presentation of the research design and the thesis structure. A reflective account of my experiences as an anthroposophic nurse specialist exposes any research bias and subjectivity. The following chapter focuses on the theoretical foundations of this study and introduces the frameworks and concepts underpinning anthroposophic nursing.

Chapter 2 Anthroposophic Foundations as Theoretical Concepts

The responsibility is ours to draw ever anew from these rich gifts, given so freely, and to develop capabilities in ourselves to penetrate further and further into a deeper understanding of Man for the purpose of healing. Out of that which has been given this striving must be fructified ever anew.

(Wegman, 1920/1976, p. 14)

2.1 Introduction

Anthroposophy is Steiner's philosophy of the human being and functions as a theory of "what is" (the ontology) that underpins knowledge constructs and interpretations of practice experiences (the epistemology). For the purpose of this thesis, I introduce three foundational anthroposophic frameworks critical for nurses who work with anthroposophically informed interventions. These are by no means exhaustive and offer only an introductory baseline. This chapter aims to describe the three-and four-fold framework and the 12 senses in relation to holistic health. Additionally, I offer an outline of anthroposophic external therapies with some examples of application and links to relevant resources and literature. Finally, I explain and describe Antonovsky's salutogenic model (1979) and its relevance to the principles of anthroposophic healthcare. Anthroposophic researchers and health professionals frequently refer to this model in studies and the existing literature.

2.2 Anthroposophic Anthropology: The Four-Fold Human Being

Establishing the anthroposophical paradigm's epistemological foundation is crucial before transitioning into the practice of anthroposophic nursing (WHO, 2023, Annex 1, Table A 1.2). Foundational to Steiner's view of the human being was his deep involvement with and study of Goetheanistic phenomenology (Landman-Reiner, 2021a; 2021b; Mason, 2014; Steiner, 1883/1988). The German writer, philosopher, and natural scientist Johann Wolfgang von Goethe (1748-1832) articulated and researched this observational approach that focused on training the observer to allow

the object or phenomenon to speak for itself. However, Goethe also described various archetypes found in nature that facilitate more complex insights into the process of metamorphosis (Landman-Reiner, 2021b). The theoretical and conceptual descriptions in the following sections can only provide a superficial initial understanding of this intricate and interconnected (holistic) epistemology but are necessary for any anthroposophically oriented training and health professionals. These theoretical concepts underpin anthroposophic healthcare delivery and are essential guides for assessment and diagnosis, deciding on interventions, and the evaluation of therapy outcomes.

Engaging with anthroposophy includes developing a level of perception encompassing the spiritual characteristics of humans and the natural environment. Steiner's insights offer several ways of working and developing awareness of the formative forces that influence human existence (Heusser, 2016). **Table 3** presents what is referred to as anthroposophic anthropology (Heusser, 2016), the four-fold (also four bodies of the human being; Bay, 2020; Evans & Rodger, 2017), or spiritual physiology (Therkleson, 2005). The associated natural, elemental, and temperamental characteristics anthroposophic health practitioners draw on when conducting health assessments are listed in columns two, three, and four (**Table 3**). These formative forces are illustrated in the four bodies: physical, etheric, astral, and ego. They are immersive components and are considered in addition to the "molecular [and] biochemical mechanisms active in nature" (WHO, 2023, p. 2). Each of the four bodies (folds or levels of the body) must be observed in its relationship to other elements and not in isolation. **Table 3** illustrates two examples of interconnection: the relationships in the natural environment (elements) and human characteristics (temperaments).

Table 3*The Four-Fold Human Being*

Four-fold human	Natural world	Elements	Temperaments
<i>Ego body</i>	Human	Fire	Choleric
<i>Astral body</i>	Animal	Air	Sanguine
<i>Etheric body</i>	Plant	Water	Phlegmatic
<i>Physical body</i>	Mineral	Earth	Melancholic

Note. Adapted from various sources (Bay, 2020; Heusser, 2016; Steiner, 1904/1922, 1919b; Therkleson, 2007).

The holistic nature and intent of anthroposophic assessment frameworks and concepts underscore the use of anthroposophic care and therapies alongside conventional diagnostic tools (Bay, 2020; Therkleson, 2007). Any physical assessment will always encompass the mental and spiritual levels. Additionally, each human has an individual capacity for self-healing in each developmental stage, which becomes an integrated aspect of a health assessment.

The *physical body* relates solely to the body's mass (dense and material), under the influence of gravity (earth), comprising matter. As a characteristic, the heaviness of temperament is also linked to this quality (Bay, 2020).

The *etheric body*, or the formative, life-force body (vital body), forms and enlivens the physical body. It relates to blood or lymph flow (fluid, phlegmatic), growth, reproduction, and regeneration. These qualities link it to the life forces in the plant world, and its existence is essential to restoring health.

The *astral body* reflects our senses and responds to the impressions we experience from the outside world. Feelings, sensations, likes, and dislikes are part of its fluctuating quality (airy, sanguine). These are all conscious expressions of our experiences, and the astral body imprints these on the etheric body, as without the etheric body, we would exhaust ourselves. The astral characteristic of instinct creates a link to the animal kingdom. While animals respond to instinct without thinking, humans can involve their consciousness and gauge their responses (Therkleson, 2007).

The *ego body* (the “I am”) reflects the formative forces of the spirit. Only humans possess the capacities to think (intellectual ability), express themselves in various forms and ways (individuality), develop personality, and self-reflect. The ego body or “I” can immerse itself in the three other bodies and establish a link to the warmth (fire, choleric) organism, allowing the ego to control and regulate warmth (both physical and emotional) throughout the body. The ego body is also most closely connected to the spiritual world and the higher self, and the uprightness of the human body further reflects this (Heusser, 2016; Steiner, 1904/1922).

Therkleson’s text, *Profiles in Nursing Practice* (2006), offers case studies that demonstrate the application of the four-fold concept to nursing assessments and therapeutic interventions.

2.3 The Three-Fold Human Being: Spiritual Anatomy and Relationship to Substance

Another foundational theoretical concept and analytical tool for assessment is the three-fold form of the human being (also see **Table 4**). It consists of the neurosensory, metabolic, limbic, and rhythmic systems. The three-fold system is commonly known in the context of health as “spiritual anatomy” (Therkleson, 2007, p. 10), and it is described as having a “functional polarity with inherent rhythmic processes” (WHO, 2023, p. 3). These three dynamic and interpenetrating systems (Steiner, 1904/1922, 1923) include organs and organ systems, which are relevant to assessing imbalances and used in manufacturing anthroposophic medicines (IVAA, 2011; **Table 4**).

In anthroposophy, the spirit is unique to the human being and is the element that distinguishes human life from the animal world. The spirit holds an individual’s destiny; it affects how we engage with the spiritual world and defines our life path. Our human individuality shines through our ability to think freely, fostering further perceptions that connect our physical and soul perceptions to meaningful experiences. With connection to spirit, our life paths can become opportunities for inner growth and insight (Steiner, 1922).

The three systems listed in **Table 4** and observed and described in the human body by Steiner in Lecture III on March 23, 1920 (Steiner, 1920b), represent fundamental bodily functions that extend beyond mere visual manifestations. The processes of sensing and exchanging information via nerve pathways and metabolic and rhythmic processes occur continuously in each cell, organ, and organ system. Rohen (2007, p.17) noted that “alchemists and Paracelsus were already aware of these [three systems and] related them to natural elements: Sal, Sulphur and Mercury”. Steiner reintroduced and positioned these systems within the extended spiritual scientific approach to medical thinking (Rohen, 2007). Besides its application to medicine, anthroposophy refers to the three-fold concept, for example, in the societal and economic domains (European Alliance of Initiatives for Applied Anthroposophy [ELIANT], n.d.).

The *nerve-sense system* is accountable for processing information, responding to stimuli, and connecting to brain function and the nervous system. In AM, this is linked to “any processes of the upper system and includes all sensory organs” (Rohen, 2007, pp. 20-22). Correlating this with using, for example, plant material for remedies (internally or externally administered), a polar or opposite relationship occurs. In practice, this could be, for example, using ginger (as an external application) to support a person experiencing migraine symptoms (Vademecum, n.d. -a).

The *rhythmical or middle system* is connected to the heart and lungs. Relevant characteristics are any rhythmical processes, such as regular or irregular heartbeat and respiratory function, inhalation, and expiration. It also includes the rhythmical patterns of sleeping and waking. The middle system is a negotiator or bridge between the two other systems and “mediates between catabolic and anabolic processes” (WHO, 2023, Chapter 1). Relating this knowledge to plant observation and the use of substances for therapeutic interventions, the leaves, with their ubiquitous ability to conduct photosynthesis, are best related to the rhythmical middle system.

The lower system and its related metabolic processes include functions in the digestive tract (abdominal organs), the pelvic cavity, and the periphery (limbs, blood vessels; Rohen, 2007). A balanced interplay between the nerve-sense (lower) and the metabolic (upper) poles results in a harmonious rhythmical system. The essence of AM

therapies lies in their ability to recognise and work with the polarity inherent in the human body. By embracing this therapeutic approach, individuals receiving care can experience this as active participation through their choices.

Table 4

The Three-Fold Human Being in Relationship to Natural Substances

Thinking <i>Sal</i>	Nerve-sense system	Roots
Feeling <i>Mercury</i>	Rhythmical system	Leaves
Willing <i>Sulphur</i>	Metabolic limb system	Blossom & fruit

Note. Adapted from various sources (Bay, 2020; Heusser, 2016; Rohen, 2007; Steiner, 1920b; Therkleon, 2007)

2.4 The 12 Senses


Steiner’s (1916a) interpretation of the human senses depicts another concept underpinning anthroposophic medicine and healthcare which adds to the conventional/mainstream healing paradigms. The way human beings experience the world around them (microcosmos) is mirrored or reflected in the macrocosmic presentation. Steiner (2016b) stipulated that the sun’s orbit through the Zodiac (12 signs) is an outer influence on the inner human soul life and consequently impacts the sense perceptions (see **Table 5**). He drew a parallel between the day/night rhythm of the sun’s movements and human awareness (conscious or unconscious) of their senses. Hence, our upper senses (day, conscious) are those linked to the spirit, the “I”; the middle senses to our feeling/soul life; and the lower senses to the physicality of our body (Steiner, 1920a, p. 11; WHO, 2023, vii).

Anthroposophic health assessments consider the person’s biographical path, including life events that, depending on the significance for the individual, will affect the equilibrium of the body’s layers (three-/four-fold, 12 senses). While certain milestones characterise each 7-year phase, the meaning of and connections to spirit, destiny, and

freedom of choice can be modifying and influencing factors (Lievegoed, 2005; Steiner, 1916a). These indications are not rigid or do not have defined boundaries but are guiding conceptions intended to preserve and maintain the uniqueness of each individual. Anthroposophic medicine and healthcare view outer (physical) and inner (soul and spirit) development as essential to a holistic assessment and care.

Table 5

Visual Presentation of the 12 Senses

Spirit outer 	Upper senses (conscious/'day')	The "I"- sense or ego Sense of thinking Sense of speech Sense of hearing
Soul	Middle senses	Sense of taste Eyesight Sense of warmth Sense of smell
Body inner	Lower senses (unconscious/'night')	Sense of touch Sense of life Sense of self-movement Sense of balance

Note. Adapted from Deckers, 2020; Steiner, 1920a.

Some of our senses, for example, the sense of speech ("day"), are associated with the meaning of language, which holds parts of our identity (ego, "I"). If this sense is affected by illness, there are consequences to expression and identity (for example, after a stroke) that, depending on other holistic considerations, will need to be addressed in caring interventions. The sense of balance is a learnt experience in early life and is linked to the physiology of the inner ear and associated with physical movement. Once acquired, we are no longer consciously aware of it ("night"), unless it is impaired.

We become aware (conscious) of touch when there is movement, creating a sense of boundaries and awareness of contact with the outside world. While the middle senses

nourish our soul and connect us with our surroundings and nature, the upper senses move us into a relationship with self and others while being able to differentiate and think consciously.

Integrating knowledge and observation about the 12 senses into interventions and documentation is vital to AN. Observing imbalances in patients when sense perception is impaired or has changed due to illness has therapeutic consequences. For example, Deckers (2020, pp. 417-431) presents nursing considerations and care for the senses in patients diagnosed with cancer. Care that is observant and cognisant of changes in sense perceptions has been shown to improve patients' and their families' quality of life (Ozolins et al., 2015).

2.5 Salutogenesis and Anthroposophic Healthcare

A core element and holistic characteristic of anthroposophically informed healthcare is building resilience by fostering the development of innate healing abilities. Targeting health and healing strategies from a strength-based and health-generating perspective is not unique to anthroposophic care/medicine.

Salutogenesis, from the Latin *salus* (health) and Greek *genesis* (origin, coming into being) was first defined and explored by the medical sociologist Antonovsky (1979) but aligns well with anthroposophic values in relation to how to view and manage health (Bertram & Kolbe, 2016; Evans & Rodger, 2017; Kienle et al., 2019; Mittelmark & Bauer, 2017). Salutogenesis is based on the premise that "health generating" aspects of human experiences contribute to overall well-being and, if realised and accepted as meaningful encounters, contribute to resilience. Antonovsky (1979) found that people's abilities and resources to manage impactful or traumatic life events significantly influence their overall health and well-being. Once he had established this fact through his research, his main interest shifted away from pathogenesis and began to evolve around the question, "What makes people healthy?" (Antonovsky, cited in Mittelmark & Bauer, 2017, p. 7). Therefore, a salutogenic approach to health focuses on preventative factors, particularly emphasising the sense of coherence (Eriksson &

Mittelmark, 2017). Antonovsky describes the sense of coherence (SoC) as a triad of protective aspects:

Comprehensibility is a genuine ability to believe that events occur in a way that can be understood and it can be predicted whether they will occur again.

Manageability refers to having the skills and ability to manage, including access to relevant resources, the ability to ask for help, and feeling in control.

Meaningfulness is a belief that life is worthwhile, has meaning to the person, and is a source of contentment and purpose (satisfaction; Eriksson & Mittelmark, 2017, pp. 97-98).

Antonovsky (1979) explained the concept of salutogenesis as, “an orientation that thinking in terms of the mystery of movement toward the ease pole of the ease-dis/ease continuum, is a significant and radically different approach to the study of health and illness than the pathogenic orientation” (xiv-xv). Rather than considering a person as well or unwell, the ease dis/ease continuum is a view shared by the anthroposophic paradigm and conceptions of salutogenesis. Glöckler (2020) argued further:

...by using the concept of the metamorphosis of the levels of human existence, it is furthermore possible to show how and why or by what psychosomatic pathways the sense of coherence or the peak experience can have a positive effect on physical health. (p. 68)

The anthroposophic view of human development considers ill health as an essential and normal step in a person’s lifetime that, according to Steiner and Wegman (1925/1983), “sharpens the conscious spiritual as body (ego body) and is an essential part of a natural process” (p. 12). As in salutogenesis, the approach to managing ill health is not by exploring its pathophysiology but by establishing where imbalance or disharmony manifests. This perspective contrasts with the conventional/biomedical paradigm which focuses on the physical symptoms, with cure as a goal, rather than on the spiritual healing opportunities that are alluded to in anthroposophic medicine and care (Bertram & Kolbe, 2016; Hasselberg & Heine, 2020; Heusser, 2016; Mühlenpfordt

& Seifert, 2022). Anthroposophy views illness as an essential part of one's biography that has meaning and purpose in how illness is experienced, lived, and managed.

There are diverse viewpoints on how a salutogenic approach can be utilised to understand health perceptions and engage with healthcare consumers. Recent research (Brosnan et al., 2023) investigating salutogenesis and its relevance to patient-practitioner relationships in CAM consultations found it helpful when considering psychosocial and physical aspects of well-being. However, Brosnan et al. (2023) focused primarily on the sociological perspectives, exploring the power construct between the recipient of CAM and the CAM provider. They argued that applying a salutogenic focus to CAM consultations does not necessarily imply a power shift in favour of the patient as frequently assumed. While they favour using a salutogenic approach, the authors/researchers (Brosnan et al., 2023, p. 1023) additionally questioned whether CAM practitioners understand the complexity of a salutogenic approach (which includes population-level health promotion).

In anthroposophic healthcare, the sense of coherence resembles a salutogenic construct that is also supported by anthroposophic therapies (Bertram & Kolbe, 2016; Evans & Rodger, 2017; Glöckler, 2020; Mühlenpfordt & Seifert, 2022). Anthroposophic therapy aims to trigger a healing impulse in the recipient of care that is separate from the external therapeutic encounter between the patient and therapist, who is only one part of the therapeutic encounter.

2.6 Anthroposophic Nursing Interventions

This section summarises the most commonly used external therapies in anthroposophic nursing care and provides literature sources that illustrate their use in practice and best practice recommendations. A repertoire of all external nursing interventions is publicly available via the [Vademecum website](#), a collaboration between IFAN and a project team consisting of an editorial group and anthroposophic health professionals (Vademecum, n.d.-g).

Applications - compresses or cloths, which can vary in temperature and consistency depending on the substance and rationale of application (Ghadjar et al., 2021; Stritter et al., 2020; Therkleson, 2014a, 2014b; Vademecum, n.d.-c; Vagedes et al., 2022).

Rhythmical body oiling (RBO or *Einreibung* in German) – application of a therapeutic substance in rhythmical spheric movements. The quality of the touch is light in contrast to a conventional massage (therefore, the term embrocation is used in some literature sources). It can be a full or partial body oiling (Berger et al., 2019; Layer, 2006; Vagedes et al., 2019). A distinct form of massage called rhythmical massage, developed by Hauschka and Wegman (Hauschka, 1990) expands on “classical massage by rhythmic, expanding and contracting, circular and lemniscate movements, and movements progressing from the depths to the periphery of the body” (Mühlenpfordt et al., 2022, p.3, Table 1). A trained massage therapist usually performs rhythmical massage unless an AN/ANS has completed additional education.

Hydrotherapy – while applications like a footbath (Vagedes et al., 2018), steam or sitz bath are prepared with a therapeutic substance, a ‘tinkling’ wash (*Klingende Waschung* in German; Vademecum, n.d.-h) utilises water as the only therapeutic medium. In contrast, a specific device prepares an oil dispersion bath, distributing a therapeutic oil with water pressure so that the oil molecules become small enough to be absorbed via the skin and exert a therapeutic effect on the whole organism (Büssing et al., 2008; Höffmann et al., 2018). The temperature of an oil dispersion bath is marginally lower than the person’s body temperature, which stimulates the “I” (ego-body) to immerse itself in the physical body further. As noted in the sections on the three- and four-fold body, the ego is affiliated with warmth, and oils resemble a manifestation of warmth in nature (Büssing et al., 2008). Oil dispersion baths are helpful for certain chronic conditions, including mental illnesses and during cancer therapy (Büssing et al., 2008). Other forms of hydrotherapy in anthroposophic healthcare are inhalations and nutritional baths (Vademecum, n.d.-c).

2.7 Chapter Summary

The objective of this chapter was to delve deeper into the theoretical and philosophical context of the thesis, expanding on the background information about anthroposophically informed healthcare. While the three foundational frameworks presented are not exhaustive, they form the foundation of any anthroposophic nursing assessment and underpin the planning and execution of therapeutic interventions.

The chapter also introduced the meaning of salutogenesis, a frequently referred to concept in anthroposophic medicine and healthcare. AM. Although Antonovsky did not have anthroposophic foundations in mind when developing his salutogenic model and the triad of aspects to its sense of coherence, both approaches share several conceptual elements. Moreover, it is crucial to highlight that AM's integrative system can be interconnected and interlinked with various other conceptions of health, and its spiritual insights are dynamic rather than static.

Chapter 3 Literature Review

Do not now seek the answers which cannot be given you because you would not be able to live them. And the point is to live everything. Live the questions now. Perhaps you will then gradually, without noticing it, live along some distant day into the answer.

Rainer Maria Rilke (*Letters to a Young Poet*)

3.1 Introduction

In this chapter, I critically discuss the literature and highlight the gaps. The format of a narrative literature review allows the inclusion of a wide variety of studies and an overall summary with interpretation and critique (Sukhera, 2022). Narrative reviews are also well suited to the interpretive paradigm of a qualitative inquiry and are considered dynamic rather than linear (Ferrari, 2015). Anthroposophic nursing plays a crucial role in the comprehensive multimodal system of anthroposophic medicine (AM), with nurses working as integral members of interprofessional teams. By integrating the empirical literature on anthroposophic nursing care, I aim to provide a comprehensive overview of nurses' roles within anthroposophic medicine and healthcare and insights into the implications for anthroposophic nursing practice. After summarising both the empirical (Appendix E) and grey literature (Appendix F), I group the results of the empirical literature review under subheadings. I then outline key points on anthroposophic nursing care from the grey literature sources. The chapter concludes with a discussion outlining the limitations of current knowledge in the literature and the methodology gap which informed my research question.

3.2 Literature Searches and Selection Criteria

I conducted a literature search in May 2024 encompassing the years from 1985 to 2024 to update the search carried out in May 2019 for my PGR9. A search in CINAHL (via EBSCO) using the keywords "anthroposophy" OR "anthroposophic" OR "anthroposophical" AND "nurs" OR "nurse" OR "nursing" OR "care" OR "practice" OR

“strategies” OR “approaches” produced 47 results. After applying the selection criteria, 15 were considered relevant for my research inquiry (six empirical and nine grey literature sources).

I also searched the Ovid and Medline databases which produced additional results since the first search in May 2019, but not applicable to my research question.

The available literature included various types of studies including published studies, case studies, and qualitative and quantitative research that assessed the effectiveness of anthroposophic medicines and therapies. Anthroposophic physicians were the primary researchers involved in these studies. Furthermore, the grey literature comprised discussion papers, narratives, and unpublished theses that offered detailed descriptions of anthroposophic nursing.

3.2.1 Selection Criteria

Contextual Relevance

While the research question for the literature review centred around the practice implications for ANs/ANSs in Aotearoa New Zealand, an extended range of literature sources was explored and consulted due to the limited number of empirical studies focusing solely on the practice of anthroposophic nurses. The distinct gap in data capturing anthroposophic nursing experiences outside of Germany and Switzerland was an additional consideration, given the decision to only include English publications. I aimed to collate studies and literature showcasing the traits of this nursing practice as it is applied and interpreted by registered (anthroposophically trained) nurses. Therefore, the main criterion for literature inclusion was that it described registered nurses’ practice informed by the anthroposophic paradigm. Although numerous studies have examined anthroposophic therapies, medicines, and care from the patient's point of view, I focused on sources with qualitative data showcasing the characteristics of and practice implications for the nursing role. Anthroposophic medicine (AM), as defined by anthroposophic health professionals, refers to a holistic and integrative approach to health encompassing multiple disciplines and modalities (Bartelme, 2017; Kienle et al., 2006).

English Literature

Historical and current events shape cultural and sociopolitical characteristics impacting health structures, and language plays a significant role in these factors. The integration and use of anthroposophic medicine and healthcare have expanded globally; however, empirical studies that illustrate the breadth of practice by anthroposophically educated registered nurses are very limited. The rationale for considering sources published in English and not those in other languages was purely based on my research aims and the research question which was situated in and focused on the Aotearoa New Zealand health context.

Expanded Searches

In keeping with my secondary intent, I searched for grey literature, theses, and dissertations linked to anthroposophic nursing in several other databases covering Aotearoa New Zealand and the world (Google Scholar, ProQuest Dissertations & Theses Global, and WorldCat). These searches retrieved: one master's thesis (2003) and one PhD dissertation by Therklison (2009), a NZ scholar and ANS, from Edith Cowan University, Australia, and one master's thesis by Klich-Heartt (2003) from the USA.

This review excluded six PhD and master's studies from Brazil (written in Portuguese) and studies from Europe written in German. Overall, the literature published in English exploring and articulating the practice and experiences of anthroposophic nurses is limited.

Other literature search strategies, such as a generic Google/Google Scholar search using the terms "anthroposophic" and "nursing" OR "caring" generated results about anthroposophic training institutions (in Aotearoa New Zealand and overseas) and website details/contacts for AN professional bodies which linked to additional literature sources.

Given that AM is commonly grouped under CAM, I carefully examined reference lists of the sources initially collected to identify any literature that focused explicitly on anthroposophic nursing. Finally, I explored the following academic journals to find

literature on anthroposophic nursing/care: *Complementary Therapies in Medicine*, *Holistic Nursing*, *Australian Journal of Holistic Nursing*, and the *Scandinavian Journal of Caring Sciences*.

In the subsequent sections, I focus on anthroposophic nursing as depicted in the empirical literature and examine how registered nurses with anthroposophic education use the anthroposophic paradigm in clinical practice.

3.3 Summary of Empirical Literature

Eight empirical studies (Appendix E) were selected that examined various aspects of anthroposophic medicine and drew on some aspects of the nurses' practice experiences. Key studies included Arman et al. (2008), Ben-Arye et al. (2018, 2021), Dahlberg et al. (2016), Rutert et al. (2021), Therkleson (2014a), Tröndle et al. (2021), and von Schoen-Angerer et al. (2017).

The methods used in these studies included:

- Qualitative methodologies: used primarily in the studies including open-ended questionnaires, case reports, and interviews
- A quantitative approach: a pilot study assessing cost, acceptance, and satisfaction using questionnaires with open-ended questions
- Mixed methods: evaluating collaborative work in multidisciplinary teams within anthroposophic healthcare settings.

The study populations included physicians, nurses, and allied health professionals either anthroposophically educated or with practice knowledge in complementary and integrative medicine (CIM); multidisciplinary teams; and patients (both adult and paediatric) and their families across various clinical settings, including oncology and respiratory diseases. Five studies presented multidisciplinary collective findings, which included the nurses' perceptions of their caring practice. The empirical studies by Arman et al. (2008), Dahlberg et al. (2016) and Therkleson (2014a) were conducted by nursing scholars. While not solely focused on nurses' perceptions of working with

anthroposophic foundations and therapies, these three studies aligned most closely with the research intent of my study.

I borrowed principles of Braun and Clark's thematic analysis (2006, 2022) to formulate the following key themes:

Theme 1: Management and safety of anthroposophic medicines—this theme focused on the use and safety of remedies, substances, and therapies for specific diseases.

Theme 2: Integrating anthroposophic care and medicine into clinical services—this theme examined nurses' and allied health staff's experiences of integrating anthroposophic care and medicine into existing clinical services, and evaluating their benefits to patients and families.

Theme 3: Oncology focus—studies within adult and paediatric oncology contexts.

Theme 4: Anthroposophic caring perspectives—underpinned by theoretical anthroposophic concepts, particularly focusing on nursing interventions.

Theme 5: Caring culture and patient experience—sociological aspects of caring relationships informed by anthroposophic principles.

Theme 6: Collaborative multidisciplinary work—addressed the broad spectrum of professions involved in anthroposophic healthcare/medicine, emphasising the importance of teamwork but noting the often-overlooked role of nursing.

3.4 Summary of Grey Sources

A range of discussion and commentary publications outlined the role of nurses practising from the anthroposophic paradigm. Twelve sources were included based on the eligibility criteria. None of the sources were based on a specific research question or required ethical approval. Most of the grey literature illustrated experiential/practice-based narratives/case reports and were written by ANs/ANSs, AM physicians, and RNs (by discipline and perspective). Grey literature was sourced via database searches, Google Scholar, and websites.

3.4.1 Methods/Types of Publication

Most studies were written in a descriptive/reflective narrative style with the intent to inform nursing groups and the public on the role and specific interventions ANs/ANSs work with. The authors were mainly anthroposophically trained RNs (Cooksley, 2021; Heine [Ed.], 2020; Sustick, 2017; Varriale, 2019). See Appendix E for a list of all publications.

- Two sources included case reports (Deckers et al., 2016; Therkleson & Stronach, 2015) with rationales for patient interventions and substance descriptions.
- Two publications were commentaries published in the NZ Nursing Journal Kai Tiaki (Freeman Rock, 2014; Manchester, 2009) which presented anthroposophic nursing as a holistic expansion of the RN role.
- Therkleson's (2005) discussion paper/expert opinion delved into anthroposophy's theoretical foundations and underscored the esoteric and spiritual elements of anthroposophic nursing training.
- In Kramer et al. (2022), also a discussion paper/expert opinion, the authors extended their discussion by adding a short narrative on a pilot study testing the integration of the 12 Nursing Gestures.
- Heine's (2020) comprehensive edited text covers the foundations and concepts of anthroposophic nursing with chapters on specialised clinical areas (various chapters of this textbook are referred to in this thesis).
- A textbook edited by Seifert & Längler (2022) included a repertoire of EATs for nurses and health professionals working in paediatrics.
- Trevelyan (1997) reported on an interview with an AN expert.

Additionally, a search of the grey literature including theses and dissertations linked to anthroposophic nursing was conducted in several databases covering Aotearoa New Zealand and the world (for example, Google Scholar, ProQuest Dissertations & Theses Global, WorldCat), as discussed above

3.4.2 Summary of the Grey Literature

A significant addition and defining characteristic of anthroposophic nursing practice is the use of external applications or external anthroposophic therapies (EATs), also often referred to as anthroposophic nursing therapies (see Chapter 2). Therkleson (2005) published a discussion paper in Aotearoa New Zealand examining the ontological and epistemological perspectives of anthroposophic nursing and exploring the relationship between the three- and four-fold foundations and nursing interventions. The analysis of a patient case report in this discussion paper underscored the applications of anthroposophic foundations in a specific practice setting.

Other commentary and discussion papers published in Aotearoa New Zealand (Freeman Rock, 2014; Manchester, 2009) aimed to introduce the integrated and holistically grounded practice of anthroposophic nursing to the broader nursing community. Therkleson and Stronach's paper (2015) provided more detail about the work and contributions of anthroposophic nurses in Aotearoa New Zealand. To illustrate the core attributes of anthroposophic nursing care, their case report emphasised the "fostering warmth and intentional care" to support overall well-being (Therkleson & Stronach, 2015, p. 346). Varriale (2019), an ANS from the US, described her practice based on anthroposophic foundations within palliative care. She noted the benefits of interdisciplinary collaboration (including with anthroposophically trained allied professionals, for example, art, music, speech therapy and eurythmy therapists) to provide individual, person-centred holistic care. Alongside the assertion that offering self-management strategies to patients and families enhances autonomy, Varriale (2019) highlighted that "the inner attitude or gesture of the nurse is a valuable feature in anthroposophic nursing" (pp. 15-17). Cooksley (2021) reflected on her professional journey from an interest in holistic nursing that developed into a curiosity about anthroposophic nursing education to further her professional growth. Through her narrative, Cooksley (2021) explored the intricacies of engaging with anthroposophy and expressed her belief in the advantages of completing further education in anthroposophic nursing as it broadens and extends conventional nursing practices.

A peer-reviewed expert discussion by Kramer et al. (2022) proposed integrating the 12 Nursing Gestures (Heine, 2020d) into conventional nursing to validate and articulate the unseen (intangible) aspects of nursing care. The authors (Kramer et al., 2022), two of who are ANSs, contended that many nursing interventions go unrecognised as they remain subtle and intangible, and are therefore challenging to evaluate and measure. They attribute this to the single focus on economic metrics and the failure of parts of the health system to comprehend and consider nursing practice's hidden and nuanced values. In their work, the authors introduce the 12 Nursing Gestures (Heine, 2020d) as a nursing model that aims to make intangible facets of care more easily observable, tangible, and concrete.

Furthermore, two publications showcased the relevance of EATs as characteristic extensions of conventional nursing care (Deckers et al., 2016; Seifert & Längler [Eds.], 2022). Both outlined the reasoning and methods for various EATs, encompassing extended and integrated clinical practice considerations.

An essential textbook was edited by Rolf Heine and first published in German in 2017. The English translation became available in 2020 and is the version cited here. *Anthroposophic Nursing Practice* is the most extensive text on anthroposophic nursing to date, encompassing the methodological, practical, and spiritual aspects of care based on the anthroposophic paradigm. One of the contributing authors (Bay, 2020) argued that “anthroposophic nursing is not merely a theory, rather it endeavours to develop humaneness in the nursing profession by applying a comprehensive anthroposophic understanding of what it means to be human” (p. 31). Part of anthroposophic nursing education includes attention to observation, thinking, and perceiving with the end goal of “developing self and social competencies” (Layer, 2020, p. 23). Nurses engaging in anthroposophic studies are encouraged to explore their biographical journey and actively work on their inner self through meditative and reflective practice (Heine, 2020b, 2020c, 2020d). Anthroposophic nursing education deliberately expands consciousness and “cultivates nursing attitudes affecting the energetic field surrounding the patient” (Heine, 2018a, para 5). All contributing authors of this comprehensive text on anthroposophic nursing practice are ANs/ANSs.

Alongside the theoretical anthroposophic foundations, it contains a dedicated section on anthroposophic nursing care for specialised clinical areas, outlining rationales and planning for practical nursing interventions.

3.5 Discussion of Key Themes

In the upcoming sections, I discuss the results according to the themes covered in the empirical sources. Additionally, I incorporate relevant grey literature to provide a comprehensive analysis.

3.5.1 Integrated Care: Grounded in Anthroposophy

A highlighted theme is the notion of integrated and extended care informed by anthroposophic concepts. The empirical results reported mainly on collective multidisciplinary responses (Ben-Arye et al., 2021), including patient views of anthroposophic care (Arman et al., 2008; Ben-Arye et al., 2018; Rutert et al., 2021; Tröndle et al., 2021; Zeugin et al., 2018). One of these studies focused on the patient's perspective, explicitly considering anthroposophically informed nursing care (Arman et al., 2008). In contrast, Therkluson's (2014a) presentation of a case report evaluates the ginger compress from the ANS knowledge base and perspective.

The findings from these studies provide a limited understanding of how ANs/ANSs integrate anthroposophical concepts into clinical settings unfamiliar with anthroposophic healthcare. However, the benefits of this integrated and holistic approach are emphasised throughout. Two recent studies (Ben-Arye et al., 2018, 2021) avoided the terms "holistic" and "whole-person" care altogether but explicitly stated that they evaluated an AM approach to care, which required further education of nonanthroposophically trained staff. In contrast to studies with a focus on AM, the research conducted by nursing scholars offered context for the meanings of holistic and integrated care (Arman et al., 2008; Therkluson, 2014a). This noticeable distinction was also highlighted in the discussions and commentaries by nurses (Cooksley, 2021; Kramer et al., 2022; Therkluson, 2005, 2006, 2007; Therkluson & Stronach, 2015; Varriale, 2019) who discussed their ontological stances grounded in anthroposophic theoretical concepts and foundations in relation to context.

The following subthemes outline considerations and practice implications for anthroposophically educated nurses. The discussion also includes a section on patients' comments about nursing care received in anthroposophic clinical settings.

3.5.2 External Anthroposophic Therapies (EAT)

One of the characteristics of anthroposophically informed healthcare and medicine is its use of external therapies. These are practical, therapeutic interventions based on human touch, preparing and applying a natural substance. EATs can include rhythmical embrocations (RE) and massage, applications/compresses, footbaths and oil-dispersion baths (Fingado, 2005; Heine, 2020a, 2012; Mühlenpfordt & Seifert, 2022; Mühlenpfordt et al., 2022; Tröndle et al., 2021; van Bentheim et al., 1987; Weber, 2020). Research in CAM and whole-system medicine such as AM has contributed to expanding conventional medicine with touch and external therapies (Deckers et al., 2016; Mühlenpfordt et al., 2022; Ostermann et al., 2008; Therkleson, 2014a, 2014b) by evaluating their benefits for various patient groups (Mühlenpfordt et al., 2020). The pathways for EATs are linked to temperature, the medium/substance used, the psychological effects of physical human interaction and the environment (Heine, 2020a). Rhythm and warmth are crucial elements described in the nursing literature which contribute to the effectiveness of EATs (Camps, 2020; Fingado, 2005, 2012; Heine, 2020a; Sustick, 2017; Therkleson, 2005, 2007, 2014a, 2014b; van der Star, 2020) and are distinguishing points of difference between anthroposophic and conventional nursing.

3.5.3 Changes in the Caring Relationship

Ben-Arye et al. (2018, 2021) conducted two studies with qualitative designs that reported on the impacts of CIM (including anthroposophic medicine) training days for healthcare professionals (HCP)². The study in 2018 included 12 nurses out of 25 HCPs, and subsequent research in 2021 involved 13 nurses out of a group of 30 HCPs participants who received further training in anthroposophic external therapies (EATs). The researchers found that post training the communication within the

² Note: 'training days' and 'HCP' was terminology used by the researchers Be-Arye et al. (2018, 2021).

interprofessional team had improved (Ben-Arye et al., 2018). Furthermore, following additional education in touch therapy and its integration into patient care, a distinct shift in patient/HCP relationships occurred (Ben-Arye et al., 2021). These results align with outcomes in other studies conducted by nursing scholars exploring anthroposophic care (Andermo et al., 2017; Arman et al., 2008; Dahlberg et al., 2016). Arman et al. (2008) evaluated patient/nurse encounters, the care provided, and the applications of various EATs carried out by nursing staff. The researchers established changes that went beyond relationships and engagement and noted the shift in caring culture in nursing staff that evolved into a lived and embodied caring (culture).

It is important to note that most studies were conducted in favourable clinical settings for AM and other forms of CIM. Ben-Arye et al.'s (2018, 2021) research reflected collective viewpoints and detailed data from a nursing perspective is limited. Notable findings from participating nurses were that they felt empowered after completing education in anthroposophic care and felt that their "attitude had changed" and they felt more open "towards the process of dying themselves" and the patient (Ben-Arye et al., 2018, p. 2255). These findings resonate with narrative statements from ANSs and their experiences of extending conventional nursing skills with anthroposophic knowledge and therapies (Cooksley, 2021). Varriale (2019) emphasised the "valuable insights & skills that enhance[d] the effectiveness and expand[ed] the repertoire of [her] care" (p. 12). Furthermore, these narratives are consistent with descriptions in earlier publications by anthroposophic nurses (Trevelyan, 1997) of their role in this extended practice and its alignment with anthroposophy's foundational concepts of the human being.

Ben-Arye et al. (2018) reported a change in nurses' perceptions of practice after being introduced to anthroposophic concepts and experiencing improved communication with patients, families, and allied HCPs. Ben-Arye et al. (2018) also discovered that these results led to higher levels of job satisfaction. In contrast, time constraints posed challenges and potential barriers for nurses to incorporating additional therapeutic interventions such as EATs, particularly in acute settings (Rutert et al., 2021). Concurrently, others (Kramer et al., 2022) confirmed links to nurses' increased

motivation and job satisfaction after integrating and applying the 12 Nursing Gestures (Chapter 2), "...because it was a way to bring themselves [nurses] as human beings into their work" (p. 289).

3.5.4 Values of Anthroposophic Care

A range of human interactions can influence the quality of nursing care as perceived by the care recipient. One significant and unique component of caring in anthroposophic nursing is touch. For anthroposophically informed nursing care, touch, rhythm, warmth, and a natural substance are essential therapeutic components of nursing interventions (Fingado, 2005, 2012; Sustick, 2017; van Bentheim et al., 1987; van der Star & Camps, 2020; Weber, 2020). Ben-Arye et al.'s (2021) research assessing a manual treatment programme for patients in oncology extended their previous findings in evaluating the impact of training health professionals in hands-on touch therapy and how they perceived the care they provided. Again, the researchers (Ben-Arye et al., 2021) observed changes in behaviour in all participating HCPs, pre- and post-training in selected EATs. The patients reported clinical experiences of "deepened and enriched relationships, spirituality, breathing space and privileged access" while participating HCPs described their experiences of using EATs as "life-altering" (Ben-Arye et al., 2021, p. 234). A particular finding expressed by HCPs in the study was their experience of enhanced person-centred care when using touch, which also affected their nonverbal engagements with patients.

As earlier noted, adding anthroposophic concepts and frameworks to existing caring knowledge influences and changes the interactions between health professionals and patients. Ranheim et al.'s (2010) study focused entirely on nursing encounters providing one specific form of touch therapy used in anthroposophic nursing care, namely rhythmical embrocation (RE; also see Glossary). The participating nurses described becoming more receptive to the patient's responses/needs; they also observed an increased awareness of themselves and their environment. Most notable was that the "caring act represented the enactment of embodied perceptions that give the power to see the other human being" (Ranheim et al., 2010, p. 245). While most other studies concerned with anthroposophic care have reported on patient

experiences (Ostermann et al., 2008; Ozolins et al., 2015; Therklason, 2009, 2012; Vagedes et al., 2021; 2022), this qualitative study from Sweden by Ranheim et al. (2010) illustrated the interconnections between head (thinking), heart (feeling), and hand (acting) and showed that the nurse's role and their experiences in delivering existential care go beyond the physical dimension. On reflection, the researchers acknowledged that, despite finding it easy to relate to emotional responses, grasping and verbally presenting the spiritual dimension was much more difficult (Ranheim et al., 2010, p. 246). Regarding the breadth of anthroposophic nursing care, this study presents a unique insight into nurses' responses to one EAT intervention and the possible practice implications for anthroposophically trained registered nurses.

3.5.5 Anthroposophic Nursing and Holistic Care

Historical and contemporary discussions surrounding nursing's relationship and alliance with holism have repeatedly questioned where and if holistic care principles are evident in daily patient and practice encounters. Nursing is fundamentally holistic, encompassing ethical, moral, and intrinsic aspects of caring, as affirmed by various nursing theorists (Watson, 1988, 2018). Frisch and Rabonowitsch (2019) have also confirmed that the terms and definitions of "holistic," "integrative," and "whole-person" care are often used interchangeably and affiliated with nursing practices that integrate CAM modalities. Earlier studies considered in this review explored anthroposophic care from the patient perspective with the aim of establishing fundamental aspects of integrative, whole-person care using a qualitative phenomenological methodology (Arman et al., 2008; Dahlberg et al., 2016; Ranheim et al., 2010). A caring culture and whole-person approach enriched with anthroposophic anthropology (Bay, 2020) increases the conscious presence of the nurse and creates meaningful encounters in patient-nurse relationships. Koster et al. (2016, p. 2264) affirmed a correlation between an open, holistic stance when providing anthroposophic care and the patient experiencing this as "an equal caring relationship...being fully seen and heard as a whole human".

The "grey" literature on anthroposophic nursing upholds that spiritually extended practice is founded in a multilayered and holistic perspective of the human being (four-

fold in anthroposophic anthropology; see Chapter 2; Heine, 2020a; Therkleson, 2005, 2006, 2014a). This whole-person approach is still somewhat in contrast to conventional healthcare delivery, where emphasis is placed on scientifically tested pharmacological solutions (Forlano, 2023), and using holistic models may seem adjunct and be compartmentalised in therapeutic consultations (Star, 2023).

The term “holistic” was not included in the RN competencies in Aotearoa New Zealand (NCNZ, 2016), despite the expectation for nurses to include holistic worldviews when caring for and working with Indigenous communities (NZNO, 2014, 2018). The reviewed NCNZ standards of nursing competency (2024), which will come into effect in April 2025, now include holistic care and recognise it as an essential component for delivering complex care. Additionally, while a spiritual impetus for nursing interventions (as, for example, in anthroposophic nursing) may not always be part of nursing values, there is much emphasis on delivering spirituality within Indigenous health models (Egan et al., 2017; McColgan, 2022). Holistic nurses and nurses working within integrative models (Burkhardt & Nagai-Jacobson, 2016; Quinn, 2019) are explicit in their commitment to caring for the human spirit, while in conventional nursing, spiritual care “has been severely marginalised” (Quinn, 2019, p. 87). These results validate the need for further clarification of the meaning of “whole-person care” for anthroposophically trained nurses working in Aotearoa New Zealand, and to what degree practice is interpreted and reflected in nursing actions.

Ethnically diverse countries like Aotearoa New Zealand, may benefit from integrating anthroposophic care, as found in Ben-Arye et al.’s earlier study (2018). The researchers underscored the beneficial impact of their cross-cultural training programme on multidisciplinary teams. Specifically, the “enriched use of the bio-psycho-social-spiritual model in palliative care” was noticed (Ben-Arye et al., 2018, p. 2251). While the study focused on end-of-life care in an anthroposophic clinical setting, these findings may also be relevant when ascertaining the impact of anthroposophic concepts on nursing practice in healthcare systems marked by ethnic diversity. Additionally, within the healthcare context of Aotearoa New Zealand, this could also include adopting and integrating various holistic approaches, such as traditional

Chinese medicine or ayurveda, as well as other complementary and integrative medical practices.

3.5.6 Patient Experiences of Anthroposophic Care

Ongoing professional development in nursing requires staying up to date with evidence-based research, necessitating a lifelong commitment to learning and growth. Patient evaluations of care are a driving factor in informing future improvements in nursing interventions and highlighting areas of concern. According to Andermo et al. (2017), a caring culture based on anthroposophic values and a shared culture between patients and caring staff can nurture a whole-person care environment. Furthermore, evidence has positioned the patient as the “bridge-builder between conventional and integrated anthroposophic care” (Arman et al., 2008, p. 362). These findings also resonate with a key value in various nonconventional and CAM approaches: the patient as the driver of health system changes (Kristiniak, 2011). Patient demand motivates health professionals and policymakers to integrate more inclusive and less reductionist models of care.

A relational, inner and outer caring dialogue enhances anthroposophically trained nurses' perceptions of their practice as “truly holistic” (Therkleson, 2005, p. 43). If and to what degree various external anthroposophic nursing therapies (Ostermann et al., 2008; Ozolins et al., 2015; Therkleson, 2009, 2012, 2014; Vagedes et al., 2021, 2022) can aid these therapeutic encounters is worth exploring as it may also open up educational opportunities in conventional nursing curricula.

Researchers from Nordic countries have focused on and explored patients' experiences of anthroposophic care in general (for example, Andermo et al., 2017; Arman et al., 2011) and responses to nursing care (for example, Arman et al., 2008; Ozolins et al., 2015) in particular. The primary objectives of these qualitative studies were to explore and evaluate the influence of care guided by holistic anthroposophic concepts and principles. Patients whose care and therapies were based on anthroposophic foundations noted increased personal growth and meaning in life (Arman & Backman, 2007, p. 444), alongside a deepening of the therapeutic

relationships with the caring staff (Arman et al., 2008). Although often limited to palliative or cancer care, these findings highlight what others have also explored; when the patient can make sense of a situation or illness, existential needs are addressed (Bauereiß et al., 2018; Halldorsdottir, 2008; van Bentheim et al., 1987), and building resilience becomes part of the caring interventions.

A notable factor to consider when evaluating the results of these studies of anthroposophic nursing care is that the studies were conducted in anthroposophic clinics and health environments favourable to anthroposophic care (Andermo et al., 2017; Arman et al., 2008, 2011; Arman & Hök, 2016; Dahlberg et al., 2016; Ozolins et al., 2015).

3.5.7 Anthroposophically Extended Practice and Education

Further education in anthroposophic nursing and therapies has complex implications for registered nurses. Familiarisation with additional practical interventions is only one part of anthroposophically informed nursing care. The effects on personal and professional development after engaging with anthroposophy have been documented in various “grey” literature sources, including anthroposophic nursing textbooks. Furthermore, the paradigmatic foundations of anthroposophic healthcare have been articulated by anthroposophic nurses describing and exploring their practice experiences, often accompanied by references to EATs (Cooksley, 2021; Therkleson, 2005, 2006, 2007; Therkleson & Stronach, 2015; Sustick, 2017; van Bentheim et al., 1987; Varriale, 2019). Additional education in anthroposophic healthcare brings about a changed perception of practice and has been found to affect the nurse/patient relationship (Tröndle et al., 2021) but also, according to nurse participants in Ben-Arye et al.'s (2018) research, to lead to feelings of empowerment through being able to offer expanded nursing interventions through EATs and increased openness towards the patient's experience (of dying in Ben-Arye's research). Additional education in touch therapies provides nurses with a broader range of therapeutic interventions and enhances “commitment to patient-tailored care” (Ben-Arye et al., 2021, p. 2255). Furthermore, education in anthroposophic touch therapies aids conversations with patients, especially about previously unspoken distress and suffering (Ben-Arye et al.,

2021, p. 234). Various nursing scholars (Meehan, 1998) have explored touch in nursing, ranging from intentional, task-oriented touch to compassionate and therapeutic/intentional touch. At the same time, nurses are not always comfortable and confident with touch (Pedrazza et al., 2018). Nursing as a conscious act of caring for another human being entails stepping into the other's space (Lemermeyer, 2022), and this includes extending oneself across a boundary. In contrast, studies that have included an anthroposophic spiritually extended view have considered the various layers of human existence (as in the four-fold conception of human nature; see Chapter 2) in relation to therapeutic touch. Field observations by Zeugin et al. (2018) revealed these connections between nurses and patients during end-of-life care and illustrate the patients' sense of spiritual support to let go of the physical body. However, it also emerged that nurses contemplate using their extended knowledge in anthroposophic nursing only "when they consider it not to be in conflict with conventional medical practice" (Zeugin et al., 2018, p. 227). These latter findings raise further questions about what informs ANs'/ANSs' practice when working in dominant mainstream settings and to what degree anthroposophic nursing knowledge is applied to care planning.

3.6 Limitations of Existing Literature and Justification for this Research

Despite the existing empirical research in the field of AM, there is a noticeable absence of thorough examinations of anthroposophic nursing, particularly in relation to how registered nurses integrate their understanding of the anthroposophic paradigm into their practice within a conventional healthcare environment. I now discuss several limitations identified in the eligible studies.

The empirical studies included in this review were predominantly conducted by physicians working in anthroposophic hospitals or clinics. While the focus was frequently on multidisciplinary care that aimed to integrate anthroposophic therapies and interventions, the targeted clinical areas had positive and favourable attitudes towards AM. Clinical areas that are less familiar or even unfamiliar with anthroposophic healthcare may present various challenges for ANs/ANSs, especially if there is an absence of like-minded anthroposophically educated professionals.

Furthermore, there is a noticeable gap in research to understand the way registered nurses with anthroposophic education navigate conventional health structures unfamiliar with the integrated approach of anthroposophic healthcare. More research is needed to explore the impacts on practice, the individual nurse, and the collective caring philosophy.

An additional limitation in the empirical literature is the lack of clarity and detail relating to nurse participants' backgrounds in anthroposophic nursing. Studies which include data from nurse participants who have only completed a short course in one intervention may misrepresent the theoretical and practical knowledge ANs/ANSs have to offer. The empirical studies included in this review aimed to integrate AM by providing education in selected EATs only. Therefore, there are no specific evaluations of the professional positioning of nurses when advocating for AM therapies in nonanthroposophic clinical settings. While these studies evaluated the integration of some EATs (and CIM; Ben-Arye et al., 2018, 2021), it is arguable if the patients in the studies experienced the full breadth of anthroposophic nursing care as the main focus was on selected physical therapies which represent only fragments of anthroposophically informed nursing care. Furthermore, the professional constellations (multidisciplinary and CIM practitioners) in these studies may have precluded further exploration of the nurse's unique professional positioning.

Holistic models of care are essential to nursing in Aotearoa New Zealand, as evident in the *Code of Conduct* (NCNZ, 2012), *Code of Ethics* (NZNO, 2019), and *Competencies for Registered Nurses* (NCNZ, 2016, 2024). However, knowledge about holistic models does not always translate into practice or is arduous to apply because of systemic barriers (Egan et al., 2017; Espiner et al., 2021; Neville et al., 2022). The generic notion of holism has become an overused, misplaced, and frequently misunderstood term globally in healthcare and the public domain (Taubner, 2002). As nursing research has continued to validate holistic care and its impact on patients (Povlsen & Borup, 2011), concurrently, the situations described in earlier critiques of how nurses interpret holism in practice (Owen & Holmes, 1993) persist (Frisch & Rabinowitsch, 2019). Mason (2014; also see Chapter 2) introduced Goethean science to differentiate

between holism and embodiment, which is fitting for anthroposophically trained professionals but potentially challenging for mainstream HCPs. Therefore, the lack of studies of how nurses in Aotearoa New Zealand who have undergone anthroposophic education apply these principles in conventional healthcare settings represents a significant gap in the existing literature.

3.7 Chapter Summary

Nurses trained in anthroposophic care may offer unique perspectives on holistic patient care in both the global health context and Aotearoa New Zealand. Despite the emphasis on holistic care models in NZ, there is limited empirical literature on how registered nurses (RNs) with anthroposophic education apply their knowledge within conventional health systems. The effectiveness and integration of anthroposophic concepts as holistic care models in clinical settings remain uncertain. While there is a substantial breadth of empirical research evaluating AM's safe use, application, and integration, there is a gap in the literature on how ANs/ANSs contextualise working from the anthroposophic paradigm. In the next chapter, I discuss the methodology, research procedures, and data analysis employed in my study.

Chapter 4 Method, Research Design, and Process

*Wanderer, your footsteps are the road, and nothing more.
Wanderer, there is no road, the road is made by walking.
By walking one makes the road, and upon glancing behind one sees
the path that never will be trod again.
Wanderer, there is no road – only wakes upon the sea.*

Antonio Machado (*Campos de Castilla*)

4.1 Introduction

This chapter outlines the epistemological foundations, methodology, research design, and methods for gathering and analysing the participants' narratives.

I present the philosophical considerations underpinning my rationale for the methodology for this doctoral inquiry³: the interpretive descriptive (ID) approach developed by Sally Thorne (2008, 2016). I also compare ID to other qualitative approaches and discuss the links with anthroposophic concepts.

I discuss the study's process and design in separate sections and the ethical considerations taken before and during the research process. Particular emphasis is given to the data collection that occurred during the COVID-19 pandemic restrictions in 2020.

Also, because of my professional affiliation with the group of anthroposophic nurses in Aotearoa New Zealand and my existing knowledge of the topic explored for this study, I included reflective accounts from my field journal notes to provide transparency on bias.

³ "The professional doctorate is a combination of rigorous coursework and a major piece of research. Together these activities have the expressed aim of producing what others and the authors have called 'researching professionals' as opposed to professional researchers" (Walker et al., 2016, p. 67).

4.2 Epistemological Assumptions

Epistemology endeavours to examine the essence of knowledge, its limitations, and the process of obtaining it. We acquire knowledge through various pathways, experiences, and exposures. Once knowledge is absorbed, it forms the basis for values and beliefs and informs theoretical concepts (Hetherington, 2012). How we construct the world around us is based on and influenced by our upbringing, family, gender, and the communities we live in and engage with. We interpret knowledge and experiences depending on our positioning within these social structures; it shapes us as individuals and our understanding of the world, or ontology.

The epistemological foundations of this qualitative research are based on interpretivism and constructivism (Creswell & Poth, 2018; Grant & Giddings, 2002; Lincoln et al., 2024). The participants' subjective meanings and interpretations of their practice as anthroposophically educated registered nurses are complex and dynamic, as they change and adjust to nonanthroposophic health environments, and are informed by their clinical experiences engaging with patients, other nursing colleagues, allied health professionals and health system structures. These interactions construct a subjective reality and generate new insights into how anthroposophic concepts influence practice.

The researcher's role is to ensure that the research findings are reliable, that a rigorous process (for example, choice of appropriate methods, reflective transparency) underpins each step of the study, and that possible biases and assumptions are made transparent throughout the research process.

4.3 Methodology

4.3.1 Interpretive Description (ID)

Qualitative descriptive approaches offer several strengths and benefits that make them well-suited for research in applied health sciences. First, these approaches emphasise the importance of capturing the lived experiences and perspectives of individuals within healthcare contexts, allowing for nuanced understanding of complex

phenomena. Second, qualitative descriptive methodologies are flexible and adaptable, making them suitable for exploring a wide range of research questions and topics. Third, these approaches promote a holistic and in-depth exploration of phenomena, enabling researchers to uncover subtle nuances and variations that may be overlooked in more structured methodologies.

Furthermore, qualitative descriptive approaches facilitate the generation of actionable knowledge that is directly applicable to healthcare practices. By focusing on describing phenomena in a straightforward and accessible manner, these methodologies contribute to the development of practical recommendations and interventions aimed at improving patient outcomes, enhancing healthcare delivery, and addressing key challenges within the discipline. Key theorist Sally Thorne (2016) has argued that results gained from using traditional qualitative methodologies (for example, grounded theory, phenomenology, ethnography) were often difficult to apply to practice settings. Thorne's main goal was to establish a robust methodological approach that helped enrich existing nursing practice with research results that would further improve and, in some cases, support practice change. This specific link to practice application was seen as a significant advantage for my study. Thorne's (2016) central quest was to enhance and further develop disciplinary integrity by questioning nursing's conceptual and epistemological frames (Thompson Burdine et al., 2020). Real-world disciplinary questions from the field help establish new insights into areas that are still unknown or under-explored.

As Thorne (2016) stated, various disciplines can use ID, but it originated in the need to find another way of exploring practical clinical encounters that was not bound to a specific theorist. Subscribing to a methodological approach that has shown relevance and suitability in qualitative inquiries in applied disciplines other than nursing (Bright et al., 2013; Slomp et al., 2018; Smith et al., 2013) further strengthens the study's validity and contemporary currency. Last, anthroposophic nursing has a familiar resonance with ID's core intentions. Heine (2020c, p. 78) asserted in his chapter on "Nursing as a Path of Development":

Any nursing care ethics as a basis for the training of inner abilities can, therefore, no longer rest content with establishing a general, divinely ordained system of values. It must rather take its starting point from nursing care itself. It must be developed out of the profession itself and not imposed from outside. Only then will nurses be able to freely evaluate the training of inner abilities without being patronised.

The space and emphasis that ID allows for the researcher's voice, validating their specialised professional knowledge and practice, reflects integrated and genuine facets of qualitative research (Thorne, 2016). As researchers, we have subjective knowledge and experiences that motivate us to question an area of practice. Positioning oneself outside this in an objective space is virtually impossible, especially when the researcher is a member of the studied profession, as in my situation, part of an anthroposophic nursing group.

Thorne's discussion (2016) on the foundational underpinnings of ID aligns with this view in her assertion that reality is "complex, contextual and socially constructed" (p. 82). Thorne also identified the need for the researcher to engage in and foster dialogue with the participants and emphasised the need to view "multifaceted realities holistically" (p. 82). One of Thorne's (2016) overarching messages on using ID is that researching nursing practice is an ever-changing and complex undertaking. Rather than relying on "a priori theory," the researcher is directed to observe what will "emerge and is grounded in the data" (Thorne, 2016, p. 82).

4.3.2 The ID Research Approach—Scaffolding

When I first started developing my research question, the qualitative nature of my inquiry revealed itself. My early contemplations evolved around my own theoretical allegiances and how to acknowledge worldviews and standpoints that are subjective, complex, constantly evolving, and influenced by various aspects (societal, political, environmental, and professional). Situating a research question in this philosophical realm and then working towards an interpretive framework that would find the most appropriate answers has been described by Thorne (2016, pp. 59-79) as scaffolding. She has outlined this process as a vital part of ID. The initial and substantial element of

a research project is exploring the literature and verifying the validity of the proposed research inquiry (also see Chapter 2).

The other significant features of scaffolding are “locating the researcher’s theoretical allegiances prior to entering the study”, clearly describing the stance the researcher takes within their discipline, and declaring their own ideas and biases linked to the topic explored (Thorne, 2016, p. 70).

When I first started articulating my research inquiry, I was strongly influenced by my experiences as an anthroposophic nurse (see Chapter 1). Through ongoing conversations over the years, it became apparent that despite a common philosophical foundation (anthroposophy), the experiences of each nurse were manifold and influenced by different external and internal factors. Some external factors included geographical positioning and the clinical areas nurses worked in. Approaching the topic from a constructivist stance made sense and allowed for the various realities that shaped each experience, including lived experiences generated from interactions with other patients, their family/whānau, the public, and other health professionals (Lincoln et al., 2024). Interpreting these complex views, rather than diluting or reducing them, is part of making sense of the data (Creswell & Poth, 2018; Thorne, 2016). Thorne (2016, p. 76) stipulated that the researcher using ID has a responsibility to discuss “the genesis of their inspiration for the research” as this “will reveal something of the motivation and bias of the researcher”. The researcher acknowledges that their subjective experiences shape their interpretative design. Using a reflexive approach will enhance the rigour of the study design and allow for evaluation of the analysis, and validity of findings.

Despite my initial connection with ID, I moved away from it twice while exploring my research questions. Thorne (2016, p. 29) has emphasised the significance of "methodological ancestry" and references ethnography, grounded theory, and phenomenology in qualitative research. However, she asserted that ID embraces the interpretation of a clinical phenomenon by “borrowing” from traditional theoretical methodologies; the focus is on the epistemological integrity (nursing knowledge) and

disciplinary relevance (research questions emerge from within the field) reflected in the research design.

I further reviewed ethnography with its focus on the shared patterns and cultural beliefs inherent to specific groups (Creswell & Poth, 2018; LeCompte et al., 2010). Using this methodological approach could have provided me with insights into varying beliefs and behaviours but not fully explored the integration of the practice of anthroposophic nursing. Indeed, I suspected that approaching the research questions from an ethnographic stance could have isolated and marginalised this group of nurses and their approach to caring. Emphasising the notion that nursing the anthroposophic way might be separate from nursing conventionally or the mainstream way would have negated the inherent characteristics of anthroposophic healthcare as a well-established integrated modality (Kienle et al., 2013)

On the other hand, using a phenomenological approach (Creswell & Poth, 2018; Smythe, 2012) would have highlighted the lived experiences of anthroposophic nurses and focused on understanding the essence of these expressions. Although it may have been a more relevant methodological strategy, I found the sole focus would have been on the nurses and not on their practice and how they integrate their underpinning philosophical worldview into daily clinical settings. My internal dialogue was about weighing up the conversations with anthroposophic nursing colleagues and their narratives from practice versus working towards validating a nursing approach from a theoretical stance.

However, reviewing this internal dialogue, my choice of methodology now makes good sense, and the notion that we are “epistemologically hard-wired in our disciplines to see the world in a certain way” (Thorne, 2020a) remains an essential argument for me.

Sally Thorne’s comment in one of her online presentations (2020a), still resonates when writing about the rationale for choosing ID. It not only justifies her intent to make nursing practice the central focus of a research inquiry, rather than justifying an adopted theoretical methodology, but also highlights the diverse and multifaceted health environment nurses are immersed in:

...recognising that multiple philosophical lenses can be useful to asking the questions and inquiring in a fulsome way about a clinical phenomenon so that I then can make choices of what are the best ways to presenting findings that are actually going to meet the actual need. (Thorne, 2020a)

According to Thorne (2016), the disciplinary interest and orientation of the researcher play a crucial role in driving an ID study and require clarity and transparency from the beginning of a project. Disciplinary orientation remains a distinct point of difference compared to other qualitative methodologies. A transparent presentation of the researcher's motivations and influencing factors is part of the forestructure in ID and reflects the impact of disciplinary knowledge on the study. Thorne (2016) determined that the purpose of research in applied professions was to "generate disciplinary knowledge development" (p. 73). Therefore, presenting one's disciplinary orientation "exposes" underlying the professional motivations and thinking which should be made explicit throughout the project. Thorne (2016, p. 73) argued that the researcher's disciplinary orientation is intrinsically linked to their "enthusiasm for a topic".

Making my disciplinary positioning (epistemological stance) explicit for this study relates to nursing and the extended practice of anthroposophic nursing.

Anthroposophic nursing is an integrated approach (see Chapter 1), which means that conventional nursing education is extended and broadened through anthroposophic knowledge of the human being. My nursing experience has spanned the past 30 years, and even though I started my career focusing on acute nursing in intensive care units (ICUs), I witnessed how intricate caring (for the nurse) and healing journeys (for the patient) could be. Despite recognising the necessity for critical care and providing acute interventions, I was curious about how ICU patients progressed after the acute phase and how they managed long-term health concerns alongside the emotional impacts of life-changing events. The quest for more holistic understanding and management of ongoing health concerns came to the forefront for me as a novice nurse, including recognising patients' spiritual experiences after trauma. I also became intrigued by what patients often describe as threshold or near-death experiences. As a nurse, I always intended to support and advocate for patients while being mindful of

their values and beliefs. The range of the latter perplexed and challenged me to investigate further in my earlier years of nursing practice and was a motivator to not stand still in my professional knowledge development. How can someone find peace while on a cancer journey, or after surviving a horrific accident but being left with a lifelong disability? Is my work done if I cannot provide support and care that requires more than what conventional/mainstream healthcare offers?

I became increasingly aware of the limitations of nursing within the powerful conventional/mainstream paradigm, and the experiences patients shared with me on their journeys constantly provided opportunities for continuous and profound questioning and exploration of the human experience of illness. Before becoming an anthroposophic nurse, I worked in various nursing care areas in Aotearoa New Zealand and overseas. Reflecting on my professional career path, I noticed that challenging my understanding of the holistic and complex layers of the human being motivated me to further develop my nursing knowledge beyond the scientific paradigm. I have captured these thought processes in a reflective journal throughout the research process. As a prerequisite when working with ID methodology, the researcher must uncover and reflect on potential biases and assumptions while immersed in the research process (Thorne, 2016). Completing the anthroposophic nursing education at an anthroposophic hospital in Germany from 1999 to 2000 became part of this advanced experience and development of my nursing philosophy. Through this journey, I also became more aware of differences in the health systems, how here in Aotearoa New Zealand we are committed to working with bicultural foundations in nursing, and how these can influence our practice when working with the extended practice and theoretical knowledge of anthroposophy.

Nurses rarely question how and in what ways they integrate knowledge from various practices and personal experiences, or learning derived from other paradigms not represented in mainstream/dominant health structures (Kristiniak, 2011). Patients frequently ask nurses for advice and support beyond the pharmacological and therapeutic prescriptions they receive from health practitioners (Gunnarsdottir et al., 2022; Hall et al., 2018; Shorofi & Arbon, 2017). Our moral and ethical obligation as

nurses is to respond to these questions without venturing beyond our professional scope and boundaries. Nursing is a caring profession that provides the capacity and scope to engage in a manner that recognises the human being in its entirety (Heine, 2020c; Riegel et al., 2021) rather than addressing only those parts that expose pathological processes.

The rise in chronic and long-term conditions over the past 20 years has revitalised healthcare approaches based on a biopsychosocial view (Engel, 1977) and confirmed the shortcomings of a strictly biomedical perspective. Alongside these developments, integrating person-centred frameworks (McCormack, 2020) have provided further groundwork and opportunities to care holistically. If supported by systemic structures, nursing can be a profession infused with holistic values; however, what is often experienced by nurses and patients in Aotearoa New Zealand, especially in acute hospital care, is that the biomedical discourse dominates and holistic care is reduced to a “tokenistic approach” (Egan & Blank, 2021, p. 112). Therefore, my disciplinary orientation is grounded in exploring better-integrated health approaches that affirm a one-does-not-fit-all nursing philosophy which fosters self-management and promotes salutogenic factors (Mittelmark & Bauer, 2017).

Thorne (2016) has stated her belief that any research inquiry in an applied discipline should be driven by questions that aim to enhance practice in the end. After presenting my stance, I believe there is still a lot to understand and gain from learning about how nurses use knowledge to provide better holistic care.

My personal experiences as a nurse and AN have profoundly influenced the genesis and development of this research project. Thorne (2016, p. 75) used the term “intellectual integrity”, which involves specifying and describing the researchers’ assumptions, biases, and professional complexities that will influence the project. She took it one step further by suggesting that the researcher not only influences and positions themselves within the study but also incorporates their own experiences within the discipline into the research project.

Because I achieved AN status in Germany in 2000, working at an anthroposophic hospital and completing a course to become an anthroposophic nurse, I was unquestionably influenced by this acquired knowledge and practical clinical exposure. I noticed opportunities and possibilities for integrating anthroposophy into conventional healthcare services in hospitals and community settings, working on the assumption that including suitable CIM (Complementary and integrative medicine) or CAM modalities can benefit the recipient of care. However, nurses who hold and advocate for this stance are challenged in clinical practice by their peers and allied health professionals when it becomes known that their alliance does not fit exclusively within the conventional biomedical paradigm. Typically, in my experience, there is an immediate questioning of scope, competence, and a natural request for research evidence. Therefore, this project is influenced by my own experiences as an RN, ANS and reflexologist working in various clinical settings over the past 30 years. Although the current literature supports the nursing profession's ability to provide integrative health modalities (CIM) and support to patients upon request, nurses continue to face challenges for various reasons (Balouchi et al., 2018; Gunnarsdottir et al., 2022; Hall et al., 2018; Kristiniak, 2011).

Writing this after the COVID-19 pandemic lockdown, self-management strategies and salutogenic approaches to health that foster self-healing capacity in humans seem helpful health-promoting strategies in these uncertain times. Empowering patients with relevant knowledge to enhance their health literacy fosters self-healing capacity. These self-healing strategies, of course, can involve integrating therapeutic approaches grounded in the CAM or integrative health paradigms. However, advocating for integrated approaches comes with edge-wandering and requires caution to negotiate the space between the conventional/biomedical and the complementary/integrative paradigm.

As a nurse, I believe holding these positions takes courage and confidence in one's knowledge. Before establishing this study project, I assumed that there was a lack of confidence, possibly related to a lack of peer support and opportunities for exposure to working in anthroposophic health teams in Aotearoa New Zealand. Another

assumption was that ANs/ANSs were enthusiastic about the anthroposophic approach to health and have seen the positive effects based on feedback and narratives from the community they serve.

Being of European descent (German & Swiss) and part of a Māori whānau through my children, working from and integrating a health and well-being model outside the Indigenous worldview posed various questions for me. Conversations with Māori colleagues, nurses, and nursing students were instrumental in leading me to question and challenge my stance on Te Tiriti o Waitangi and its integration into any healing space. I firmly believe that any health paradigms not grounded in the foundations of Te Tiriti and aligned to and assessed in relation to the bicultural foundations of Aotearoa New Zealand need critical dialogue. To address this in the context of my study, I have included a section in the discussion chapter (see Section 6.6.2.).

As a member of the ANANZ Education Committee, questioning my responses throughout the research process was crucial. Reflective journalling, fieldwork notes, and conversations with my supervisors were valuable processes to manage these. The learnings, insights, and challenges that I noted throughout the journalling process are included in various sections and chapters in this thesis.

4.4 Methods

4.4.1 Research Context

In Aotearoa New Zealand, 84 nurses have completed the education programme at Taruna College in Hawkes Bay since 1984 (C. Wilson, November 4, 2023). This number includes nurses from overseas, for example, Australia, the Philippines, and Japan, since Taruna College offers the only face-to-face training programme in anthroposophic nursing in the Southern Hemisphere. In the past, registered nurses had various options for completing anthroposophic nursing education. The current curriculum and training modules (Foundation Course in Anthroposophic Nursing, 2015; also see Chapter 1) are aligned with international benchmarks (WHO, 2023), guidelines, and competencies in anthroposophic nursing (IFAN, 2022).

The nurses interviewed for this project had completed the AN/ANS pathways and lived in the North and South Islands in Aotearoa New Zealand. Their professional experience in nursing care extends to various roles in conventional health settings (hospitals, residential facilities, and community health services). Some ANs also run private practices alongside part-time roles in conventional clinical areas, offering anthroposophic nursing therapies to the broader community. While a few ANs/ANSs have independent clinic rooms, others have practice space within a PHC service or are part of an anthroposophic medical centre. Geographic location has the potential to impact opportunities for professional collaboration with allied health professionals and other anthroposophic professionals/therapists and can affect referral processes.

Strict monitoring is not in place; thus, completion of the foundation course in anthroposophic nursing does not require inclusion in the ANANZ database of registered anthroposophic nurses. Individuals may nurture regional contacts more, as these are easier to maintain (for example, geographically closer) and provide opportunities for peer discussions/reflections, reading groups, and sharing case studies. Connections with the wider anthroposophic community here in Aotearoa New Zealand are made at national conferences, regional workshops, and frequently through education (Waldorf schools/kindergartens).

The close relationship between Waldorf schools and other anthroposophic-orientated services has historically led to the development of anthroposophic communities in certain regions in Aotearoa New Zealand. For example, Auckland, Waikato, Bay of Plenty, Hawkes Bay, Wellington, and Christchurch are five gathering points for anthroposophic communities with various resources (Waldorf schools, anthroposophic medical centres, residential support services and various anthroposophically trained therapists).

4.4.2 Ethics Application

Ethics approval to conduct this research study was sought and received from the AUT Ethics Committee on May 12, 2020, No 20/74 (Appendix B).

A participant information sheet and consent form were developed (Appendix G & Appendix H), as well as an invitational email (Appendix I) that included a short biography and professional profile of the researcher outlining the motivators for conducting this study. A crucial ethical matter was that I, as the researcher and a member of the ANANZ group, did not influence the recruitment process in any way; therefore, the ANANZ coordinator circulated the participant invitation (Appendix I).

As discussed in Chapter 2 in the sections outlining the implications of and relationship between culture and health practices/views, this research inquiry was focused on establishing insights into the work of ANs/ANSs and what it means to apply another paradigmatic lens alongside mainstream practice.

Peer discussions within the anthroposophic nursing group over the previous 2 years and my own experience alerted me that the nature of this work could potentially challenge the practice of ANs/ANSs. Liamputtong (2019) noted several implications for involving small subject groups in research projects and cautioned that this exposure could lead to marginalisation or even misinterpretation of practice. These ethical considerations led to measures being put in place to minimise harm (Liamputtong, 2020) which included ensuring that records are kept confidential and avoiding disclosure of any defining characteristics of the participants (for example, geographic location of participants and places of work). Since this group of nurses is small, I have not included specific demographic data linked to each participant. Instead, I discuss this in generic terms (see Chapter 4). For example, participants interviewed worked in various clinical areas—in PHC, A & E, community and district nursing, palliative care, private practice, community mental health, and Māori health. Despite this precaution, maintaining the anonymity of participants was difficult to guarantee because of the small number of nurses in this group and inside knowledge of each other's practice area and geographic location.

As I am known to this group of nurses and a member of the ANANZ Education Committee, I had to ensure the recruiting process occurred without coercion and bias. The ANANZ coordinator circulated the invitation to participate in the research via an email list which included many eligible participants. I declared my involvement with

ANANZ in the participant information form (Appendix G). I also declared that I was receiving financial support (a scholarship for an AN/ANS undertaking postgraduate studies) from the Weleda Trust during the first 2 years of my doctoral studies.

Each participant was offered the opportunity to withdraw from the study or to make changes and/or amendments to their comments before the analysis was completed. (This was outlined in the participant info sheet and reiterated before starting each interview.).

To ensure confidentiality and protect participants' identities and data, names were removed and replaced with pseudonyms in the findings and transcripts. All audio recordings were deleted from the Zoom platform after downloading and storing these on an external hard drive (password protected). An online transcription service (Trint®) was used to convert recordings to a Word document. Once the interview was available in a Word document on Trint®, the original audio and the transcripts were deleted from the platform.

While reading through the initial transcripts, the participants' names were removed and replaced with letters in alphabetical order and numbers (in sequential order linked to the interview dates) to ease the process of data analysis and create anonymity.

All participants interviewed were offered a summary of findings as an option in their consent form (Appendix H). After submission of the thesis, I will present the findings to the ANANZ community either at an in-person conference or via an online session.

4.4.3 Ethical Considerations for Engaging with Participants and Publishing Findings

While interviewing and starting the first analysis, I became acutely aware of my involvement in the process as a researcher and as a member of this nursing group. I chose my words with care and caution, driven by the increasing sense of responsibility for how my interpretation of their voices could impact this small group of nurses. Given the lack of research on this nursing approach in Aotearoa New Zealand (see Chapter 2), the project findings will serve as a representation of the nurses'

experiences in a public space. Liamputtong (2006) referred to conducting studies with groups that might experience impacts from the findings as “sensitive research” and highlighted factors that could impact a small, defined group after publication. I considered two main factors before starting this research. First, we still have limited knowledge about the challenges that ANs/ANSs might encounter in terms of their breadth and opportunity to integrate knowledge when considering approaches that are not part of the mainstream. Additionally, as discussed above, my interpretation of the data could affect the representation of anthroposophic nursing identity and status. Creswell and Poth (2018) alerted the researcher using qualitative methods to note the positionality of their writing and highlight how the reader might interpret the findings.

Without a doubt, qualitative research is subjective, which highlights the researcher’s responsibility to carefully examine their interpretations of the data.

4.4.4 COVID-19 Pandemic Considerations for Ethics Application

While preparing the ethics application, Aotearoa New Zealand moved into COVID-19 lockdown Level 4, which meant face-to-face contact was no longer possible. Foreseeing when this would be safe again proved challenging.

This new situation resulted in the proposal for online interviews. A separate section, “How to Safeguard Online Interviews,” was added to the ethics application to assure participants were aware of the potential implications of being interviewed online.

The revised ethical application took into consideration that the potential interviewees were first-line responders in the pandemic; therefore, offering flexible time frames was pivotal. I offered interviewees the choice of two short interviews rather than one long interview. Being aware of time (the length of the interview) and mindful of any early signs of tiredness, lack of concentration, or withdrawal were important.

Participants could choose from three platforms: Skype, Zoom, and FaceTime. To avoid and prepare for any technical issues, I offered a short pre-interview chat to check connectivity. Where possible, links to the virtual interview room had a password so only the participant could access it.

Another consideration was time constraints relating to the participant's availability. For example, I offered possible interview times after working hours and on the weekends but also signalled that I was open to rescheduling at short notice if the participant's work hours changed.

I emailed a reminder of the interview time and location (the online link) and provided additional information on ensuring privacy by establishing a confidential space and avoiding any accidental disclosure of the interviewee's personal space. This involved considering the possibilities of family-related interruptions, unexpected internet issues, and how to manage these calmly. A further concern, which required reminders to the interviewees and myself, was to avoid additional noise within close surroundings, as this could impact the audio quality.

I conveyed my appreciation to the participants by sending either an email or text message after the interview and asked if they had any further comments to offer.

4.4.5 Te Tiriti o Waitangi

Any research conducted in Aotearoa New Zealand should first consider the impact the findings might have on Tāngata Whenua (Indigenous people of Aotearoa), especially when the outcome of a research project could affect health services and future health practice (Silcock & Hocking, 2021). Second, although the study did not focus on Māori nurses, researchers must be prepared and aware that participants might identify as Māori.

Previous discussion (see Chapter 1) of anthroposophic nursing in the Aotearoa New Zealand health context has highlighted some crucial questions that must be addressed when working from a paradigm not inherent in the Indigenous worldview. Although there might be some shared holistic values between health practices based in Te Ao Māori and the paradigm of the 4-fold anthroposophic human, it would be inappropriate and unsafe to claim or assume Tāngata Whenua share these perspectives and values.

I also do not want to position this study and its findings in a dualistic insider/outsider space (Bishop, 1998), reducing and diminishing experiences Tāngata Whenua might have with the anthroposophic way of nursing and suggesting that the anthroposophic paradigm fits into Te Ao Māori just simply on the grounds of its holistic nature. My awareness and self-reflections as a non-Māori researcher engaging in and exploring the integration of a paradigm with European roots are captured in the reflective journaling I conducted throughout the preparation and data collection phases of this study. Allowing this self-reflection and the ongoing conversations with some of my Māori colleagues were essential parts of the ethical considerations before starting this research.

4.4.6 Sampling

Purposeful sampling (Flick, 2018; Thorne, 2016) was used to recruit those in the best position to help explore the nature of the phenomenon under study. This type of sampling is frequently used in qualitative research. The process involves selecting the participants who are best positioned to contribute to data collection to answer the research question (Patton, 2015). Liamputtong (2020) has asserted that in qualitative research, sampling and sample size decisions are focused on “depth” and “flexibility” (p. 1897). For this study, nurses needed to articulate their practice and relate their experiences to the cultural, social, and political context of Aotearoa New Zealand. Of course, this also required that participating nurses were in current clinical practice (with an annual practice certificate [APC]) and could articulate the meaning of anthroposophic nursing for them.

4.4.7 Recruitment Process

As noted earlier, the number of practising anthroposophically educated registered nurses in Aotearoa New Zealand is small. Also, not all nurses who have completed education in anthroposophic nursing are members of ANANZ, on the ANANZ email contact list, live in Aotearoa New Zealand, and/or hold a current APC. I expected that inviting eligible nurses via the ANANZ mailing list would be the most efficient recruitment strategy, capturing those who fitted the inclusion criteria. The ANANZ coordinator facilitated the circulation of an invitational email on May 29, 2020, which

ensured the recruitment process occurred in a public space open to all ANANZ members.

4.4.8 Recruitment Steps

The participant information sheet (Appendix G) outlining the aim and intention of the study was attached to the invitational email (Appendix I) along with the consent form (Appendix H). This strategy ensured that essential information was available before contacting the researcher with more questions or accepting the invitation to participate. The process allowed participants to ask questions and avoid giving consent hastily to the interview because they knew the researcher.

After the initial invitational email (May 29, 2020), I received one response within a few days, followed by another three during the next four weeks; all of those responders were happy to be interviewed after reading through the participant information sheet and forwarded their consent forms. The invitational email was re-sent twice, first on July 13, 2020, and then again on October 26, 2020. Both emails generated another five participants who proceeded to arrange an interview time with me. Additional snowballing (Liamputtong, 2020) occurred, as covered by the ethics approval (Appendix B), instigated by those who had already participated in the interview process and felt motivated to encourage others to do so. I recruited three more participants for the study, adding up to a total of 11 interviews.

I intended to start recruitment as soon as I received ethics approval and continue until I had gathered sufficient responses and data to provide authentic insight into the research question(s). The proposed time frame was between February 2020 and October 2020. However, as a result of the COVID-19 pandemic, interviews were conducted from June to December 2020, following national Level 4 lockdown in March and subsequent restrictions.

On reflection, the recruitment process was challenging at times for me, as I was acutely aware of the familiarity I had with some of the participants and the topic under research. To ensure the safety of the prospective participants and myself during the recruitment process, I took notes during the interview process, before and after, to

help me to make any necessary adjustments to the process and the questions. I paid extra attention to my responses to the participants. After a warm welcome, I reiterated the steps covered in the consent form and reminded the interviewee of my role as a researcher and not as their colleague. I used the fortnightly supervision meetings to discuss and reflect on my responses, ideas, and assumptions I experienced/observed during the interviews. The reflective notes were essential to digesting my responses. These notes revolved around and tested my role as the researcher and the boundaries that needed to be maintained. I noticed throughout the interview process that some of my responses to participant statements were linked to and emerged only because of my own experiences working as an ANS. Exposing and discussing these observations in the supervision sessions helped keep the process transparent, facilitated self-reflection, and limited possible bias.

4.4.9 Recruiting Participants

Most nurses on the ANANZ email register have completed the anthroposophic nursing education pathway, and some are also qualified as anthroposophic nurse specialists (ANS). The curriculum for the Foundation Course in Anthroposophic Nursing, offered through Taruna College in Havelock North (NZ), is aligned with international guidelines (WHO, 2023) and accredited by the IFANA (2014). ANs who advance to become ANSs (anthroposophic nurse specialists) must adhere to additional professional guidelines and requirements (IFAN, 2022). After the initial purposeful sampling via the ANANZ email list, snowballing occurred through word-of-mouth.

4.4.10 Inclusion and Exclusion Criteria

Inclusion criteria:

- Registered nurses who had completed an accredited foundation course in anthroposophic nursing in Aotearoa New Zealand.
- RNs who held an up-to-date APC, ensuring awareness of contemporary health issues, best-practice guidelines, and experience in clinical nursing. The focus on currency demonstrated the expertise and characteristics of established nursing knowledge among participants (Liamputtong, 2013, p. 26). It facilitated data

collection by embedding nurses' contemporary experiences alongside articulations of their understanding of the anthroposophic perspective.

Exclusion criteria:

- RNs who had completed education in anthroposophic nursing offshore OR were not accredited by IFANA (2014)
- RNs with an expired APC and no work experience within Aotearoa New Zealand

4.4.11 Data Collection

4.4.12 Developing the Interview Schedule/Guide

My expectation of the interviews was that the participants would share their thoughts, offering deep insights into their practice informed by anthroposophic concepts and frameworks. Despite this assumption, I needed to develop some core questions and be prepared for follow-up questions (Appendix J & Appendix K) that reflected the current knowledge on the topic in the existing literature and related to my research aim and question (Brinkmann & Kvale, 2015). Despite the participants' familiarity with the investigated topic (phenomenon), it was crucial for me to have a guide with prompts, open-ended questions, and probing questions. Bearman (2019) identified three stages relevant to preparing an interview schedule: the introduction, exploration of the core phenomenon, and final reflections. I noticed that inviting the participants to share the motivator(s) which led them to exploring anthroposophic nursing was an effective start to the interview and extended into meaningful and reflective explorations of their journeys. My research questions were designed to elicit comments and examples which applied anthroposophic concepts to clinical practice. Therefore, inviting participants to share experiences and interactions from their clinical area that demonstrated anthroposophic knowledge worked well. I was cautious not to introduce overused terms, for example, holistic and holism, while cognisant that participants' responses were influenced by the prerequisite notion that anthroposophic care means embracing the whole person. After each interview, I carefully reviewed the initial interview question guide in collaboration with my supervisors and adjusted questions as necessary, always keeping the core inquiry of my study in mind.

4.4.13 Semistructured Interviews and the Interview Process

Choosing a semistructured interview format gave me, as the researcher, some control over the themes explored, and using a few preprepared questions helped maintain focus during the interview (see Appendix J).

Although Holloway and Galvin (2024) have stated that unstructured interviews can present the richest data, I had to ensure that the core areas linked to my research question were covered. Using preprepared follow-up questions and prompts led to more detailed answers (Brinkmann & Kvale, 2015). Inviting the participants to articulate their experiences in this semistructured fashion revealed their phenomenological positioning (Bearman, 2019), which was especially useful when narrating challenging experiences. Thorne (2016) has challenged the historical, existential notion of “essence” in phenomenological terms and advises the researcher to focus on patterns. She believes that when interviewing, we (researchers) learn something that we can empathise with, and this experience can then influence future practice (Thorne, 2016, p. 87).

For me, the task was to facilitate the interview, and this was best achieved by using open-ended questions and allowing sufficient time for the participant to respond. I noticed that a generous timeframe was critical when participants were trying to express their feelings about a situation in which their integrated paradigmatic view was exposed.

Since I knew the group of nurses interviewed, it was crucial for me to avoid dominating the dialogue during the interview. Using a semistructured interview design allowed participants to guide their interviews and add as much information as they felt was appropriate. The invitation to share their entry points into anthroposophic nursing set the scene and allowed for deeper insights into the motivators for choosing this path in nursing. Having follow-up questions and prompts to supplement the open-ended questions facilitated focus, producing rich, in-depth statements (Bearman, 2019). This strategy was also useful to avoid leading the participant to a specific answer, which was important considering my familiarity with this group of interviewees.

I found it difficult in some interviews not to rush the participant to answer, especially when I noticed a struggle with choosing the words to describe a complex paradigmatic context. Encouraging a collaborative and interactive dialogue during the online interview was crucial (Edwards & Holland, 2020) while avoiding monopolising the conversation. The core purpose was to generate and collect topic and theme-related data connected to the main goals of my research, alongside the biographical narratives.

The existing literature relating to the topic under inquiry should also guide and inform the interview questions (Brinkmann & Kvale, 2015; Holloway & Galvin, 2024). As mentioned in previous chapters, the gap in the literature exploring anthroposophic nursing care gave me scope to be creative with questions, adjusting these to each participant's evolving narrative and then following up with more in-depth questions. This also posed challenges as I was fully aware that as an insider in the context, as a researcher with knowledge of anthroposophic nursing, this was a point in the project where my own biases and experiences could easily influence the line of questions (see Section 4.4.13). I therefore avoided leading questions and invited participants to use terminology they felt comfortable with.

Participants felt encouraged to offer examples from practice and elaborated as much as needed, anticipating a sense of "telling the whole story."

I conducted 10 Zoom interviews and one (1) interview using FaceTime over a period of around 7 months. The interviews were audio- and video-recorded and lasted between 45 and 90 minutes.

Additionally, I took notes during the interviews as an adjunct to my observations. Thorne (2016) has emphasised the importance of this step for the researcher, as it may capture socially constructed, underlying motivators. This way of gathering data is a core element of ethnographic research (LeCompte & Schensul, 2010) and a valid aspect of nursing assessments. Collecting participants' cues and noticing responses added valuable insights when revisiting and updating the interview schedule/questions. The video function supported a relational and collaborative

environment and alerted me when adjustments were needed. I observed this issue in two interviews where the participants were unable to utilize the video feature. This impacted the interview progression; it took longer to build rapport and arrive at a trusting and relational dialogue (Jowett et al., 2011). The lack of face-to-face contact had a two-fold impact. For me, the researcher, I noticed I focused much more on what was said and missed the additional nuances of visual observations. For the participant, not being visible may have reduced the senses of relationship with the researcher during the interview process.

The memos created during each interview and my reflective journaling captured another layer of “data” and supported me to view the extent of anthroposophic nursing practice from various perspectives.

Following the journaling, an essential step involved revalidating the core questions (Appendix J) while keeping the research aim in mind. This ensured that a flexible and fluid interviewing process alerted me to areas I might have overlooked. I came away from some interviews thinking I had got lost; however, when returning to the recordings or transcripts, I noticed the depth of context emerging in the data.

After completing an interview, I deleted the video recording from the Zoom platform and downloaded the audio version to a designated external hard drive.

I noticed that for some nurses these interviews presented a long-awaited opportunity to share their views, practical experiences, and passion for this way of nursing. Keeping track of time frames and regularly reinforcing the purpose of this research to both myself and the participants was vital.

As the researcher and having insight into anthroposophic nursing practice in Aotearoa New Zealand and overseas, I had to be careful to avoid leading questions and not make assumptions. Before starting the interview, it was crucial to remind the participants that my role was that of a researcher and not that of a colleague.

4.4.14 COVID-19 Pandemic Considerations for the Interview Process

As already noted in the discussion on ethical considerations (Section 4.4.3), interviews had to be moved to an online space because of the COVID-19 pandemic restrictions. I had to adapt some processes and also be mindful that communicating via Zoom could be a novel experience for some participants.

To keep any technical issues to a minimum and avoid distraction during interviews, I contacted each participant after they had signed and forwarding their consent to me and offered a short pre-interview Zoom meeting to check that the video and microphone were working and talk through the process on Zoom where an access password protected each Zoom interview-meeting. These short check-ins also included reminders:

- to create a quiet space for the duration of the interview
- to allow for privacy— a sign on the door was suggested.so interviewees would not be interrupted without warning
- that a secure space also meant less environmental noise that could impact transcribing later

These premeetings reassured participants, made them feel more at ease with the Zoom platform, and provided a sense of how it might feel to be interviewed online (Irani, 2019; Jowett et al., 2011; Salmons, 2011). Most participants were interviewed in their own familiar environments; two participants were interviewed in their workspaces.

Considering the impact the COVID-19 pandemic has had on health professionals and health systems, it is worth noting here, that the last interview I conducted was on December 11, 2020. The COVID-19 vaccination subsequently became available in Aotearoa New Zealand on February 3, 2021, and was made a mandatory requirement for practicing registered nurses on November 15, 2021 (NCNZ, 2022a).

4.4.15 Transcribing of Interviews

The recorded interviews (audio) were transcribed verbatim with the support of an online tool (Trint®). Once the automatic transcription was received, the document was converted to Word format and uploaded to a password-secured external hard drive. After this step, the transcription and the audio recording were deleted from the Trint® platform to ensure the protection of data.

I then went through the “raw” transcriptions, removed the names of participants, replacing these with initials (alphabetically), and assigned a number to each interview transcript. The consequent final step was editing the automated transcripts. This involved reading through the transcription while listening to the recording and correcting misspellings or misalignments because of errors in the automatic transcription.

4.4.16 Data Saturation

An essential element of sampling in qualitative study designs (Flick, 2018; Lincoln et al., 2024; Morse, 2012) is ensuring a representative sample has been gathered. Thorne (2016, 2020b) cautioned and invited the researcher to thoroughly question what they were looking for when stating that saturation has been achieved. She differentiated between theoretical and data saturation. Thorne (2016) has warned that overreliance on saturation alone could prematurely end an inquiry. She has challenged how data collection for an applied discipline like nursing could claim that there are no more “new variations and diversities on a theme” (Thorne, 2016, p. 107). Her standpoint also implies allegiance to the constructivist belief in an ever-evolving experience of truth and reality. In this study, Thorne’s thoughts on saturation reminded me of the use of the term “freedom” in the anthroposophic context. In the health profession, we often apply step-by-step approaches or algorithms for pragmatic and scientific reasons. Although these are not wrong and are most helpful in practice, they can miss the underlying complex realities that differ for each individual, diminish or “reduce” a collective, and lead to fixed assumptions about culture, health, and worldviews.

Sample size is a topic that has been fiercely debated and challenged by qualitative researchers in recent years (Boddy, 2016; Morse, 2012); however, Thorne (2016, p. 105) has asserted that there “is no firm and fast rule” on how to determine the right sample size, especially in the nursing context (Thorne, 2020b). Considering this study’s aims and research question, a cohort of at least 10 registered nurses who had completed their education to become an anthroposophic nurse in Aotearoa New Zealand seemed reasonable, as a proportion of the overall number of ANs/ANSs practising here. Despite the small number of nurses who met the inclusion criteria (not all the 84 nurses who completed an education program in anthroposophic nursing were eligible as some were not practicing or had moved overseas), I also wanted to ensure the sample size was representative and authentic (Thorne, 2020b).

Although interviewing between 10 to 15 participants seemed to be justified as providing a representative voice for ANs/ANSs in Aotearoa New Zealand, I kept an open mind throughout the data collection. I tried to avoid aiming for a fixed number and focus on the diversity, richness, and depth of responses rather than seeking to find commonalities in this stage of the research (Boddy, 2016).

4.4.17 Data Analysis—Initial Thoughts

My understanding of ID was initially somewhat naïve, primarily driven by the notion of ID opening a pathway for me to “truly” report what is occurring in practice and not having to divert from these findings because of any methodological allegiance. The more I became immersed in writing my research proposal, the more I felt the need for a supporting structure (method) to ensure a transparent data analysis process. During this journey, I also contacted Sally Thorne (see Appendix D), inquiring about her thoughts on whether the use of thematic analysis (Braun & Clark, 2006, 2022) as a method of data analysis would work against the methodological foundations of ID. Her response stimulated me to think critically and reminded me of what other qualitative researchers have said about data analysis (for example, Morse, 1994, 2012; Sandelowski, 2011). My initial impressions were that reflexive thematic analysis (RTA; Braun & Clark, 2022) could be useful for “organising” my data and helping me not miss important codes and statements. However, the further I immersed myself in the

coding process (see below), the more I noticed I was focusing too much on “working the method” rather than paying attention to the meaning of what was said. Of course, this is not the intention of RTA (Braun & Clark, 2022, p. 128), but at this point, I decided to let go of this method and use Morse’s framework of “comprehending, synthesising, theorising and re-contextualising” as endorsed by Thorne (2016, pp. 184-185).

Trusting in the process of “working the data” (Thorne, 2016) ultimately led to a robust ongoing dialogue between myself and the collated data, but, more importantly, I had to explore the meaning of allowing the data to speak for itself and “harvesting” these voices rather than categorising them. Working with not only the data from interviews but also memos, notes on observations, and journal entries added to the complexity, which is the main characteristic of qualitative analysis (Gibbs, 2018, as cited in Flick, 2018). I planned to find overarching meanings or categories and then “bunch” the initial codes into tighter groupings for a better overview of preliminary themes. As I gathered more and more data from all the sources noted above, I realised I had to create a more visual process to see facets that were different, new, and surprised me to form a “thick description” (Geertz, 1973). The process then shifted from algorithmic and technical data handling (Saldaña, 2016) to interactive visual mapping. Entering the data analysis stage brought a real temptation to revert to one of the traditional methodologies, where the process of analysis hinges on fixed steps. I experienced what Thorne (2016) expressed as the “most painful yet most essential element of ID” (p. 155).

I believe I was also developing a heightened awareness of my responsibility as a researcher (in my case, a novice researcher) when presenting interpretations of thoughts and ideas that were not my own. This increasing level of authority and responsibility to provide a genuine and trustworthy interpretation of the data prompted a fluid movement backwards and forwards in this stage of analysis (Thorne, 2016).

4.4.18 Analysis—Process and Execution

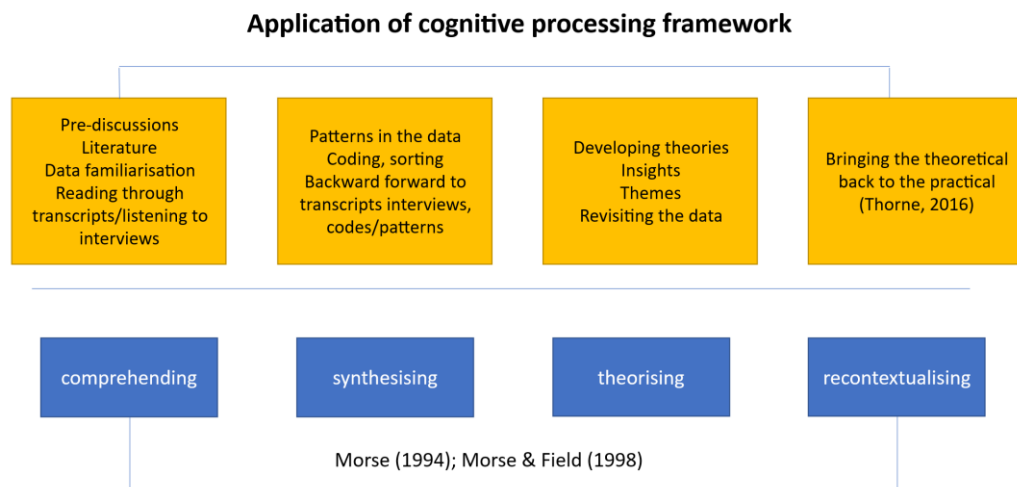
Thorne (2008) has described the analysis process as an interactive and iterative pathway between the researcher and the research subject. It involves intimate engagement with the data, which aids in affirming rigour and adding validity to the findings.

The audit trail I used for the process of analysis in my study comprised a series of steps. First, the interview questions were reviewed after each interview; I documented each step in the analysis, kept a reflective journal, and shared interview transcripts with supervisors. Data collection and initial coding, followed by identifying possible patterns, subthemes and themes, occurred alongside discussions with my supervisors. To support the process of theme development, I generated poster sized visual maps, which improved the overview of the data collected. A constant process of comparative and reflexive engagement with the data aimed at producing inductive analysis evolved.

Although acknowledged and highlighted by other researchers as a significant challenge (Hunt, 2011), ongoing and comparative analysis is a core element of ID. I frequently questioned “my method” and noticed that I felt uncomfortable with not moving fast enough. Thorne et al. (2004) warned that coding with too much detail or closing the process too early can lead to misrepresentation of the findings. For the unusual and the exceptional, returning to the existing data pool is one way of avoiding premature analysis (Thorne et al., 2004).

Figure 2

Use of the Cognitive Processing Framework by Morse (1994) and Morse & Field (1998)



Additionally, it is crucial to recognise that these processes, as outlined by Morse (1994) and Morse & Field (1998, p. 103), do not necessarily occur sequentially, although a robust level of comprehension is required before synthesising can start.

Comprehending

Long before I engaged with the actual data from the interviews, I had numerous consultations and conversations with health professionals and allied practitioners working from anthroposophic foundations (see Chapters 1 & 2). These discussions formed milestones and, alongside my exposure to and work as an ANS, were precursors and stepping stones for this first phase of comprehension. Many of those conversations continued throughout the process of my thesis and aided and challenged my thinking.

Entering the process of analysis started with editing the transcribed interviews and listening to the recordings multiple times. I reacquainted myself with the data several times and revisited the original data sources at various stages of the analysis to avoid missing anything. During this process, I took notes when significant statements appeared, such as any unexpected statements that I might have heard before but now presented a different perspective on a similar issue. Following this, I created a table for

each interview and highlighted the relevant codes. I completed the first four (4) interviews in this manner and then paused and closely inspected all the first codes, aiming to establish possible patterns or similarities. I found the table format helpful (Appendix L), as it allowed space for possible interpretations that enabled me to connect back to my research questions and the literature. This reflecting step was a check-in moment and an opportunity to revise the interview questions.

I subsequently created large posters for each interview to improve the visual connection with the codes. The codes were transferred to a separate sheet, cut out, and then placed into groups on the large poster. These coding mind maps helped me see possible themes and subthemes (for photos of sample poster, see Appendix M). Journalling during this process exposed my biases and helped document data transformations through emerging possible interpretations. I based my assumptions about possible themes in the data on a previous survey (Te Huia, published in the ANANZ newsletter; also see Appendix C) I had conducted in 2018. The themes/topics then included the values of holistic nursing practice, the meaning of and barriers to extended nursing practice, and comments on the epistemological views based on the anthroposophic picture of the three- and four-fold human.

Synthesising

Both steps (conceptualising and synthesising), as per Morse (1994), effortlessly blend into one another as part of the cognitive processing of data. I noticed how I had to remain flexible in my data sorting and ordering approach; only by dissecting and observing the process during and after each stage can the researcher pause and take time to arrive at themes. The step of synthesising includes “sifting through the data” (Thorne, 2016, p. 185) and decontextualising the individual stance to find commonalities and typical or composite patterns.

I include an example in Appendix N of an initial attempt to find common themes and patterns in Interviews 1 and 2. At this stage, I noticed that my bias was well entrenched, and I was rushing towards early prototype themes. Once I realised this, I returned to the transcriptions and table coding. Another observation I made in those early stages of analysis was my tendency to describe rather than try to find patterns

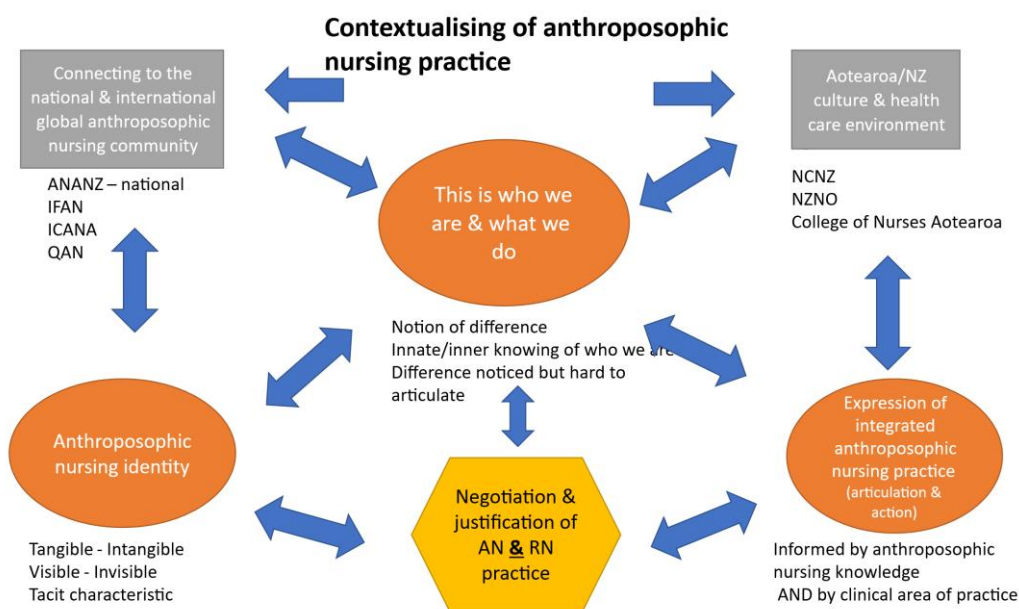
and categories. These were valuable insights, and after a discussion with my supervisors, I added a fourth column for potential prototype themes (see Appendix M & Appendix N).

Theorising

Some of the theoretical concepts I reviewed during the process of analysis were linked to literature and research previously conducted which reported how anthroposophic healthcare and nursing have been portrayed and presented, for example, in discussions of concepts of holistic nursing, CAM, the anthroposophic paradigm in general, and specific anthroposophic nursing frameworks. Amongst the latter were the 12 Nursing Gestures (Heine, 2020d). Part of theorising is the constant return to question established patterns and look at emerging theories that require checking/verifying by revisiting the codes or statements. Once I noticed some initial patterns, I created a mind map of potential themes and reoccurring topics that either linked to an overarching theme or illustrated a subtheme.

Figure 3

Initial Visual Spread of Potential Themes

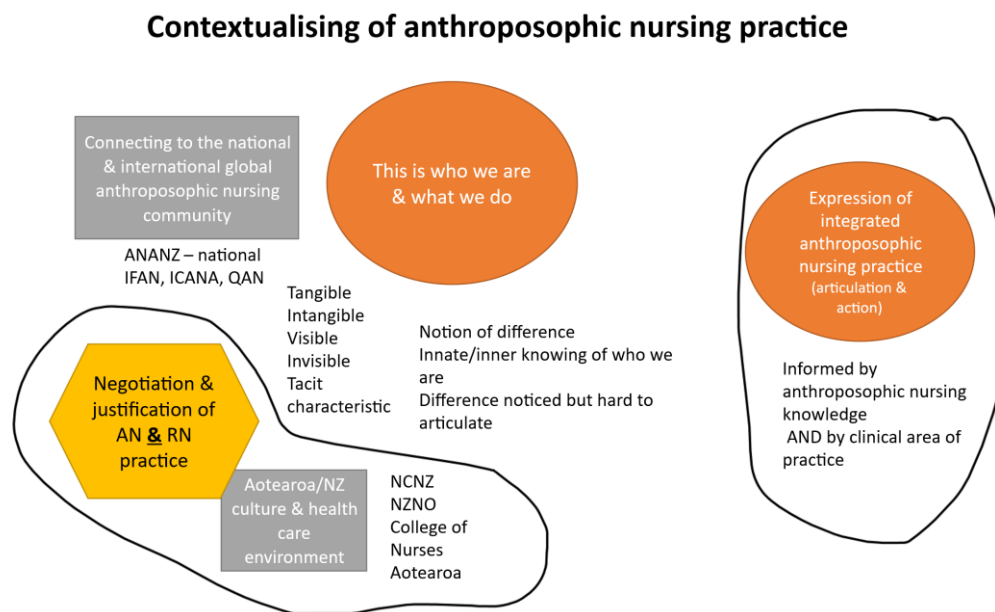


A hard copy of this mind map and notes and observations from my journaling supported the revisiting of the interview tables with the additional interpretation column (see Appendix M & Appendix N).

Examination of other studies conducted using ID revealed that the various stages of data collection and analysis were informed by contrasting and comparing the results with data from participant observations and field notes (Nkulu Kalengayi et al., 2012). Once data from all interviews had been considered, I reorganised my initial mind map (see **Figure 4**).

Figure 4

Three Key Themes



Recontextualising

In this step, the researcher is asked to apply the theory back to practical settings. It should also include suggestions for changes to practice or implications for future practice. Thorne (2016, p. 185) noted that recontextualising requires a “full appreciation” of the impact this new knowledge creates. The Findings and Discussion chapters report and discuss the study’s results. Chapter 7 makes recommendations and outlines implications for future practice based on the findings.

4.4.19 Rigour & Trustworthiness

Ensuring that the findings from data collected on individuals’ subjective experiences are credible and trustworthy is pivotal to the study outcomes and adds to their acceptance by the wider scholarly community. Ellis (2019) proposed that the processes

of data collection and analysis of the retrieved data are two significant stages in a research project that will confirm or weaken rigour. To ensure internal consistency and credibility, I audio-recorded the interviews and took notes during each interview. I regularly reviewed the interview guidelines in collaboration with my supervisors (Brinkmann & Kvale, 2015). The offer to participants to contact the researcher and change their statements or have the opportunity to clarify their answers was an essential component and a sign of trustworthiness. An ongoing field journal with additional notes before, during, and after interviews, alongside memos that I generated during data analysis, further verify and support the authenticity of the data. As described above, engagement with the data in text form was achieved through the use of visual layouts. I returned to the raw data (the interview transcripts and audio recordings) several times throughout various stages of the analysis while writing up the findings and discussion chapters. For example, I went back to the interview transcripts when writing up findings for the subtheme of anthroposophic anthropology with particular attention to the language participants used.

Furthermore, I utilised the supervision sessions as a form of member checking to review and discuss processes, challenges, findings, and interpretations of the text and visuals. I had several opportunities to present updates on my thesis with preliminary findings to broader groups of anthroposophic nurses, including at annual ANANZ conferences (November 28, 2020; November 27, 2021) and during two ANANZ Education Committee meetings (September 14, 2021; February 13, 2022).

To underpin and support the analysis and findings (Liamputtong, 2013, p. 29), I include quotations and excerpts from the participants throughout Chapter 5: Findings. Main themes and subthemes are present in a table format (**Table 6**), allowing the reader to critique the rigour and assess the research findings' trustworthiness.

The concept of rich (thick) description, frequently emphasised in qualitative studies, reflects the rigorous process and adds depth to the presented findings. (Liamputtong, 2013). Since anthroposophic nursing is relatively unknown in Aotearoa New Zealand, I include sections on the origins of anthroposophic medicine/nursing in Chapter 1 and

the core elements of anthroposophic anthropology in Chapter 2 to strengthen the rigour of description.

To preserve the trustworthiness of a research study, Thorne (2016, p. 70) has stipulated a “theoretical forestructure” that facilitates precise positioning for the researcher and is utilised to scaffold the research project. This forestructure entails three aspects: locating one’s theoretical allegiance, one’s disciplinary positioning, and one’s personal positioning. Alongside a literature review, the forestructure is an essential foundation for building the rationale for an ID research inquiry.

In addition, consideration was given to Thorne’s (2016, pp. 233-235) four guiding principles for evaluating ID research: epistemological integrity, representative credibility, analytic logic, and interpretive authority.

Thorne posited that “all qualitative research must demonstrate epistemological integrity” (2016, p. 233), which implies that the researcher must recognise the epistemological positions surrounding the research question and develop strategies that honour those positions (Thorne, 2016). As a researcher, I presented and acknowledged my experiences as a nurse and an anthroposophic nurse specialist. My reflective account included biases and assumptions I might bring to this research project. Additionally, the epistemological stance is underpinned by direct participant quotations throughout the findings, emphasising practice experiences informed by anthroposophic knowledge and articulated considering the local health culture and context.

Representative credibility necessitates that the claims made in the research are congruent with the methodology employed in the study and a sustained engagement with the phenomenon under investigation (Thorne, 2016, p. 234). All participants had completed further education in anthroposophic nursing within the local context, which ensured the findings resembled practice experiences relevant to Aotearoa New Zealand. Furthermore, all participants were advanced RNs with a minimum of 20 years of work experience across various clinical specialities.

Analytic logic demands transparency in the researcher's reasoning, beginning with the forestructure and extending to the interpretations and knowledge generated from the study. To clarify the decision-making process in this research, each transcript was analysed visually (see Appendix M) and with the aid of a data table (see Appendix L), to grasp its underlying meaning (Thorne et al., 2004; Thorne, 2016). Analytic logic was maintained through a thorough audit trail of the analysis, ensuring analytic consistency.

Interpretive authority is imperative to ensure reliable descriptions that convey truths beyond the researcher's inherent biases or personal experiences (Thorne, 2016, p. 235). In addition to the already noted reflective account acknowledging my assumptions, I ensured self-reflection was used alongside the process of analysis.

While I had initially assigned pseudonyms to each participant, the deeper I became involved in the data analysis, the more I questioned the appropriateness of ascribing a name to nurses known to me. Using the term 'participant' offered additional distance.

4.5 Chapter Summary

This chapter has outlined the methodology for this research project and my professional positioning within the constructivist interpretative paradigm. I have discussed the essential characteristics of ID and outlined the process of scaffolding (Thorne, 2016) that proceeds with the data collection and is specific to this methodology. As a researcher with insider knowledge of the topic under investigation and given the small group of nurses involved, issues around ethical considerations, transparency, and bias were highlighted. Because this research was conducted under pandemic restrictions, amendments to the ethics applications were added that affected the data collection. With all research conducted in Aotearoa New Zealand, possible impacts relating to bicultural obligations based on the legal obligations of Te Tiriti o Waitangi were considered and outlined. I have presented these potential issues based on my ethical obligations as a non-Māori health professional/researcher.

Chapter 5 Findings

A truth which comes to us from without bears ever the stamp of uncertainty. Conviction attaches only to what appears as truth to each of us in our own hearts.

(Steiner, 1894/1916b)

5.1 Introduction

The intention of this research has been to understand how registered nurses who have completed further education in anthroposophic nursing in Aotearoa New Zealand apply this knowledge in their practice. Therefore, gathering data that provided a contextualised understanding of the observed healthcare environment was crucial.

Before discussing the study's findings, I introduce the participating nurses and their connection to anthroposophy. Following this, I present the three key themes that emerged and their relevant subthemes. I have used quotes from individual interviews to underscore the findings and acknowledge the distinct perspectives of each participant.

5.2 Introducing the Participating Nurses

Due to the small number of anthroposophic nurses in Aotearoa New Zealand, specific demographic data remains confidential to protect participants and their privacy. The participants' characteristics, including their practice areas, anthroposophic nursing education, and age, highlight anthroposophic nurses' unique cultural and professional backgrounds in Aotearoa New Zealand. The ethical considerations section in the previous chapter provides more information about the participants' characteristics in relation to the research question.

All nurses participating in this study were female, with ages ranging from 50 to 65. They had all completed their anthroposophic nursing qualifications in Aotearoa New Zealand between 1998 and 2015 and, as a group, their nursing careers averaged 25+

years. Some also had experience in conventional nursing abroad, while three had worked in anthroposophic hospitals in Europe after completing their anthroposophic nursing education here in Aotearoa New Zealand. Out of the total 11 participants, six had achieved the qualification of an anthroposophic nurse specialist (ANS) after completing certification requirements in Aotearoa New Zealand (IFAN, 2022).

The nurses were located in the North and South Islands at the times of the interviews, practicing in various clinical areas and health settings. They had a wide range of nursing skills including acute care, primary healthcare, cardiac care, mental health, forensics, school nursing, palliative care, and nursing in therapeutic communities and private practice.

5.2.1 “Where did it begin?”: Entry Points to Anthroposophy

As mentioned in the previous chapter, I began the interviews by asking the participants how they had discovered anthroposophic nursing. While this approach established a point of entry to the interviews, it also enabled the participants to self-reflect on their position of working from a paradigm not generally known in Aotearoa New Zealand. What emerged from this initial question were the motivating factors that led participants to choose to become anthroposophic nurses. Participant 3 (ANS) stated that she “hadn’t heard of Steiner and anthroposophy until someone invited her to come to a Waldorf kindy fundraising event”. She commented that this had come about at a time when she noticed her discontent with mainstream schooling, and getting to know the Waldorf (Steiner) philosophy further emphasised this.

Participant 3 described finding anthroposophy via Waldorf education as a “light bulb experience” and feeling that “Steiner education would meet and understand her child”. She later discovered that anthroposophy also offered a pathway and framework for nursing practice. In contrast, for two other participants, the initial motivator was searching for a more encompassing and holistic way of nursing.

Participant 4 (ANS) expressed a realisation that she “needed to go nursing” after starting a law degree; however, once she completed her nursing degree, Participant 4 found that she “didn’t know what to do with [her] hands”. Her partner, a Waldorf

kindergarten teacher at the time, sparked her interest in exploring this paradigm further after finding information on anthroposophy in the UK. She was juggling being a mother to three young children when she started her education in anthroposophic nursing in 1998.

Similarly, Participant 7 (ANS) had grown disillusioned while studying for her nursing degree but could not articulate what was missing for her. She described the missing component:

...what I didn't know then, but what I would now call the reductionist medical model. I did an assignment in that second year looking at acupuncture and just was...like I had a question within me that there had to be more or different ways of looking at things...(Participant 7, ANS)

Participant 7 expressed deciding to go nursing in the first place as “a calling”, and although she wanted to “stick it out” and complete her nursing degree, she had her first child while studying and had to take some time out. Being a mother led her to further explore alternative health approaches, including anthroposophic medicine, which influenced her beliefs about childcare and self-care. Her experiences with natural therapies and homoeopathy before having children solidified her belief in the benefits of “other” health paradigms. After completing her nursing degree, she found shift work challenging while looking after her young family. Already familiar with anthroposophic healthcare, Participant 7 worked in a PHC practice in collaboration with an anthroposophic GP before starting her anthroposophic nursing education in 1998.

Participants 2 and 6 (ANSs) had both been involved in pioneering anthroposophic work in the 1970s through various anthroposophically oriented groups, such as biodynamic gardening and farming, Waldorf education (McElroy, 2013; Sydney Rudolf Steiner College, 2024; also see Chapter 1 & Glossary) and supporting people with disabilities in the community. Due to the lack of educational opportunities for registered nurses in Aotearoa New Zealand at the time, Participant 6 spent time in an anthroposophic hospital in Europe to gain greater insight into this nursing approach. Both highlighted the significance of exchanging knowledge among different professions in alignment

with the anthroposophic approach, starting with a fundamental understanding of anthroposophic principles. They saw the establishment of anthroposophically-orientated groups throughout Aotearoa New Zealand as essential to their further interest in anthroposophic nursing.

Once an anthroposophic nursing educational pathway was established in 1998 in Hawkes Bay, other registered nurses became interested through word-of-mouth. Participant 5 (ANS) recalled that before engaging with anthroposophic nursing, she worked with an AN in her practice area and noticed that “patients were more settled at night” and “there was a peaceful ambience”. This observation sparked Participant 5’s interest in anthroposophic nursing and encouraged her to pursue it. After becoming familiar with anthroposophy, Participants 10 and 11 (ANs) felt that they had found a more holistic nursing model that acknowledged and integrated spiritual aspects of care, satisfying their search. This marked their entry point into anthroposophic nursing education. Most encounters leading to the exploration of anthroposophic nursing occurred alongside various engagements with other anthroposophic groups, for example, biodynamic gardening and nutrition (Participant 9, AN).

Although the participants’ accounts outlined a variety of motivations to access the anthroposophic nursing pathway, searching for and finding a way of practice that differed from conventional general nursing was a dominant subtheme throughout the individual testimonies. Furthermore, the participants’ professional paths were also influenced by their personal journeys, which often revolved around motherhood or parental responsibilities in relation to education. The connection between parenthood and the desire for holistic healthcare for their family was evident in their accounts. This prompted a thorough examination of holistic concepts and shifts towards lifestyles influenced by anthroposophic beliefs about nutrition, education, and health.

Participant 8 (AN) commented that her relationship with “alternative ways of managing ailments” stemmed from knowledge passed on by her grandmother. Although Participant 8 was unaware of any connections her grandmother may have had with anthroposophic groups in Aotearoa New Zealand, upon reflection, she had

become convinced that her grandmother's treatment of ailments within her family was linked to the anthroposophic activities within her local community.

Later in this chapter, I highlight the ties between culture, community, and health. The seeking and sharing of knowledge with communal support while sharing values and beliefs is a well-documented characteristic of health culture (Bergdoldt, 2008; Dew & Kirkman, 2002; Helman, 2007), and I explore this further in the discussion chapter. While this introduction to the participants has focused on individual motivations to explore anthroposophic nursing, the following section presents now the key themes and subthemes of the study.

5.3 Key Themes and Subthemes

As discussed in the previous chapter, I worked with Morse's (1998) four-step cognitive processing analysis to support data extraction, grouping, and the development of themes. Reiterating Morse's comments on the significance of this conceptual process for working with the data, Thorne (2016) emphasised that data analysis cannot be simplified to "following a recipe" (p. 185) but stipulated that Morse's framework (1998) presents a structure for the iterative process of interpretive description.

The following table summarises the themes and subthemes.

Table 6*Main Themes and Subthemes*

Main themes	Subthemes
“Our way of being”—the question of identity	anthroposophic paradigm inner path—expressions of spiritual development anthroposophic anthropology guiding practice professional relationships with patients, nurses and allied healthcare professionals
Expressions of anthroposophic nursing practice	visible and invisible nursing presence dimensions of nursing practice
Negotiating place—nursing with anthroposophic foundations in Aotearoa New Zealand	culture and health—the bicultural context challenges to practice—when there is a fit and when there is not

Theme 1, “our way of being,” captures what participants perceived as their professional nursing identity. It includes statements of values and descriptors of how the role of anthroposophic nursing is experienced, understood, and lived.

The first subtheme comprises the anthroposophic paradigm and anthropology as explained and presented using anthroposophic concepts and frameworks, also referred to as anthroposophic anthropology (Heusser, 2016). The second subtheme to emerge in the context of anthroposophic nursing identity was the inner spiritual development of nurse participants. The third subtheme includes participants’ ways of being (as ANs/ANSs) with patients, nursing colleagues, and allied health professionals in relationships and collaborations related to the health culture of Aotearoa New Zealand.

Theme 2, “expressions of anthroposophic nursing practice,” captures visible and invisible gestures, traits, and facets, as the first subtheme, while the second subtheme introduces dimensions of practice through participants’ accounts that describe the breadth of anthroposophic nursing practice, the rationale, and the planning of care interventions.

Theme 3, “negotiating place: nursing with anthroposophic foundations in Aotearoa New Zealand,” delves deeper into the context of practice for ANs/ANSs in contemporary healthcare. The first subtheme encompasses findings related to bicultural nursing practice as an essential component of professional nursing practice in Aotearoa New Zealand, and the second subtheme captures areas of practice experienced as challenges or barriers when utilising anthroposophical nursing knowledge.

5.4 Theme 1: “Our Way of Being”

Theme 1 explores the blending of personal and professional journeys driven by strong aspirations to integrate holistic values. It provides essential insights into the philosophical foundations and approaches to anthroposophic nursing and reveals what it means for the participants to identify as anthroposophic nurses.

5.4.1 Subtheme 1: Anthroposophic Paradigm

The participants’ statements reflect how they understand the anthroposophic paradigm and concepts based on anthroposophic anthropology and then connect these to patient observations and situations. Participant 3 (ANS) tied this practice to a fundamental understanding that “all is connected” beyond the physical sphere. Anthroposophy views human beings as affiliated entities influenced not only by their immediate physical and social environments but also by planetary and cosmic forces (Heusser, 2016; Holdrege, 2014). The notion of “all being connected” originates in what others have called ecological dimensions of the relationship of individual parts to one another. Holdrege's (2014) examination of Goetheanistic phenomenology highlights the contrast between viewing reality as a cohesive entity versus perceiving it as separate and disconnected systems. This approach emphasises the interrelation

between various aspects of existence and the influence of natural forces on each individual part. Recognising patterns and the relations of phenomena to these helps foster imagination and develop inner capacities and sensitivities and allows a view of the whole (Holdrege, 2014). Participant 3 (ANS) observed that an “ability to layer perceptions” and a “dialogue of observations” can heighten perceptions of the connections to the natural world around us, as articulated in Goetheanistic science.

All participants saw applying anthroposophic principles as an additional tool for understanding a person’s symptoms and ailments. Chapter 1 outlines how anthroposophic nursing utilises the three- and four-fold human frameworks that underpin and facilitate assessment and care planning.

Participant 11 (AN) articulated the experience of nurse and patient interaction as a “meeting versus overwhelming” the person. Engagement with and deeper learning about anthroposophy “changed my nursing approach” (Participant 11), a statement frequently used by all participants when reflecting on their perceptions. Two participants pointed out that other nursing colleagues unfamiliar with anthroposophy commented on the unique nature of the anthroposophic nursing philosophy and its difference from conventional/mainstream approaches. The term “difference” appears multiple times in the participants’ accounts. A few participants who were less descriptive in explaining their stance on anthroposophy nevertheless commented that completing the education to become an AN had made a difference in their nursing practice.

Although some anthroposophic nursing interventions “appeared small” as Participant 11 (AN) expressed when referring to “just using a heart cloth” (a muslin cloth with aurum/lavender/rose ointment, see *Vademecum*, n.d.-h), they differed from the biomedical treatment approaches, which Participant 11 compared to a “mainstream sledgehammer approach”. She further clarified the previous statement and added that she noticed anthroposophic nursing interventions allowed the patient “to respond to the interventions on all levels of their being” (Participant 11).

Allowing the recipient of her care the time to respond was also referred to as “freedom”, intended to support “innate healing abilities” and foster a “returning of equilibrium” (Participant 11, AN). Similarly, other participants saw that applying anthroposophic frameworks to accommodate human behaviours and expressions improved their nursing practice:

...anyone who has come to understand the human being out of these sorts of bigger pictures is never the same anyway. (Participant 3, ANS)

The testimonies illustrate practical applications of both conventional/mainstream and anthroposophic approaches. Participants described both paradigms as intertwined with no clear demarcations, and they valued the anthroposophic approach to health as an extension of the conventional/biomedical model. Participants confirmed and acknowledged the relevance of current health structures and systems. The participants discussed this paradigmatic differentiation in various ways during their interviews without reaching any clear consensus. Despite the references to an interwoven and integrated healthcare model, differences in personal philosophical standpoints appeared.

Comments from a number of participants illustrate this integrated view of coexistence and a “non-dualist perception of the world” and describe the individual experience of illness as linked to the concept of “freedom” mentioned by other participants (for example, Participant 5, ANS). Participant 5 stated that her work in end-of-life situations has made her “look at illness in a different way”. Participant 2 (ANS) shared that “the capacity to accept that there is meaning, wisdom and value in illness...I really appreciate illness”. For her, the links anthroposophy makes between destiny, karma, and illness as part of one’s biographical journey were significant and led to a deeper understanding of her nursing practice:

I know that sounds like a bit like an old...I don’t know, pretty weird, but there’s nothing I’m not frightened of illness because I can just see the wisdom in that, and I accept that wisdom. (Participant 2, ANS)

For Participants 4 and 7 (both ANSs), anthroposophy represented an overarching paradigm, and both described its influence on their professional selves as a gradual

learning process with stepping stones. They asserted that other nonanthroposophic nurses had commented on this as being “different”. Building on that, Participants 4, 7 and 11 (ANs) also established a connection between anthroposophy and the idea of “freedom for the individual”, placing particular emphasis on this in relation to health decisions and the autonomy of the patient/recipient of care.

Furthermore, the translations of anthroposophic concepts into contemporary healthcare, for example, in articulations of the process of inflammation, pathophysiology, or treatment approaches to long-term conditions underpinned by anthroposophic concepts (Participant 11, AN), were indicators of knowledge integration and the coexistence of AN and RN identities.

A distinction of anthroposophic nursing care is the emphasis on spirituality, not only as a practice, but as an integrated element of caring. Participant 10 (AN) felt that the spiritual aspect of anthroposophic nursing had facilitated her collaborations with and care for Tāngata Whenua:

I think that one of the biggest things is the sense of knowing, and I feel like it is a knowing out of my personal experiences, I guess before I came to studying anthroposophic nursing...the knowing that there is a spiritual world out there that our ancestor and our loved ones...in anthroposophy, we sit with [that] quite comfortably. (Participant 10, AN)

Participant 10 (AN) also articulated the experience of illness as a milestone in a person’s life journey:

...giving them the reassurance that what they are going through now it’s an important part of their life journey. And I think it’s really reassuring and that sense of, you know, comfort of...and you watch them unfold, and you watch them grow. (Participant 10, AN)

These participants’ accounts illustrate the poignant role of the nurse working with the patient to understand illness as part of a larger life journey and individual biography. The emphasis on salutogenic factors, rather than pathology, was a notable feature in the data.

Participant 6 (ANS) had been involved with the anthroposophic movement in Aotearoa New Zealand long before ANANZ was founded. She noted that her overseas clinical experiences and the core intent to connect conventional and anthroposophic healthcare concepts have influenced her anthroposophic nursing career. She outlined how her collaborations with allied anthroposophic health professionals had benefitted her professional journey and given her the confidence to establish an independent nursing practice early on. She connected most of her work to PHC services and principles, including intersectoral collaboration with Waldorf schools, and she is deeply passionate about the first 7 years of a child's development. Bringing her knowledge of anthroposophy "into the meeting ground of two people" presented as a "unique and amazing" opportunity in her nursing practice, "once you work with anthroposophic nursing [knowledge], you cannot NOT work with it" (Participant 6, ANS).

This statement expressed a profound realisation by the Participant and suggests that knowledge acquired is inevitably practice-changing. Participants reported various changes in their values, beliefs, and worldviews after meeting anthroposophy. This finding emerged through various themes and subthemes, and I propose that this overlap is primarily attributable to the innate principles of anthroposophy as a spiritual science. How we see and experience the world around us (ontologically) never has a singular impact but rather an all-encompassing (holistic) one.

5.4.2 Subtheme 2: Inner Path—Expression of Spiritual Development

Working with anthroposophic concepts and frameworks includes nurturing self-development and recognising humanistic values in therapeutic encounters and how spiritual impulses transfer into nursing interventions. This section illustrates how participants articulated these perceptions in their testimonies and incorporated them into practice.

Participants 2 and 5 (both ANSs) perceived anthroposophy not as something linear that one could read, learn, understand, and then practice. Spirituality was situated as a process of lifelong learning, which was expressed as a foundation for anthroposophic nursing (Participant 1, AN), a call to nursing, and a tool to develop capacity from within

(Participant 4, ANS). Participants noted that an openness to spirituality facilitates and fosters engagement with anthroposophy in general. They also viewed the spiritual world as a supportive ally in nursing practice. A few participants noted heightened awareness of self and others after becoming mothers, leading to quests for more holistic ways of life, while one participant (Participant 2, ANS) reported a heightened sense of intuition in this context. Participants 1 and 8 (both ANs) and Participant 3 (ANS) described preexisting beliefs and family values, such as upbringings based on Christian principles, as enabling factors that created openness toward anthroposophy.

Working on the self and conscious attention to inner development is essential for developing anthroposophic nursing skills or, for that matter, delving further into anthroposophy per se (see Chapter 1). Any deeper engagement with the anthroposophic paradigm necessitates attention to an inner meditative path. Participants illustrated this in their accounts, expressing their spirituality and emphasising its role as an essential facet of ongoing inner development in their nursing practice and a core element of their role as anthroposophic nurses.

For all the participants, the concept of holism was not something in question, and this included spirituality; the existence of a reality beyond the physical was undisputed and normalised in all interviews. Participant 3 (ANS) emphasised that focusing on materialism hinders a holistic worldview.

Another example of spiritual connection when immersed in nursing practice came from Participant 2, who noted:

...it's that inner spiritual orientation, which I'd carry with me...and that sort of consciousness...that plays into how I am as a nurse as well. But I'd say just over time, probably the most important useful thing for me is to work actively with some substance, and that comes from nature.

(Participant 2, ANS)

In anthroposophic nursing therapies, practitioners frequently use the term substance (see Glossary and Chapter 1) when describing any medicinal plant, animal or mineral-based material that is applied externally. Speaking about a connection between the natural world and an inner spiritual orientation in this context might be challenging for

a nurse unfamiliar with the anthroposophic healing approach. Using more mainstream, clinical language, the use of the therapeutic self might align well in this context and can illustrate the dialogue between the nurse (carrying knowledge and inner spiritual attitudes about the substance), an external nursing application (use of substance), and the patient (recipient of the substance/intervention and inner spiritual attitude of the nurse toward the patient). The following statement from Participant 4 provides further insight into how anthroposophic concepts coupled with inner knowing (spirituality) and the use of natural substances for external nursing applications form practice reality:

I would say that because I have taken this substance and had the time to know it or work with it or seen it grow out of being interested in it. And because I've learnt how to combine it with other elements to transform it into something that's more readily available and accessible as a healing process, and because I understand the human being from a larger perspective, which incorporates all our nonvisceral activity...and our soul life and our spiritual integrity, and because I know how to put those things together to offer an impetus to the person to respond to this substance in a way that will pick up a therapeutic situation and brings some transformation. (Participant 4, ANS)

These quotes show how nursing action can incorporate the interconnectedness of the three layers of anthroposophic anthropology (body, soul, and spirit), their relationships to the natural environment, and the cosmic influences within (Bay, 2020; Heine, 2020b; 2020c; 2020d). Remarks by Participant 2 (ANS) on the value of the nurse's spiritual presence impacting the caring encounter echo Heine (2020b). While Participant 3 (ANS) described this way of caring as "listening and engaging from the heart", Participant 10 (AN) reflected on the professional use of spiritual presence, describing how anthroposophic nursing education and the extension into the spiritual have influenced her personal journey:

...in my personal journey...I think I guess one of the biggest things was that was the awakening to, well, the acceptance [of] the awakening [to] the spiritual world. (Participant 10, AN)

These findings are evidence of ongoing inner spiritual development and self-reflection, which is then transferred to practice encounters and forms epistemological insights.

Further to that, and in contrast, Participant 3 (ANS) acknowledged an external influence, describing how she achieved a “better understanding of the subtle connection with the universe” through her interactions with patients. To expand on this, several participants mentioned the effects of planetary influences on human beings and their inner world.

The nurturing of this inner, spiritual work was articulated in various ways. Participant 1 (AN) talked about “allowing the spirit to care for you”, stating that this takes a while to develop. Participants referred to the existence of a spiritual world and working with its beings as allies when helping others. Participant 2 (ANS) noted that to her, “nature is an enlivened being”. Once she has opened up and developed an awareness of the qualities of natural substances, she “brings it to [her] consciousness”, which enriches well-being.

Another participant reflected on both her personal and professional selves in relation to inner development and spirituality:

...you are learning as an anthroposophic nurse about all these different aspects of the human being, you're learning about yourself, and you're taking yourself on in this ongoing journey to try to become more and more of your authentic self. So, therefore, you're more available to the other person for whatever their needs are. (Participant 4, ANS)

For some participants, the topic of spirituality was also associated with experiences in their daily clinical practice. One nurse commented that the question of what happens to life after death had triggered her thinking, and she felt that knowing about anthroposophy facilitated this inquiry (Participant 5, ANS). Others associated exploring one's spirituality with a deeper involvement and engagement with anthroposophy as a spiritual philosophy, not limited to the health context. For example, Participant 4 (ANS) confirmed that being a “therapeutic tool means going into anthroposophy per se, taking oneself on” and “viewing the world from different standpoints”. In contrast to this more active engagement, Participant 1 (AN) simply noted that “allowing the spirit to care for you” is enough for a spiritual foundation. Participant 5 (AN) further defined the spiritual connection as two-fold, “with oneself and the outer world” while

Participant 7 articulated their sense of place and meaning through the following statement:

...it's one of the ways that I am able to stand in the world of spiritual science and in anthroposophy, which is the stream that I am profoundly connected with. (Participant 7, ANS)

Engaging with anthroposophy as an esoteric and spiritual philosophy was seen as enhancing and improving inner development, leading to the recognition of universal influences, such as rhythm and “order [in] daily life” (Participant 10, AN).

The use of anthroposophic terms for working with spirituality was noticeable, which can lead to confusion or misinterpretations unless one is familiar with anthroposophic concepts. Participant 4 (ANS) explained that the nurses’ meditation (Heine, 2020b, p. 108) supports this inner development and generates that capacity from within, which for her meant “...working out of these different qualities of light, of heart, and using the full will of our soul” (Participant 4, ANS).

Participant 6 linked this inner (meditative) work, which anthroposophic nurses are encouraged to do, to a core element of the nurse/patient relationship:

...anthroposophic nursing maybe takes that understanding that inner work a step further...that person who comes through the door, that's what matters. (Participant 6, ANS)

This subtheme, centred on fostering inner spiritual development, illustrates the significance of spirituality, spiritual connections, and inner development for ANs/ANSs. Testimonies relate to how participants perceived their spiritual identity/self and how their inner attitudes nourished their nursing encounters.

5.4.3 Subtheme 3: Anthroposophic Anthropology Guiding Practice

Most participants refrained from using anthroposophic terminology when explaining knowledge and expressing their views on what distinguishes conventional nursing from anthroposophic nursing. The need to adapt their language to explain and translate all things anthroposophic to other nursing colleagues or health professionals may have influenced this.

However, when specifically asked how anthroposophic anthropology (see Chapter 1 and Glossary) had influenced their nursing approach, Participant 11 (AN), for example, explained that “the whole idea of polarities made so much sense” to her. In anthroposophic nursing, the term polarity is used to refer to the existence of opposite forces that affect the human body or are related to specific individual symptoms. Recognising and working with a contextual understanding of these counter-poles or opposing forces is an essential part of anthroposophic nursing patient assessment and, therefore, influences nursing interventions, for example, by underpinning the rationale for specific external nursing therapies.

For most participating nurses, there was no question that they applied anthroposophic concepts and frameworks to their daily encounters with patients/recipients of care. “Seeing patients through the four-fold [view] has changed the nursing approach” (Participant 11, AN).

ANs/ANSs integrated the concept of the four-fold body (physical, etheric, astral, and spiritual) by linking nursing assessment data with the subjective observations from the patient. Nursing care reflected the manifestation of this internal dialogue.

For Participant 4 (ANS), the complexity and application of anthroposophic frameworks were all-encompassing and captured various layers of human existence, potentially affecting health balance. Her comment demonstrated inclusiveness, referring to the holistic foundations of the ecological and communal factors an individual may encounter:

I think anthroposophic nursing provides us with that amazing ability to assess a patient in a so much wider way; we can look at the four-fold [body], what is happening in each of the four bodies of the human being. Where is the balance at or the polarity and the three-fold spectrum of the human being? What is happening with the seven life processes, the 12 senses, and the 7-year biographical rhythms? And in a way, that’s an amazing gift because you are no longer looking at people singularly; you can look at them from all these different perspectives that enable you to see what the person, who they are so that you’re not putting anything in there, you’re observing it and recognising it through these different filters. (Participant 4, ANS)

This statement highlights the plethora of anthroposophical frameworks and concepts nurses can apply to their assessment processes and caring interventions. While the participant perceived these theoretical foundations as a “gift”, her subsequent comment validated their use as observational tools to aid the nonjudgmental recognition of a person as an interlinked being rather than a singular entity.

As noted earlier, nurses working with anthroposophic concepts find it challenging to use the terminology and articulate clinical assessment and interventions when working in nonanthroposophic services. The participants’ accounts reflected these challenges during therapeutic encounters with patients, nursing colleagues, and health services.

In contrast to Participant 4 (ANS), Participant 7 (ANS) explained that feeling accepted within the health professional team took her a long time. She, therefore, tried to avoid anthroposophic terminology to avoid further alienating herself. Participant 7 used the term “big picture stuff” when she commented on the holistic facets of patient support in more generic terms:

...there is a way to support anybody at any phase of their life with anything that’s going on, and that’s, you know, that’s to do with the big picture stuff that underpins it as well. (Participant 7, ANS)

In this context, she also reflected on the importance of the interconnection between anthroposophy and spiritual science for her as a nurse and an individual:

What anthroposophic nursing brings to me...it’s actually one of the ways that I am able to stand in the world in spiritual science and anthroposophy, which is the stream I am profoundly connected with. (Participant 7, ANS)

Expanding on this, Participant 2 connected the spiritual impulse anthroposophy offers to her nursing care when using a specific substance for a therapeutic compress or application. However, she also added that a willingness to learn about spirituality is a prerequisite:

Well, when I eventually get to the spiritual world, who are these beings going to be? Because they’re real helping beings...nature is an enlivened being to me and for my work as a nurse. They have a lot of

capacity to help if I can learn about them. Yeah. They're ready and willing to help. And that goes all the way through to like copper ointment or yeah, anything... (Participant 2, ANS)

Recognising imbalances when working with patients, participants expressed their knowledge of the four-fold body and reflected on their assessments using their inner imagination. Participant 11 (AN) explained that two of the anthroposophic frameworks served as imaginary sculptures in their mind while engaging with the patient. This conscious awareness of the unseen anthroposophic anthropology created the basis for developing interventions, guides, and connections to the 12 Nursing Gestures (see Chapters 1, 5 & 6; Heine, 2008, 2020d; Kramer et al., 2022).

Participant 11 expressed that “holding both [*knowledge of the three- & four-fold human picture in her mind*] while in relationship with the patient” was a tool to assess and plan care. Her conceptual thinking about individual aspects of the four-fold human was also captured when she explained:

[a]...depleted etheric, and the astral is just so much stronger than the ego is...holding that is to how you can approach the person that you have in front of you. (Participant 11, AN)

In anthroposophy, etheric forces have a relationship with neurosensory activity, rhythmic, and motor metabolic activity (Heusser, 2016; also see Chapter 1).

Referencing the “mediating middle”, Participant 11 was applying her knowledge of the three-fold body to articulate connections between thinking, feeling, and willing (Steiner, 1919b, 1928/1951; Evans & Rodger, 2017, pp. 61-67) and relating this to her nursing assessment and diagnosis. This example illustrates insight into the intricacies and semantics of anthroposophic concepts and frameworks when contrasted with the conventional clinical health context.

One participant elaborated that anthroposophic anthropology offers the possibility of “assessment in a wider way” and further reflected:

...learning about these different aspects of the human being, you're learning about yourself; you're taking yourself on in this journey...[to]

try and become more of your authentic self; therefore, you're more available to the other person. (Participant 4, ANS)

For anthroposophic nurses, interpreting and articulating the various frameworks inherent in anthroposophic anthropology is essential to comprehend a person's complex, holistic layers. Applying and integrating these foundations with conventional nursing will then facilitate the development of nursing interventions and aid decision-making in liaison with other health professionals (anthroposophic, conventional/mainstream or CAM), which are core elements of a person-centred approach. Part of this evolving process is the nurse's role as a "partner" in the therapeutic process, aiming to achieve "a real shift" (Participant 11, AN) rather than seeking a cure. The emphasis on the autonomy of the patient/recipient of care is visible here, emphasising the focus on the therapeutic alliance.

5.4.4 Subtheme 4: Professional Relationships with Patients, Nurses, and Allied Healthcare Professionals

The following sections focus on the subthemes of professional collaboration and relationships as experienced by the participants. First, the findings pertain to the participants' collaborations and relationships with patients/recipients of care and their families/whānau. Then, discussions explore how the participants perceived their professional engagements with other health professionals. These professional collaborations included working with other anthroposophic health professionals (doctors and nurses and art, music, and movement therapists [eurythmy, see Chapter 1]) and healthcare services outside the dominant mainstream, for example, CAM therapists.

Collaboration with the patient/recipient of care and their family or whānau was an essential part of creating a therapeutic environment for the nurse/patient consultation. Participant 4 (ANS) emphasised the importance of "being really in the moment" and incorporating nursing care that fosters the patient's reconnection to equilibrium while negotiating time, space, and treatment options. The patient/nurse relationship was articulated as the "person being in the centre and not the condition" (Participant 6, ANS).

Building relationships was vital for Participant 10, working in mental health, knowing that about 80-90% of her clients were of Māori descent, and valuing spiritual connection was “huge”. She expressed her experience as follows:

...there is a spiritual world out there and that, you know, that our ancestors and our loved ones and all of that...in anthroposophy we, you know, we sit with quite comfortably. So, what is within typically within Māori clients, and so, it's not...it's a place I can just be in very comfortably...it's a shared belief. (Participant 10, AN)

The relationship with patients receiving anthroposophic nursing therapies and care was interlinked with providing “dedicated space and time” (Participant 4, ANS). An additional differentiation between treatment and healing space led Participant 4 to comment further on nurses’ relationships with time and space, which were considered significant factors when preparing a therapeutic space. Participant 11 (AN) mentioned the importance of her “holding” the anthroposophic knowledge “while in relationship with patients”. She further explained that “touch makes all the difference” in this relational aspect of nursing. Alongside her allegiance to anthroposophic nursing, she considered engaging with a patient via touch as a core element of nursing practice. She believed that warmth, in its broadest definition, was expressed through her inner attitude (informed by anthroposophic knowledge) when engaging in therapeutic dialogue with a patient/recipient of care. Touch, as an outward gesture (a physical expression/action), complemented the concept of inner warmth (an invisible attitude).

Various accounts captured in the data illustrate the nature of professional collaborations. Participant 11 (AN) contemplated and critiqued the professional engagement she had noticed between her medical colleagues and patients in primary care. She wondered if better collaboration between the nursing and medical professions could improve patient satisfaction with healthcare services. However, some of her experiences reflected time constraints and the quality of time spent with patients.

Participant 8 (AN) also noted time as an impactful factor. She used anthroposophic therapies for her family, and her focus was on creating a “special place”, which for her

also reflected “making time”. Her work in a busy accident and emergency department does not allow for much nursing care outside the conventional/mainstream approach; however, completing the anthroposophic nursing education has strengthened her observational and assessment skills as a nurse. Despite the limitations of anthroposophic nursing interventions, she identified opportunities to integrate and validate her anthroposophic knowledge.

ANs/ANSs reported on a range of multilayered professional relationships within the wider PHC community. They reported liaising with allied health professionals (GPs and other allied health professionals including, for example, physiotherapists and osteopaths), anthroposophically trained therapists, CAM practitioners, and local Waldorf schools. Several participants emphasised close collaboration between health and education professionals, especially in those communities that foster anthroposophic values (Waldorf schools), and the growing demand and support for health services that exist. Multidisciplinary and intersectoral work by educators, doctors, nurses, eurythmists (movement therapists), art therapists, agriculturalists, and other social support workers is prevalent in anthroposophic communities. An example is the Hōhepa curative community (Hōhepa Hawkes Bay, 2024), whose breadth of support expands into offering their residents vocational opportunities and social networking. Providing holistic therapies such as eurythmy, nursing therapies, and school doctor consultations, is a common practice, especially in Waldorf schools. Where and when required, these schools can allocate time and funds to help support the pedagogical curriculum strategies and child development. These holistic interventions based on Steiner’s anthroposophy reflect the special character of Waldorf schools. They are designed to promote and support a healthy lifestyle and nurture child-parent relationships, but can also target specific concerns or health issues a student may experience:

The stuff that I do with the school is very much based on development. It’s not sick children. Sometimes I get referrals from X or somebody for a sick child or a recovering child, but...on the whole, the work with the school is about development. So, you’re watching to see in the context with the parent. What’s growing in the process of our time together...what grows and changes... (Participant 6, ANS)

This distinct collaboration between Waldorf education and anthroposophic nursing emerged in more detail in three interviews. Participant 6 (ANS) has worked for many years supporting babies and children under 12 in her nursing career. She called this way of nursing within the Waldorf school system and in the classroom a “wrap-around approach”, and anthroposophic nursing represents only one chain in this process. Alongside her nursing therapies, the children would also have sessions with an eurythmy therapist, and the school would schedule regular visits by the anthroposophic doctor. Participant 6 stated that her approach to establishing diagnosis and treatment plans was based on her classroom observations and individual consultations with the child and their family/whānau. Parents requested and supported this holistic approach while part of a Waldorf school community. Working with the underpinning pictures of anthroposophic anthropology was a collective professional effort, and for her, providing various nursing therapies during school hours was an integrative part of holistic education.

Participant 4’s (ANS) experience working in relationships with parents outside the Waldorf community was similar. One of her projects included developing and facilitating a parent support group for new parents. It provided parents and caregivers with education and strategies to self-manage at home when their children were unwell. She stated that often, these strategies focused on “little things”, for example, managing sleep or separation issues:

But basically, I think one of the big messages comes from the actual doing and observing and just being part of the mood and watching their children. (Participant 4, ANS)

Most of her referrals (not linked to an anthroposophic group) came from midwives within the community. Whānau Āwhina Plunket (a national support service for children under 5 years old and their families) only referred parents “because they didn’t quite fit. So, they were looking for something more...”

For Participant 1, using “simple terms” when explaining the purpose and interventions of anthroposophic nursing therapies signalled her perception that anthroposophic terminology might be challenging to understand and impact the relationship with the

recipient of her care. Other participants also voiced this in relation to their engagements with the public and when this topic arose in conversations with other nurses and allied health professionals in mainstream services.

Participants felt a sense of belonging when connected to those “channels of anthroposophic movement” within the community (Participant 9, AN), and they appreciated professional collaboration as “a gift” (Participant 7, ANS) or “a blessing” (Participant 6, ANS). The participants (Participant 7, ANS, and others) greatly benefited from interprofessional collaboration, which provided both professional and personal support. Despite fostering peer connections and sharing anthroposophic professional spaces in PHC clinics, long-term differences continue to impact nurses, whether they are self-employed as ANs/ANSs or working for healthcare services unfamiliar with anthroposophic nursing as an integrative practice. “It took me many years to be comfortable with and find my place within that practice” (Participant 7, ANS).

Two participating nurses stated that teaching and passing on knowledge either for the Anthroposophic Nursing-pathway or by presenting workshops in the community had increased their knowledge and confidence when engaging with other health providers and professionals unfamiliar with anthroposophic healthcare (Participants 3 & 4, both ANSs).

In addition, Participant 7 (ANS) added that when working with health professionals unfamiliar with anthroposophic medicine as a whole-person integrative approach extended with spiritual science, she noticed herself being more cautious and self-aware in her professional responses. Her comments related to reactions from (conventional/mainstream) nursing colleagues when she used specific anthroposophic terminology in clinical conversations. Participant 7 suspected these responses were reflections of challenged conventional beliefs and mainstream processes. Participant 6 (ANS) deliberately avoided anthroposophic jargon while working with parents in community settings after she noticed this was unhelpful.

According to the participants, working together with other anthroposophically trained professionals or services (Waldorf schools) offered the ideal working environment that

enabled the integration of the anthroposophic paradigm. However, Participant 7 (ANS) emphasised that the opportunity to collaborate with anthroposophic therapists or health professionals was not guaranteed.

Participants in the study (Participant 6, ANS and others) expressed that working with anthroposophically trained health professionals and healthcare providers open to approaches other than the conventional/mainstream was a “sustaining factor”. Collaboration and collegiality among the anthroposophic nursing group, which are nurtured by annual meetings at nursing and other anthroposophic conferences, were valued by Participant 2 (ANS) as opportunities to “share common ground” and build and sustain the professional nursing community.

Participant 2 (ANS) also mentioned that national professional collaboration among anthroposophic nurses extends to and is influenced by international relationships. The curriculum for the anthroposophic nursing pathway taught at Taruna College follows the guidelines of the International Forum of Anthroposophic Nursing (IFAN, 2014, 2022) at the Medical Section of the School of Spiritual Science at the Goetheanum in Dornach, Switzerland (n.d.) and the WHO (2023). Therefore, maintaining, nurturing and building on these international relationships creates reassurance for practising ANs/ANSs. Various opportunities to connect with the international group of ANs/ANSs by, for example, attending online workshops and participating in peer learning with the North American Anthroposophic Nurses Association (NAANA) have increased since COVID-19 lockdowns.

Despite this, it remains challenging to foster these connections after completing the anthroposophic nursing qualification. Another challenge is the lack of exposure to the uses of external anthroposophic nursing therapies (Section 2.6) when working in conventional/mainstream services, especially in rural and more remote areas (Participant 10, AN). Participant 10 noted that the limited availability of health services in rural regions in Aotearoa New Zealand, further impacted the accessibility of anthroposophic nursing care for patients unless ANs/ANSs were operating independently. The limited number of anthroposophically trained GPs in Aotearoa New Zealand is an additional factor linked to this.

In contrast to the professional relationships with conventional/mainstream services, the participants spoke of the meaningfulness of collaboration within the group of anthroposophic nurses in Aotearoa New Zealand, which was articulated as a sense of belonging, especially when jointly held anthroposophic terminology and practices (for example, case studies and plant observations) were shared.

5.5 Theme 2: Expressions of Anthroposophic Nursing Practice

The findings under Theme 2 pertain to nursing care and how nurses express care that is grounded in the anthroposophic paradigm. The first subtheme divides the data into those nursing actions/interventions/gestures that are visible, measurable, and tangible by the observer and those that are intangible/invisible and, hence, difficult to measure. Subtheme 2: dimensions of clinical practice presents data relating to clinical encounters with patients. Both subthemes aim to elucidate nursing actions, gestures, and care informed by anthroposophic concepts but also to explore and expose potential enablers and barriers in the clinical context.

5.5.1 Subtheme 1: Invisible and Visible Nursing Presence

This first subtheme illustrates attitudes, actions, and facets of nursing presence described by the participants as different from conventional/mainstream nursing. The invisible facets capture tacit nursing values and experiential knowledge which are then further explored via participant comments.

Participant 4 (ANS) described her role as a nurse as a fundamental element in the triangle: substance – patient – nurse. Her knowledge of a particular substance, combined with her nursing assessment based on the anthroposophic four-fold nature of the human being (Bay, 2020; Section 2.2), is at the core of decision-making.

Being in the nurse's role when meeting patients in therapeutic settings was expressed as meaningful but not accidental:

And it's fundamental to this understanding that everything's connected and that there's a reason, there's a responsibility in the moment for why it's me and that...and that nothing's by

accident...and it sort of challenges a little bit more responsibility, I think.
(Participant 3, ANS)

These inner, invisible (intangible) attitudes to the role of the nurse were evident in other comments as well. Participant 2 (ANS) voiced that her beliefs around illness enabled her to comprehend the relevance of a patient's biography to their health journey and sustained her work when caring for people with chronic conditions. She further explained that knowledge of a person's journey is one element of their broader social context and cannot be isolated. "...the whole home care work is part of a culture rather than me as the individual nurse doing the therapies" (Participant 2, ANS).

Furthermore, the inner attitudes and invisible and intangible values the nurse brings to the role were seen as core elements infused with spirituality:

I think it's that inner spiritual orientation, which I'd carry with me, you know, being part of the influence of [Archangel] Michael in our time and what that asks of us. And that sort of consciousness would be that I would take elsewhere. And, of course, that plays into how I am as a nurse as well.
(Participant 2, ANS)

After learning about anthroposophy, participants found that they became more conscious of how their inner human conceptions and attitudes were imprinted, resulting in a more transparent and impactful nursing practice and affecting their self-development. For example, Participant 5 noted that:

I am a therapeutic tool. And so that's the first thing, that is how I am with the patient, and then I have to really, you know, stop and concentrate and be with that person and really hear what they're saying. And so, all those things that I knew, this is a good way to relate to people. But I really learnt them over years of studying anthroposophy...if I didn't have any external oils or compress or something that I can still be...therapeutic and myself.
(Participant 5, ANS)

Participant 10 (AN) expressed her struggle to align invisible knowledge (her anthroposophic understanding of the three-fold body and the biography of a person) to various nursing actions/interventions (physical therapies, for example, footbaths "to

awaken the will forces”), highlighting the tension between holding anthroposophic knowledge and practicing in mainstream services.

Additionally, participants’ comments underscored the importance of the earlier mentioned inner attitude towards nursing care, with various statements reflecting on their role as nurses:

What I am working with is not simply to suppress something and make it go away, but if you can give warmth or rub something with some oil or give a nice herb tea or get someone to sit and keep company...
(Participant 2, ANS)

Participant 7 (ANS) explained that she noticed increased awareness and sensory alertness when responding to a request for anthroposophic nursing therapies, saying: “...so I think it’s to do with those qualities of hearing, listening, receiving, seeing the other...the sort of quality of exchange of dialogue between one human being and another...” (Participant 7, ANS).

An interesting aspect of social practices was that they did not have to be linked to verbal or nonverbal communication and could just involve body-oriented elements. In addition to this, Participant 7 (ANS) described a sensing that occurs between the thinking and soul faculties. Education for ANs/ANSs includes activities related to the 12 senses (Steiner, 1916a), which are part of their observational skill set (Layer, 2020). Participant 3 (ANS) emphasised the importance of listening as an activity coming from the heart.

Participant 2 (ANS) expressed the impact of touch alongside the facets above as a visible extension of these invisible gestures. Although communication has a physical quality for the patient, the “value of touch”, as she noted, is part of a more extensive process, including sensing a particular substance alongside touch and perceiving impulses or rhythms via the skin. All these participants’ accounts added substance and shape to the notion of the invisible foundations of AN/ANS practice while also indicating a level of satisfaction with the nursing role. Invisible nursing features represented a core element of therapeutic engagement.

Alongside these comments expanding on facets of invisible interactions, the use of anthroposophic terminology appeared on several occasions. Making hidden, invisible anthroposophic terms visible requires translation for nurses and patients unfamiliar with specific terms, such as the etheric body, polarities, or nursing gestures.

Participant 4 (ANS) described her journey to becoming a registered nurse in juxtaposition to that of an anthroposophic nurse:

...primarily [it's] an outward expression of a learning process which you have your own inner and private engagement with. Whereas in anthroposophic nursing, the outer journey of the capacity of becoming a competent AN is part of a journey which actively acknowledges the nurse's inner path and inner journey...(Participant 4, ANS)

Although this quote focuses on being a nurse rather than the practice of nursing, it highlights the importance of invisible but influencing factors in the anthroposophic nursing paradigm.

The concept of dialogue was implicit in comments capturing invisible presence. Movement from the spoken word as the communication tool to the pathway of sensory perception as a nonverbal exchange between the nurse and the recipient of care was noted. Participants' accounts validated this exchange by contrasting functional touch with a task-oriented approach to therapeutic touch which adds sensory and meaningful attention to nursing care. Participant 7 saw:

...the nursing therapies provide a way of walking alongside somebody through a therapeutic touch process and using therapeutic substances to help keep things moving. (Participant 7, ANS)

Participant 4 (ANS) elaborated on the nursing presence during a therapeutic encounter as "offering an impetus to another human being in need". She further elaborated that her knowledge of what the "archetype of nursing" means to her in connection to the human being she is caring for AND the use of a substance in anthroposophic nursing therapy are closely connected. The term substance was also assigned to the "spiritual integrity" (Participant 4, ANS) that the nurse needs to bring to the therapeutic

encounter to facilitate transformation for the patient (the words “cure” and “healing” were not used in this context).

The invisible facets of anthroposophic nursing related to the values and expressions of therapeutic presence were associated and linked to the inner development of the nurse (the spiritual presence or the inner attitude of the nurse). They also included the subtle characteristics of the paradigmatic foundations of anthroposophic anthropology, which aim to capture the varying levels of human existence.

The visible facets of anthroposophic nursing practice described here include all those actions and interactions participants observed and the feedback received from, for example, patients, whānau, and nonanthroposophic nursing colleagues. Furthermore, this section extends to nursing interventions that are part of anthroposophic nursing therapies (for example, external applications such as compresses, poultices, wraps, rhythmical applications of oil, and hydrotherapy) and are visible by nature. Chapter 2 (Section 2.6) provides short descriptions and explanations of these therapeutic nursing applications. The participants working with the external anthroposophic nursing therapies perceived the substances used for these applications as connecting points between nursing and the natural world.

The following examples revolve around participants’ accounts of patient responses. For instance, Participant 10 (AN) recalled a woman with a traumatic brain injury whom she had cared for during the rehabilitation stage and noticed a therapeutic effect after a series of rhythmic applications of oil. The patient had been experiencing anxiety and stated that she had “found it [the treatments] helpful” for her recovery.

Participant 7 (ANS) juxtaposed talking therapies with anthroposophic nursing therapies and considered these as an alternative option for patients to “digest” and use to work through their challenges:

...through working through the skin, with the different oils and something like the rhythmical body oiling and something as simple as a foot bath and creating a therapeutic space and environment for people...an experience of being nurtured, wrapped, a sense of who I am and where I am in the world.

(Participant 7, ANS)

Participants described therapeutic presence as interactions and actions, dialogue with the patient, and the nurse's capacity to be present in the moment. Those comments were captured alongside the physical (hands-on) gestures of wrapping the patient during and after therapeutic interventions. Several participants highlighted the value of warmth in all encounters as a core ingredient of anthroposophic nursing therapies (Participants 3 & 4, ANSs; Participant 11, AN).

Participant 2 (ANS) described how she focuses on the "very tangible basic sense of well-being" that includes, for instance, sleeping patterns and how robustly someone manages their illness.

Participant 11 (AN) stated that when patients present with sensory overload, using touch therapies efficiently triggers a balancing of symptoms. Most participants described positive responses to heart compresses and footbaths when patients were experiencing anxiety and restlessness. This was amplified by reports from two participants who detected the benefits of these therapies when supporting communities after the Christchurch earthquake in 2011.

As noted in other sections of this chapter, anthroposophic terminology frequently made it difficult to engage or explain the practice of anthroposophic nursing to colleagues unfamiliar with this paradigm. Consequently, if the terminology was not translated, it presented as a barrier or challenge. A dichotomy Participant 9 (AN) pointed to was linked to the use of language. However, she had discovered that anthroposophic language resonated with her views that "there is an actual language here for my beliefs like it was like I'd been given a language and I, I...had all the stuff in me that I didn't know...it could be formatted..." (Participant 9, AN).

For her, something once invisible or intangible had become visible and tangible in the way it was expressed through anthroposophic concepts and frameworks (paradigm and language). Participant 9 experienced such a strong sense of connection to anthroposophy that she felt "a door opened". For some participants, tacit knowledge was expressed in visible applications of the anthroposophic paradigm in how they acted and stood in their nursing roles. "... anthroposophy is actually optimising me in

the role of nurse...” (Participant 3, ANS). For others, it found expression via their interventions and actions when providing anthroposophic nursing therapies. “...and ultimately, you know, having a body oiling is being wrapped and rested and cared for” (Participant 2, ANS).

Participant 5 expressed her stance of “helping people to help themselves” as a way to instil self-efficacy in palliative care patients and their families/whānau. After conventional/mainstream options were exhausted, anthroposophic therapies could still be used. Among those visible interventions most frequently mentioned was using a footbath or heart cloth (Vademecum, n.d.-b) to support sleep and reduce anxiety.

5.5.2 Subtheme 2: Dimensions of Nursing Practice

One notion of difference several participants referred to was the use of the term “anthroposophic” to contrast anthroposophic with conventional/mainstream nursing practices. Two distinct views were expressed regarding this term. From the outside (etic) view looking in, for example, Participant 5 (ANS) stated that when she came in contact with anthroposophic nurses in her clinical area, she noticed that there was “something different about this group of people, ... something attractive”. Participant 5 had noticed this before commencing the anthroposophic nursing education programme, and it stimulated interest in this way of nursing since she also observed the effects of this difference in caring for patients:

And when I was on night shift, it was noticeable that she'd been on for the beautiful smell that was in the corridors and rooms. And the other thing was how patients were very settled and slept. (Participant 5, ANS).

The emic view was expressed in ways that centred around the anthropological foundations of anthroposophy as an extension to the biomedical scientific view of the human body/being. Within this, an emphasis was put on holistic expressions of practice observation and therapeutic engagement with the patient.

Some participants had opportunities to apply anthroposophic nursing therapies in their clinical practice area. This was different for ANs/ANSs working for anthroposophic health centres, GPs, or in private practice. The data in this section presents

experiences that participants encountered and were connected to in various clinical settings. Only a few of those interviewed were operating in private practice, sometimes alongside part-time work in conventional/mainstream settings. It was important to determine if experiential knowledge from both settings (conventional/mainstream and anthroposophic) influenced each other, if these experiences impacted future decision-making, and how participants articulated this influence. Most participants volunteered examples of practice and their impressions of patient responses when using anthroposophic therapies.

One participant described the way her patient responded to an anthroposophic nursing therapy sequence (Participant 11, AN). This example shows the participant's interpretation of the nursing interventions through an anthroposophic lens. Participant 11 discussed noticing an “awakening” in the patient in response to their current situation that occurred after the first therapy, which offered them a “new experience” (perspective). The second therapy, she explained, showed more “progressive relaxation” into the therapeutic process, and during the third session, she often noticed “a shift” happening for the patient. Participant 11 (AN) described the novel experience for most patients of being wrapped up and warmed through created sensations beyond their expectations for therapy. She articulated this as “meeting the patient”. As a nurse, she valued this sense of meeting versus overwhelming the patient —“I love that”. When Participant 11 outlined this situation, she also contrasted the role of nurses to those of medical practitioners, emphasising prescribing. She stated that nursing, in general, not only anthroposophic nursing, fosters therapeutic relationships. She went one step further by commenting that the warmth in the patient/nurse relationship itself facilitates the healing process. Participant 11 described the move from mainstream nursing to anthroposophic nursing as “a natural tilt” in her professional development towards holistic approaches.

When invited to present an example that, in her mind, reflected the integration and alignment of the anthroposophic paradigm with the mainstream, she offered the following:

...the mainstream recommendations and suggestions that are now given to people are...go along with the three-fold and four-fold...So, if we're looking at the polarities and the idea that you know, if you have a lot of stress say in your life, and it's not necessarily what you perceive to be stressful, that can be what your body perceives to be stress, then, first of all, there'll be a lot of inflammation, and then that inflammation can become hardening...so examples would be diabetes, hypertension, the impact of drinking a lot of alcohol is stressful for the body, and so, first of all, we get the inflammation, and then we get sclerosis. If it is stress indeed, then the rhythm is so important in this so you can physically deal with your rhythm in terms of your breathing. So, consciously controlling your breathing. So, I would use it, you know, but it's also quite mainstream now as well.

(Participant 11, AN)

Participant 11 continued by explaining that other lifestyle factors like nutrition and exercise contribute to maintaining healthy rhythms which support metabolic processes. When she noted the effect of working with “polarities”, she was referring to the intent to stimulate or rhythmically influence (synchronise) one aspect of the human being in response to one another. By strengthening the metabolic system, the sense system is positively affected. The “excessive heat” that emerges when the metabolic system is overstimulated increases inflammation, affecting, for example, cardiovascular function. Stimulating the rhythmic system can lead to a rebalancing of the three bodies (Section 2.3). “And so, you're just sounding as though you're giving them regular advice, but you are carrying the three-fold [body] within that” (Participant 11, AN).

Working in a residential community for people with lifelong disabilities made Participant 2 (ANS) value the salutogenic approach in anthroposophic nursing. Her work includes fostering and strengthening self-management and self-efficacy for those in her care. She discussed a resident with Downs Syndrome who had learnt to manage their lack of peripheral circulation by using rosemary footbaths. Participant 2 (ANS) stated that “...the home care work becomes part of the culture rather than me as the individual nurse doing the therapies” (Participant 2, ANS).

These findings illustrate a focus on supporting innate healing abilities and self-management by increasing health literacy for people with lifelong conditions. While

she may hold the knowledge of anthroposophic foundations, passing on this knowledge in the form of practical interventions that the residents can perform themselves is part of the health service culture. She has also supported people diagnosed with autism, oversensitivity to the external environment, and anxiety. Like Participant 11 (AN), Participant 2 (ANS) also applied the anthroposophic concept of polarities, working with, for example, ginger compresses over the kidney area to calm or rebalance the sensory perceptions.

Participant 4 (ANS) noted that the knowledge of the three- and four-fold body influenced her work, enabling her to “...not [look] at people’s singularity, you can look at them from all these different perspectives that enable you to see...” (Participant 4, ANS). She described using various frameworks and concepts based on anthroposophic anthropology as helpful tools when establishing nursing diagnoses and designing interventions. Her nursing assessments revolved around the 7-year biographical rhythms, the three- and four-fold understanding of the human being, and any imbalances or polarities in the patient’s presentation. She compared this way of observing to applying “a filter” to her assessment. Participant 4 also shared an example where she used an anthroposophic nursing therapy (in this case, a ginger compress) to treat hypertension. After a series of treatments, she would refer the patient back to their GP for a review of their antihypertensive medication. She felt disappointed when she did not receive a response to her referral.

Several participants reported “a shift” in their patients from the initial presentations, whether on an emotional or physical level and how frequently they achieved this not only with conventional nursing therapies but also by incorporating and referring to other anthroposophic therapies, for example, eurythmy and art therapies. Participant 4 articulated the value of interdisciplinary anthroposophic collaboration (for example, with an art therapist, eurythmist, teacher, or GP), noting:

...sometimes, you actually need to say, look, I think if you could see an anthroposophic doctor and get some specific medicines, we might find that everything is warm enough now, everything is fluid enough now that the medicine will work really effectively, and the next step would take place.

(Participant, 4, ANS)

Participant 9 (AN) experienced the benefits of using footbaths and ginger in therapeutic interventions for women with latent labour. Anthroposophic healthcare offered her an alternative way of supporting women in labour and helped her integrate her clinical assessments based on anthroposophic concepts with other possible interventions. She noticed that when women experienced fear during the birthing process, using a ginger compress helped, especially when she identified labour resistance. Participant 9 also found it helpful to consult with a more experienced anthroposophic nurse during this process of observing, assessing, diagnosing, and planning interventions.

Those participants working with people in palliative or end-of-life care noticed that although some individuals had declined medication and pharmaceutical drugs, the timing of exploration of other options was paramount. Often, participants working with people in palliative or end-of-life care noticed that delaying this step left people without choices, as the increasing pain and distress during the process of dying became unbearable.

Participant 1 (AN) was working for a specialist, and part of her role included patient education for prescription drugs. However, in agreement with the specialist, she could also offer a heart cloth if patients became anxious or stressed. For her, this small gesture (intervention) illustrated her ability to respond in a “truly” holistic way, and she noted that “she loves it” when patients request this. For this participant, being able to provide this therapeutic intervention triggered a response of professional fulfilment and satisfaction.

The therapies and work for anthroposophic nurses in the community and/or their own practices differ from those within the mainstream system. Participants 3 and 6 (both ANS) talked about their abilities to apply and use a broad range of interventions during one session. Sometimes, for example, patients arrived with precise prescriptions for nursing therapies from an anthroposophic physician, but often, they saw individuals

accessing their nursing services directly, or they worked alongside other anthroposophic services (for example, a Waldorf school or residential community).

Participant 3 offered the case example of a 50-year-old female from her practice as a self-employed ANS as evidence of the breadth of nursing observation, assessment, and care she provided. Before going into details about symptoms, Participant 3 explored the woman's situation and life circumstances. Her assessment included terminology that would be difficult to substantiate in nonanthroposophic clinical settings. Her assessment data included connecting the woman's symptoms and her own clinical nursing observations with her knowledge of the astral, etheric, and ego planes. For example, Participant 3 described a woman "in turmoil of not having digested" the stillbirth of her first child, which was affecting her current well-being. Her symptoms were an inability to sleep, being awake between 12 and 1 am every night, flight/fright responses, and exhaustion as she was caring for a second child with special needs and their younger sibling. Participant 3 pointed to her building of an internal picture of the woman's symptoms as an example of the nurse's essential role as a mediator or facilitator of meaning-making. Her approach reflected a sense-making of the woman's journey, empathy, and thoughts on how she could empower her. She offered this rationale while offering nursing therapies focused on boundaries and rhythmical touch so the woman could reconnect to a deeper consciousness:

And so, my impression was she was very depleted in her vital body or her life body, her capacity for any rejuvenation at night. And so, my picture for therapy was that actually, she needed to be breathing down into her body, you know, she was breathing quite rapidly, and my impression was that she almost was breathing herself out.

(Participant 3, ANS)

The therapy included rhythmical touch with solum oil (a peat-based therapeutic oil), which supports building a sheath and shelter from the outside world. Participant 3 also applied aurum/lavender/gold ointment to bring light and warmth to the heart force and a compress prepared with yarrow tea over the liver:

And so I did these three things and then wrapped her up and had her rest comfortably and warmly and came back about 20 minutes later.

And she had colour in her cheeks. She straight away said, "should I have some more of these?" And her breathing was deeper...And she was smiling in her conversation. Her conversation had no smiling beforehand. Just intensity. (Participant 3, ANS)

Theme 2 presented the participants' varied and complex experiences when working with anthroposophic concepts in clinical areas. The data focused on visible/tangible and invisible/intangible nursing interventions and underscored the subtle nature of care informed by spiritually extended anthroposophic concepts. Most participants articulated their interactions using characteristic anthroposophic terminology that would be unfamiliar to nurses and health professionals in nonanthroposophic settings. This theme provided insight into how ANs/ANSs work with natural substances and use and interpret assessment findings underpinned by the anthroposophic paradigm.

5.6 Theme 3: Negotiating place: Nursing from Anthroposophic Foundations in Aotearoa New Zealand

Once more, the findings reflect an etic perspective on the participants' perceptions of their nursing practice in their work environments. Participants' experiences of health structures and comments from their work environments, such as feedback and critiques, supplement this data set. Subtheme 1 captures participants' interpretations and experiences of working from anthroposophic foundations within the bicultural healthcare context of Aotearoa New Zealand. In this subtheme, I also capture feedback and comments participants received from patients, nursing colleagues, and other allied health professionals. Following this, Subtheme 2 examines encounters that brought attention to differences between the anthroposophic and conventional/mainstream paradigms, how individuals perceived these moments, and how they managed them.

5.6.1 Subtheme 1: Culture & Health—Bicultural Context

The first subtheme relates to the cultural context of health and discusses the unique relationship between the Crown and Tāngata Whenua in Aotearoa New Zealand, as manifested in the concept of bicultural relationships, nursing interactions, and the provision of culturally safe health services. The data demonstrated that ethical nursing practice hinges on the ongoing validation and demonstration of cultural safety through

the foundation of Kawa Whakaruruhau. Participant 3 (ANS) explained how the principles of Tiriti ō Waitangi underpin nursing practice, illustrating this through her experiences working in general practice and as an independent, self-employed ANS. Her testimony related to a hui (meeting, assembly; Mead, 2016) she attended and the reality of growing health inequities, as expressed by Tāngata Whenua. Participant 3 perceived the urgent need to listen to Indigenous concerns and to recognise the lack of “truly” holistic care in Western healthcare systems.

She argued that health professionals/services miss opportunities by not recognising the innate and extended connection to the universe present in Hauora Māori, while asserting that Indigenous models of health are much more capable of embracing the concept of holism. Additionally, she emphasised the need to hear what Māori colleagues are saying when they discuss ways to improve health services, as non-Māori could learn from this and engage in genuine partnership in planning for the future:

And what about the Europeans, why are they not listening? Where are they? And if we don't get this stuff, what the heck are we going to be doing in the future?...is this our peril that we don't start getting this thing?
(Participant 3, ANS)

Several participants discussed the value of Indigenous knowledge and its potential to inform better health service delivery. While one participant questioned why this “stream of knowledge is not utilised”, another commented that acknowledging the spiritual world and using whakawhanaungatanga (relationship/relationship building; Mead, 2016) to reach people in their care were essential entry points to a therapeutic relationship.

Two other participants further substantiated the meaning of whakawhanaungatanga when they noted that the significance of “being in relationship” with patients extended to the collaboration and partnership they experienced working with Tāngata Whenua.

Participant 4 (ANS) was part of an independent primary health clinic offering anthroposophic nursing therapies a few years ago. She shared the feedback she had received from Māori patients over that period:

Many [Māori patients] talked about being disillusioned with the allopathic healthcare system, and they were not able to be seen as their whole selves...or that they felt they were being perceived as a problem to be solved rather than a person on their own life journey.

(Participant 4, ANS)

She sensed that the therapeutic encounters with all patients, but especially with Māori, reflected an implicit understanding of shared holistic values. However, Participants 3 and 4 (ANSs) were both cautious about translating or transferring knowledge from one worldview to another and emphasised that this would be problematic and even reductionist. Nevertheless, both considered Te Tiriti ō Waitangi as a foundational document in the health environment in Aotearoa New Zealand. They recognised that Te Tiriti offered a unique opportunity for anthroposophic nursing, but they believed that more conversation and sharing of ideas were necessary to find common ground. Testimony from Participant 3, who connected with a Māori nursing colleague during a workshop on anthroposophic nursing, consolidated these experiences. Participant 3 reported that the Māori nurse interpreted her understanding of Te Ao Māori alongside anthroposophy, and Participant 3 experienced this dialogue as a careful layering and bridging of both worldviews. She noted it facilitated an "...understanding of the subtle connections with the universe...it is exciting and needs more conversation" (Participant 3, ANS).

Te Whare Tapa Whā (Durie, 1985, 1994) is perhaps the most well-known and widely applied Māori health model in Aotearoa New Zealand. Participant 7 (ANS) explained that despite anthroposophy originating in Europe, she felt a deep connection between the pillars of Te Whare Tapa Whā and the core elements of anthroposophic health concepts. She added that she considered both as assets to PHC service delivery. For Participant 10 (AN), knowing that she is working for a community with a population who are between 60% and 70% Māori motivated her to openly embrace spirituality and integrate spiritual values into her practice, and she feels comfortable doing this,

especially in her clinical practice in community mental health, where approaching nursing from the holistic anthroposophic worldview is valuable. She found that reassuring her clients that illness is a vital part of a life journey brings comfort and helps with personal growth.

Participant 3 (ANS) was critical of current mental health statistics and stated that these reflected an “impoverishment of the soul” and demonstrated our society’s focus on material wealth. She continued that the intense emphasis on materialistic approaches to healthcare delivery was a barrier to holistic worldviews. Both statements seem relevant considerations when working within the context of postcolonial health concerns and persistent health inequalities for the Indigenous population in Aotearoa New Zealand. These comments touched on the practical implications of the Te Tiriti o Waitangi partnership and a likening to the process of adoption of holistic health models. At this practical level, using native plant material involves much more than botanical knowledge. It requires awareness of and cultural sensitivity to Tikanga (Māori customary values and practices; “the Māori way of doing according to Māori custom”; Mead, 2016, p. 13) and narratives (case studies) of their applications. For example, Participant 1 (AN) recognised the meaning of whenua (earth, land, placenta; Mead, 2016) when working with a holistic impulse and the value of Indigenous plants as taonga (treasure, a highly prized object; Mead, 2016) became apparent when she referred to the necessity of collaboration with Māori colleagues before utilising “local” plant material for therapy.

While these testimonies illustrate the participants’ positioning as ANs/ANSs in relation to the nursing profession’s responsibilities to work with Te Tiriti, they also emphasise the need for caution to avoid a blurring of paradigmatic perspectives on the meaning of holism.

5.6.2 Subtheme 2: Challenges to Practice—When There is a Fit and When There is Not

For most participating nurses, their engagement with health services, their place of work, and wider communities that are not familiar with the anthroposophic approach

to health presented various challenges and questions about identity which had implications for professional practice. Despite these challenges, the participants actively and creatively embraced opportunities to work with anthroposophic nursing therapies. The varying geographical distances impacting peer exchanges and attending professional development opportunities to keep this specialised knowledge updated were normalised as part of the limited anthroposophic presence in the Southern Hemisphere.

Participant 3 (ANS) valued completing a master's degree and shared that postgraduate education complemented and aided in articulating the foundations of anthroposophic anthropology and the health paradigm. Most participants included reflections on the professional self, nursing identity, and positioning as ANs/ANSs in a healthcare system unfamiliar with anthroposophically oriented care. The data demonstrated a careful scoping of the environment and sensing where professional boundaries lie—is it safe, appropriate to the clinical context and helpful to the patient to declare allegiance with anthroposophic foundations? The comments relating to this positioning ranged from “finding the courage” to work with anthroposophic therapies to statements that anthroposophic nursing and medicines are whole-body, integrated approaches that extend conventional nursing skills but are not isolated or separate from professional nursing skills.

Challenges arose when participants noticed a clear divide in health beliefs, such as parents' decisions regarding childhood vaccinations and how anthroposophic medicine approaches and supports this step. Participant 7 (ANS) considered her responses carefully, but while she provided essential information, she also struggled to find common ground:

Probably the whole vaccination thing was one of the biggest, most challenging transitions for me. And it took me years to reconcile within myself the conflict that I felt and experienced. The sort of dichotomy you know...
(Participant 7, ANS)

Participant 6's (ANS) views added to this discussion, as most of her work as an ANS involved supporting parents in making decisions about vaccinations. She noticed in

conventional/mainstream and anthroposophic institutions that parents' uncertainty is frequently associated with a lack of health education and health literacy. Her work with parent groups focused primarily on how to support children's immunity from a holistic perspective, promoting healthy daily rhythms, for example, fostering the care of the senses (limiting sensory overload, supporting healthy sleeping patterns), and strengthening the body by introducing healthy eating and practices that support parents when caring for a child with a fever.

Participants 1 and 8 (both ANs) found opportunities to integrate some external anthroposophic nursing therapies. Participant 1's clinical area allowed the use of the heart cloth if a patient was anxious or unsettled. Participant 8 noticed that her knowledge of anthroposophic concepts strengthened her clinical observations and how, for example, a lack of warmth influences a patient's well-being in acute situations. For both nurses, these were minimal interventions which had to be negotiated and approved before being used within their practice area.

In contrast, Participant 9 (AN) was working in a part-time role as a community nurse and also as a craniosacral therapist in private practice. Extending her knowledge of anthroposophy and anthroposophic nursing has contributed valuable observational tools to her professional practice. After completing her education in anthroposophic nursing, she noticed that her confidence in working with craniosacral therapy increased. "So, I guess I had this latent thing that anthroposophy brought out...there was a breakthrough there" (Participant 9, AN).

Exploring anthroposophic nursing heightened her intuitive sensing and increased her trust in her capabilities in this area. Participant 9 combined sensing/perceiving, meaning making, and observation into one integrated assessment tool. This practice was also evident in other testimonies when participants made sense of practice observations not only in conventional clinical areas but in particular when working with external anthroposophic therapies. Participants frequently expressed their experiential knowledge using anthroposophic terminology.

In stark contrast to these accounts were Participant 11's experiences as an AN in a PHC practice. After sharing with the PHC team that she was enrolled in education to become an AN, she was met with what she called "derisive" comments from a medical professional in the clinical area. Her comments here related to one of these situations:

...it was from mainstream journals and talking about the effects of paracetamol and parental concerns, and the actual necessity of fever...it just ended up getting put back in my nurse's tray...I was gobsmacked.

(Participant 11, AN)

While she was hoping for some robust and open conversation amongst her peers, Participant 11 described her position from then on as challenging. She felt isolated and ostracised despite having offered evidence-based research on the use of Paracetamol® and Ibuprofen® as the first line of treatment for fever. The GP at the clinic perceived her questioning of current health practices as challenging their authority:

...you know, that's just his way. He likes to be the doctor with the knowledge, and anyone else that comes [with] anything else, he is threatened by that, that was the kind of environment I was working in.

(Participant 11, AN)

Participant 11 further explained that it had been reassuring to her in her AN practice that thoughts and suggestions Steiner made 100 years ago on the topic of fever have been now confirmed with current research. She was also amazed that some disputed this and dismissed it as insignificant. Most participants felt a sense of having to stand their ground as anthroposophic nurses when there were questions and interest in their roles as ANs/ANSs from within their conventional/mainstream clinical area. The responses from conventional health professionals and nursing colleagues ranged from curiosity to challenges, questions, and critiques of their nursing knowledge, values, and RN scope of practice.

Despite most participants acknowledging the lack of a distinct boundary between anthroposophic nursing and the conventional approach, some expressed opposing views. Participant 4 asserted that becoming more experienced as an ANS enabled her to overcome a "cold environment of care":

I think we provide interventions more than we can care. There's no capacity or time or resources or warmth, those things. Whereas I find as an anthroposophic nurse, the element to care is integral.

(Participant 4, ANS)

Participant 3 (ANS) was very open, commenting on the effect of institutional restraint and constraint. She went as far as to express that anthroposophic nursing is not widely known and, therefore, lacks support in the current Aotearoa New Zealand health system:

And again, it might need some courage... Yes, and we see that even if it's not about these sorts of conversations, it's about any sort of challenge to a status quo. You know, there are certain mechanisms to keep people quiet, that's for sure. And, you know, it's constantly a question for me every year when I do my practising certificate renewal. You know, I have to absolutely know I back myself with what I do and that I would justify everything I do to anyone. And for me, you know, if we talk about a code of conduct, you know, and the ethics around nursing. I believe it's a moral issue that if I have an understanding of something more than what, you know, a mainstream picture might be, then it's my moral duty to bring all that I can to this situation, and it would be neglect[full] and a wrong thing to not do all that I could to help.

(Participant 3, ANS)

The testimonies reflected increased confidence in anthroposophic nursing practice for those participants who had the opportunity to apply and work with the anthroposophic foundations in practice. Participant 3 reaffirmed anthroposophic nursing as a specialised area of advanced nursing practice, aligned with the RN scope, but not a replacement. The pathways to achieving professional recognition varied and depended on the openness of clinical areas to anthroposophic nursing.

When participants were respected and accepted, they integrated anthroposophical foundations into conventional health services, and the use of specific anthroposophic terminology increased, which illustrated trust and confidence. Participant 6's (ANS) experience spanned 20 years of anthroposophic nursing, much of this time in collaboration with an anthroposophic medical practitioner. Her words reflected her job satisfaction and her holistic lens that was evident in her language and interprofessional collaboration to achieve whole-person outcomes:

When he goes into the classroom with observations, and he can see your...he can actually give us...or get a bit of an insight into how that and where that child is in relation to their incarnation...into their process with their body. Where they might be a little bit stuck, where they need help and support. So, yeah, it's a very supportive role, and somehow, these nursing therapies can be magical. Really quite amazing. And then they move on, perhaps into eurythmy, where they can become more self-managing or take it another step. (Participant 6, ANS)

Most participants had had the opportunity to experience working with other anthroposophic professionals at some stage of their nursing career. These roles included, for example, working for an anthroposophic PHC clinic here in Aotearoa New Zealand and spending time overseas to gain work experience in one of the anthroposophic hospitals in Switzerland and Germany (see Chapter 1).

The findings show that once anthroposophic knowledge was acquired, nurses reported changes in their caring, professional, and personal identities. The cultural environments in which healthcare and nursing are delivered determine practice and guide the planning of care interventions. Care planning is driven by the patient/person, their family/whānau around them, and the factors that shape their beliefs, values, and standpoints.

Finally, a challenge reported by participants was the cost of therapies. Most of those who were self-employed highlighted the benefits of nursing therapies for the public; however, on the other side, the cost for patients was a significant barrier (Participant 4, ANS; Participant 10, AN). The data in this study also confirmed that anthroposophic healthcare is well-positioned in the PHC and community context (Participants 2, 3 & 4, all ANSs), but again, the lack of funding or creative fiscal schemes (as, for example, used by Waldorf schools) to ease access to anthroposophic nursing therapies was a significant barrier. (Participant 7, ANS; Participant 9, AN). One participant working with patients with long-term conditions summarised this by stating that “those who need them most cannot afford them” (Participant 1, AN).

While all participants advocated for care informed by anthroposophic foundations and illustrated the benefits for patients in different clinical areas, Key Theme 3 focused on

the challenges, barriers, and unique cultural characteristics of the position of ANs/ANSs in Aotearoa New Zealand. Overall, the testimonies showed that participants were well aware of the specialised nature of their practice and the possible barriers this may pose when employed by health services unfamiliar with anthroposophic medicine and care. Multiple participant accounts suggested adopting modified terminology to articulate anthroposophic foundations and interventions to avoid alienation and barriers.

5.7 Chapter Summary

After introducing the participants and presenting their motivations for exploring anthroposophic nursing, this chapter presented the study's findings using direct quotes to illustrate the development of themes and subthemes. Interpretative links bridged the participants' accounts within the subthemes to form a contextualised presentation of the overall meanings implicit in each key theme.

Theme 1, "our way of being," illustrated how participants perceived and articulated the anthroposophic nursing identity which guided their practice. Theme 2, expressions of anthroposophic nursing practice, investigated the participants' accounts associated with expressing anthroposophic nursing practice and how these characteristics manifest in both visible and invisible ways. Theme 3, negotiating place: nursing with anthroposophic foundations in Aotearoa New Zealand, offered insight into the participants' experiences as ANs/ANSs in the Aotearoa New Zealand health context. The subthemes provided additional information and highlighted the subtle differences between the themes.

What follows now is an in-depth discussion of the key themes and related subthemes. I use current literature to discern and compare novel and expanded findings to generate a more comprehensive response to my research question. After summarising the key findings of this study, the focus moves toward the future implications for contemporary nursing practice and recommendations for practice change and future studies.

Chapter 6 Discussion of Findings

When we study metamorphoses, we practice 'bringing to light' what is not immediately apparent to the senses. With 'bringing to light', we mean: 'making visible to our thinking.'

(van der Bie, 2003a, p.184)

6.1 Introduction

In this chapter, I discuss the way registered nurses in Aotearoa New Zealand, who have completed further education in anthroposophic nursing, apply this specialised knowledge in their clinical practice. The discussion highlights both the contributions and challenges of anthroposophic nursing within the broader healthcare system, providing insights into its current application and potential for future development.

This research examined how registered nurses incorporate anthroposophic frameworks and concepts into their clinical practice after completing additional education in anthroposophic nursing. Using an ID approach (Thorne, 2016) and Morse's (1994) cognitive processing framework for analysis, the findings illustrated that nurses embodied anthroposophic knowledge as a way of being. The findings captured three themes:

- "Our way of being"
- Expressions of anthroposophic nursing practice
- Negotiating place: nursing with anthroposophic foundations in Aotearoa New Zealand

Some of these expressions of nursing practice are more visible than others but contribute to the AN/ANS identity. How ANs/ANSs position their knowledge was expressed by negotiating place and demonstrated interplay between anthroposophic foundations and consideration for the specific bicultural context in Aotearoa New

Zealand. However, the findings also revealed the barriers faced in healthcare settings unfamiliar with anthroposophic integrated care.

6.2 Summary of Key Findings

This research aimed to gain insights into the practices of anthroposophic nurses in Aotearoa New Zealand. The central goal of this study was to investigate the way registered nurses inform their practice after completing further education in anthroposophic nursing. Due to the limited evidence of anthroposophic nursing practice in conventional healthcare services in Aotearoa New Zealand, it was imperative to explore the motivating factors that prompted registered nurses to embrace anthroposophic frameworks and concepts. The analysis exposed nurses' existential professional questioning at various times in their nursing career, voiced as "there must be more to nursing". A common theme was the search for a more holistic focus in their personal life that extended into the professional sphere. The diverse anthroposophic impulses were illustrated in searches for community connections such as involvement in Waldorf Kindergartens/Schools or other anthroposophic social collectives (for example, reading groups, horticulture, curative education) alongside an interest in further education in anthroposophically oriented nursing. These drivers align with evidence in the literature on CAM and nursing which highlights job dissatisfaction, a shift towards prioritising technological advancements over nursing care, and patients requesting better, more inclusive (holistic) care (Kramlich, 2016; Kristiniak, 2011; Shorofi & Arbon, 2017). Ning (2018) has questioned the binary positioning between CAM and biomedicine, suggesting that the emphasis on self-responsibility in neoliberal health policies has shifted the choice of holistic (complementary) care back to the health service consumer. Nonetheless, this shift does not alter the positions nurses find themselves in when approached for advice or support that diverges from the biomedical focus (Te Huia & Mercer, 2019). Nurses continue to play valuable roles in linking individuals and their families to health services, advocating for patients within the community, providing health education, and fostering intersectoral collaboration.

Through a rigorous process of analysis, I have discerned three key themes. These three key themes are further influenced by two fundamental dynamics, which stimulate an initial shift and a subsequent progressive influence on nurses practising within the anthroposophic paradigm.

Theme 1, “Our way of being,” illustrates how the role of being and becoming an anthroposophically educated registered nurse or anthroposophic nurse specialist was experienced and perceived within the cultural and sociopolitical context of Aotearoa New Zealand. One of the main features was the perceived notion of “difference” in ANs’/ANSs’ nursing care and the way awareness of this influences nursing identity. The study findings indicate that the key attribute distinguishing anthroposophic nursing from conventional nursing is perceived as a thorough (embodied) understanding and application of anthroposophic concepts and principles. Another important discovery under this theme was the intertwining of personal (inner) and professional development, as well as the challenges faced by ANs/ANSs when their practice was questioned.

Theme 2 focuses on the expressions of anthroposophic nursing practice and how values based on spiritually extended care (anthroposophic nursing care) lead to the core characteristic of “true” holistic care. Nursing identity expanded with anthroposophic values inclusive of universal connectivity manifests in how practice experiences are articulated. Some of these are visible actions, while others allude to the inner (invisible) attitude of the AN/ANS. A crucial component of the nurse/patient interaction involves acknowledging a spiritual, self-reflective, and biographical journey. It is evident that anthroposophically trained registered nurses acknowledge and normalise a unique link between the physical and nonphysical worlds, and concrete examples from clinical practice corroborate this.

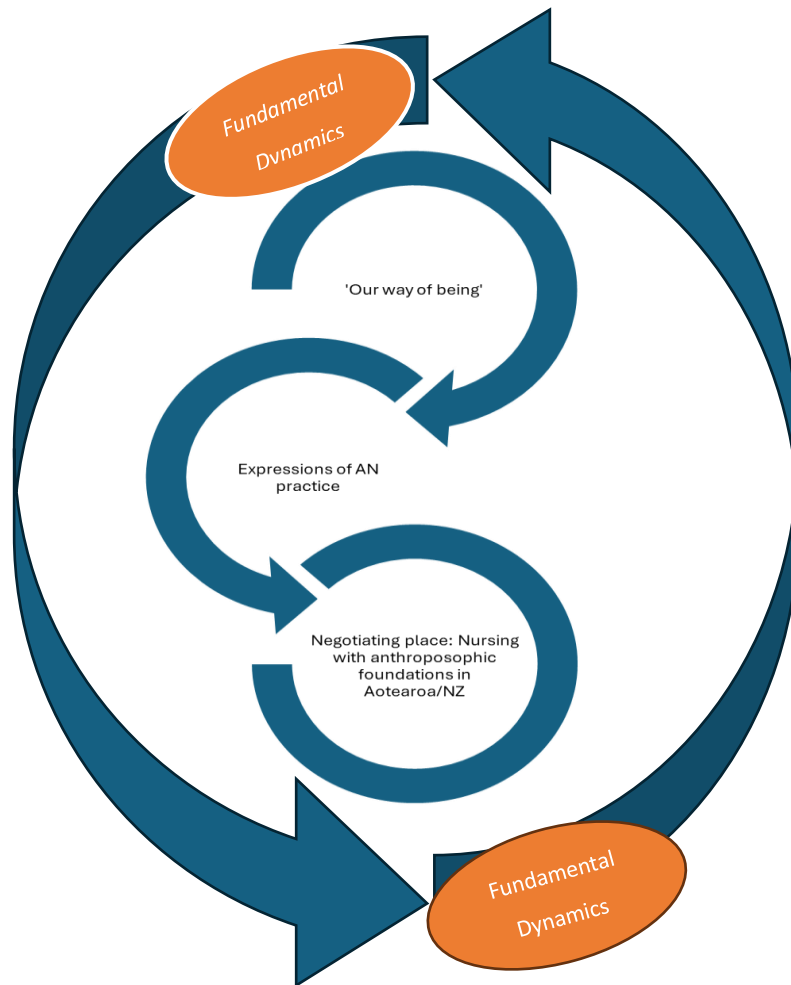
Theme 3 reveals the barriers to applying anthroposophic nursing knowledge and practice in healthcare settings unfamiliar with the anthroposophic model of integrated practice. The findings demonstrate that exploring anthroposophic practice and knowledge emphasises professional belonging and identity for these nurses despite their grounding in conventional nursing. A valuable finding in this context is that the

application of anthroposophic principles to practice is perceived as a responsive and complementary approach, able to sit alongside bicultural principles and fostering ethically responsive care underscored by culturally safe foundations.

Two fundamental dynamics weave through and underpin the three themes extracted from the data. The **first** involves a profound rethinking of existing knowledge of various elements encompassing human existence during health and ill health. Engaging with anthroposophy prompts a rethinking of the physiological and functional aspects as well as the psychosocial and spiritual elements observed throughout an individual's lifespan (Heusser, 2016). Through this deliberate process, ANs/ANSs embark on a journey that expands and transforms their understanding of nature and their interpretations of the universe. The **second** fundamental dynamic is the emphasis on human interaction in anthroposophic nursing. A profound part of the nurse's role, alongside various therapeutic interventions, is that of a mediator, bridge-builder, and essential therapeutic tool (Section 5.4.4) in supporting the patient through the journey of illness. In order to accomplish this, nurses are open to and dedicated to personal and professional growth and actively seek opportunities for self-exploration. Carrying this intent and fostering empathetic intentionality are the impulses that cultivate revitalised therapeutic connections between nurse and patient (Heine, 2020c; van Bentheim et al., 1987).

Figure 5

Two Fundamental Dynamics Underpinning 3 Themes



6.3 Recontextualising the Findings within Practice and Theory

This research focuses on the practice of anthroposophic nursing in Aotearoa New Zealand. Therefore, it is imperative to situate my research findings within the cultural context of Aotearoa New Zealand. Nurses who broaden their practice and knowledge by integrating health “novel” concepts which are unknown or outside conventional approaches may be met with curiosity, criticism, and scrutiny from their colleagues in their practice areas. One research aim has been to improve insights into anthroposophic nursing and its holistic and person-centred foundations to facilitate integration and disseminate knowledge about anthroposophically oriented care. Healthcare delivery and nursing practices in Aotearoa New Zealand are greatly influenced by unique sociocultural factors, particularly in meeting the healthcare

needs of the Indigenous population but also those of an increasingly ethnically diverse population. Aotearoa New Zealand's history as a nation with a relatively young healthcare system (NZ Parliament, 2007; Ministry for Culture and Heritage, 2024) marked by postcolonial consequences impacts any engagement by health professionals with the public. Therefore, collating empirical evidence of the role and nature of anthroposophic nursing practice relevant to Aotearoa New Zealand has been particularly crucial. The findings of this study will help improve understanding of this nursing practice, guide future research, and influence decision-making around holistic and person-centred nursing care. Furthermore, the lack of international research on anthroposophic nursing and its recognition within the conventional nursing profession disproportionately affects ANs/ANSs in countries with limited exposure to integrated anthroposophic medicine and care. According to Steiner (1922/1986), the integration of anthroposophic spiritual science with conventional medicine requires continuous development through empirical research. This responsibility for inquiry extends to all health professions, including nursing.

6.3.1 The Essence of Anthroposophic Nursing Practice

Becoming an anthroposophic nurse entails much more than completing additional education in external anthroposophic therapies (EATs); it becomes a way of being. Exploring nursing through the lens of the anthroposophic paradigm is a transformative journey that weaves together professional and personal life experiences. This study examines how anthroposophically educated registered nurses in Aotearoa New Zealand inform their practice using the anthroposophic paradigm. Previous studies that included nurse participants focused on the experiences of multidisciplinary healthcare teams working with anthroposophic medicine and therapies (Ben-Arye et al., 2018, 2021; Rutert et al., 2021; Tröndle et al., 2021), evaluated anthroposophic nursing therapies (Deckers et al., 2016; Therklason, 2009, 2010, 2012, 2014a, 2014b), captured nurses' perceptions while providing a specific therapeutic intervention (Ranheim et al., 2010), and the patients' experiences of the latter (Arman et al., 2008, 2011; von Schoen-Angerer et al., 2018). This study has been specifically interested in the responses of registered nurses who have completed a comprehensive foundation

course in anthroposophic nursing (IFAN, 2014; WHO, 2023) or advanced to become an ANS (IFAN, 2022) and explores the connections to this education that inform and influence their practice. Earlier research (Ben-Arye et al., 2018, 2021; Ranheim et al., 2010; Tröndle et al., 2021) suggested that after further training in selected EATs, health professionals, including nurses, noticed changes in their interactions with patients and the patients' families, their perceptions of the caring act, and in interprofessional communication; however, most studies provided limited insight into nurses' broader perspectives and how the anthroposophic nursing education pathway influenced their caring practices. This research focused entirely on ANs'/ANSs' nuanced perceptions of their nursing practice without distracting objectives, for example, including stakeholders' views on anthroposophic nursing or using a codesign approach, including other allied anthroposophic professionals. The research revealed the nurses' complex interpretations of holistic and integrated care and their familiarity with and embodied knowledge of the anthroposophic paradigm (See Sections 5.4.1, 5.4.2, & 5.5.2).

6.3.2 Nurses' Perceptions of "Holism" Grounded in Empirical Anthroposophic Foundations

Anthroposophic healthcare and medicine are built on the foundations of a multilayered perception of the human being illustrated through the theoretical concepts of the three- and four-fold perspectives (Bay, 2020; Heusser, 2016; Rohen, 2007; Steiner, 1919b; Therkluson, 2007). The findings of this study underscore their relevance for nurses and link these empirical foundations to whole-person practice (holism), a nondualistic worldview, and the view of a universal connection (spiritual world) beyond the human entity (see Section 5.4.1). Alongside this, this study found evidence highlighting the practical implications of the anthroposophic foundations for caring and caring culture, which also aligns with earlier research focused on patient experiences of anthroposophic care (Arman et al., 2008, 2011; Dahlberg et al., 2016; Therkluson, 2014a). Nevertheless, the findings here further emphasise the complex layers of what holistic care means to ANs/ANSs and simultaneously signal broader implications for the nursing profession as a whole. Although the term "holism" did not

appear frequently in the data, human physicality and its management within health was viewed as only one fragment of human existence (see Section 5.4.2). Interconnections between the feeling/soul and the spiritual/ego are not compartmentalised or separated during therapeutic encounters between ANs/ANSs and their patients (Arman et al., 2008, 2011, 2016; Dahlberg et al., 2016; Therkleson, 2014a) and this is evident in the theoretical and descriptive literature on anthroposophic nursing (Bay, 2020; Cooksley, 2021; Heine, 2018a, 2020c; Kramer et al., 2022; Lisenbee, 2022; Therkleson, 2005, 2006, 2007; Trevelyan, 1997; van Bentheim et al., 1987). Anthroposophic care has previously been characterised as “true holistic nursing care” (Therkleson, 2005, p. 43), which is a claim underscored by the holistic principles expressed in the perspective of human individuality as expanded by spiritual science, anthroposophic anthropology, and the three-fold concepts (Heusser, 2016; Bay, 2020; Therkleson, 2006, 2007). Additionally, knowledge and application of natural/therapeutic substances (plant, mineral, or animal) places the nurse within a therapeutic and symbiotic triad (see **Figure 6**; Sections 5.4.2 & 5.5.1). AN’s/ANS’s cognitive knowledge of spiritual anatomy, combined with conventional nursing assessment skills and phenomenological observations of the patient/substance affiliation, exemplifies a unique sphere of the nurse/patient relationship.

Holism is a contested and much-discussed concept in nursing (Erickson, 2007; Kim, 2006; Mariano, 2016; Michaelson et al., 2019; Montgomery Dossey, 2016). The call to revise and reconsider health models based on holistic considerations has led to improvements in care and values-based practices, which are, for example, evident in the development and research of the person-centred care framework (Dewing et al., 2021; McCormack & McCance, 2006). Historically, some have argued that nursing has advocated for holistic values since Nightingale (Mariano, 2016; Montgomery Dossey, 2016; Shealy, 1985; Thornton, 2019). However, nursing theories do not present and interpret the concepts of holism and holistic care in a unified manner (Kim, 2006). In the United States, the professional practice of holistic nurses is well-documented and researched (Lisenbee, 2022) and includes a separate set of nursing competencies. The American Holistic Nurses Association (AHNA) states that

Holistic nursing is not merely something we do. It is also an attitude, a philosophy, and a way of being that requires nurses to integrate self-care, self-responsibility, spirituality, and reflection in their lives. This often leads the nurse to greater awareness of the interconnectedness of self, others, nature, spirit, and relationship with the global community (AHNA, 2024, para. 2).

The notion of attitude, spirituality and reflection aligns with the terminology used in the anthroposophic nursing literature (Bay, 2020; Heine, 2020c; Therkleson, 2005) with the overarching difference that anthroposophy is a spiritual science (Geisteswissenschaft), implying an underscoring of the ontological and epistemological foundation for anthroposophic nursing practice. Conversely, it is not a novel finding that nurses experience a renewed awareness of self when opening to the possibility of spiritual connections and interconnective dialogue. It seems, however, that in conventional health environments, the terms “holistic care” and “holism” may also come with the assumption that a juxtapositioning has to occur rather than an integration or inclusion of holistic values within the scientific paradigm (Dahlberg et al., 2016; Ning, 2018). Furthermore, there is an adjunct debate on holistic care alongside person-centred concepts in healthcare (Foley & Steel, 2017). Lastly, more critical consideration is required as person-centred care, various holistic models, and care concepts are developed based on Western worldviews (Edgar et al., 2020) which may not align with the notion of holism as it is lived and understood by Indigenous populations.

Although the concept of holism appeared in the findings, it was apparent that it has broader connotations with biographical and socioecological implications for ANs/ANSs. The nurse’s inner attitude towards the individual in their care and biography and relationship to surrounding structures (ecology) were considered core diagnostic elements for planning nursing interventions. While anthroposophic anthropology forms the basis of decision-making for nursing therapies, the deliberate interaction between the nurse and the patient (and the patient’s surroundings) is an essential element. Holding and preparing space, especially when working with EATs, and awareness and perception of the individual receiving the nursing care are vital components encapsulated in the practice ethos of anthroposophic nursing (Cooksley,

2021; Heine, 2020c; Ozolins et al., 2015; Ranheim et al., 2010; Sustick, 2017; Therkleson, 2006; van Bentheim et al., 1987).

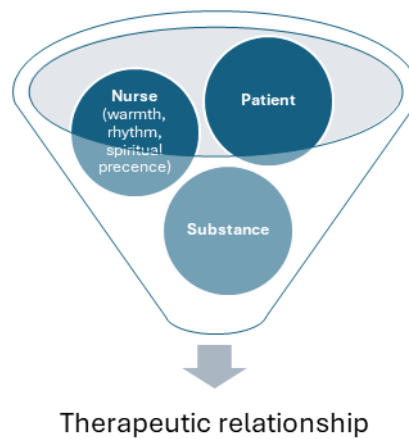
6.3.3 Therapeutic Triad: Nurses as Mediators

The findings confirm accounts from foundational anthroposophic nursing literature which describes nursing as moving between polarities, for example, as experienced and observed between distance and closeness, “nursing care happens in the polarity of uniformly rhythmic everyday life and extraordinary disturbances” (Heine, 2020c, p. 86). ANs/ANSs perceive themselves as a “therapeutic tool” (see Section 5.5.1), instrumental in bridging and negotiating between opposing or contrasting experiences for the patient. This finding aligns with earlier descriptions of anthroposophic nursing identity as “seeing [themselves] as therapeutic instruments” (van Bentheim et al., 1987, p. 18). Based on these insights, this research establishes a correlation between the spiritual integrity of the AN/ANS (see Section 5.4.1 & 5.4.2) and their role perception when shaping a therapeutic encounter. In addition, working with conscious, focused touch and warmth (as a physical and empathetic quality) and substance are essential elements that transfer the spiritual attitude of the nurse into gestures that form and inform practice interventions (see Section 5.5.1).

While holistic care can be symbolised and enacted through conscious caring and considered during multilayered interventions (physical, emotional, mental, and social factors), **Figure 6** presents a coexisting and existential notion of holistic care by ANs/ANSs experiencing themselves in a synergetic and mediating role.

Figure 6

Therapeutic Triad



The findings emphasise warmth as an existential and therapeutic medium (see Sections 5.5.2 & 5.6.2) as it significantly supports the “I” organisation in anthroposophic anthropology (see Section 2.2). These expressions of warmth align with literature sources compiled by anthroposophic nurses (Cooksley, 2021; Heine, 2020a; Therkleson, 2005; van der Star, 2020) and are evidence of the expanded notion of warmth as an existential human need expressed in the practice of EATs (Fingado, 2005, 2012; Heine, 2020a; Mühlenpfordt et al., 2022; Ozolins et al., 2015; Sustick, 2019). Meeting the human need for warmth is contextualised as a spiritual, caring provision (“I” organisation) as much as a physical one and has been observed to improve patient self-perception, especially in acute care (Section 5.6.2) and during times of emotional distress (Section 5.5.1).

ANs’/ANSs’ perceptions of these interconnected qualities are additionally expressed in the 12 Nursing Gestures model (Heine, 2008, 2020d), which further captures and frames practice interventions but was developed to define and name the often-invisible caring intentions (Chapter 1, Section 1.3.4).

6.3.4 The 12 Nursing Gestures as Interpretive Lenses of Practice

The influence of theoretical concepts on practice depends on nurses' objective assessments, perceptions, interpretations of observations, and execution of therapeutic interventions. Selected findings in this study illustrate the way the model of the 12 Nursing Gestures (Heine, 2008, 2020d) is applied to describe and articulate ANs'/ANSs' actions. In the findings, the language ANs/ANSs use acknowledges and reaffirms the value of the 12 Nursing Gestures model, asserting that the essence of a therapeutic relationship is the dialogue (not necessarily a verbal dialogue) or interplay between the nurse and the patient/recipient of care (see Sections 5.5.1, 5.5.2, 5.6.1, & 5.6.2). The exchange of experiences, observations and, consequently, nursing actions described in the study illustrate the spectrum of substituting and activating gestures outlined in the 12 Nursing Gestures model (also see Chapter 1, Section 1.3.4). While some of these actions are tangible and visible, they are also intertwined with the intangible values encapsulated and exemplified by these gestures.

Further to this, Heine (2008) described how "between action and attitude lies the gesture. The gesture is the middle" (p. 1). The movement from action to attitude might present as a moment in time or a sentient or intuitive observation, and a gesture develops and emerges from the dialogue between both stances (action and attitude). A gesture can capture complex observed and lived characteristics. A recently published case study (Riehm, 2022) affirms that nurses using the model can capture caring interventions marked by the respect, attentiveness, and attention experienced by the patient and their family. Riehm's case study (2022) reinforces the relevance of the model for the nurse when entering "into an inner discussion guided by the situation" (p. 12).

The findings in this study refer to all facets of the 12 Nursing Gestures (see examples in Error! Reference source not found.7) and contextualised AN/ANS in their practice a reas/encounters. Enveloping (as one of the substitutive gestures) was featured as an overarching gesture. The nursing interventions linked to this gesture included the provision of additional physical warmth, the provision of space for patient narratives during a mental health assessment, and honouring a person's biographic identity.

Enveloping in the spiritual sense was demonstrated when working in palliative and end-of-life care, and emphasised the creation of a peaceful environment for the patient to go inward and reflect.

Table 7

Selected Findings Linked to the 12 Nursing Gestures Model

Four-fold aspects	Data/narrative	Gestures	Interview references
Physical body	Preparing the therapeutic space	Enveloping, protecting, affirming	Participant 3, pp. 136—137 Participant 2, p. 127 Participant 7, pp. 129—130
Etheric/life body	Touch making the difference	Affirming, supporting uprightness	Participant 7, pp. 129—130 Participant 5, p. 131 Participant 11, pp. 132—133
Astral/emotional, soul body	Dedicated space and time, allowing the patient to express themselves	Supporting uprightness	Participant 4, pp. 118—119 Participant 8, pp. 120—121
I/Spiritual body	Acknowledging spiritual values	Affirming	Participant 10, p.120 Participant 7, p.129

6.4 Reframing Anthroposophic Language

The findings verified that the application of anthroposophic concepts and frameworks provided nurses with a language to express otherwise invisible values/actions in their caring, which was especially evident in the quote, “It was like I was given a language...to all that stuff I had in me that I didn’t know...it could be formatted” (see Section 5.5.1). Language as a tool of articulation shifted from interpretations of practice to spirituality integrated into elements of care (see Sections 5.4.1, 5.4.2 & 5.5.1). Characteristic anthroposophic terminology expresses a shared caring culture but also distinguishes it from conventional nursing terminology. ANs/ANSs are cognisant of this and, in some situations, are careful when sharing perspectives on healthcare that might not be understood (see Section 5.6.2; vaccination),

misperceived, or challenged (see Section 5.6.2). These findings are significant, as there is a lack of research specifically exploring anthroposophic nursing and its impact on caring within this context. Most research in AM or anthroposophic healthcare is conducted within anthroposophic clinics/hospitals or health services favourable toward integrative therapies like AM (see Chapter 3). The findings here reveal that using specific clinical terms linked to anthroposophic concepts and frameworks can lead to challenges, being “othered,” and alienation (see Section 5.6.2). It is vital for the legitimacy of anthroposophic nursing to maintain its characteristic discourse, and ANs/ANSs expressed this by noting that it takes moral integrity and courage to commit to this (see Section 5.6.2). Part of professional legitimacy is to establish concepts and foundational theories that validate a specific philosophical approach or a model of care. In order to gain recognition and improve integration into conventional health services, a level of anthroposophic health literacy amongst health professionals relating to the concepts and foundations of anthroposophic nursing would facilitate this.

Language in nursing can have powerful implications, and Watson’s (2008, pp. 24-25) term “ontological caring literacy” for the compendium of competencies emerging from her philosophical theories is evidence of this. She developed this repertoire of foundational guidelines for nurses to create links to clinical practice and generate a discourse that represented the three concepts of her caring philosophy: wholeness, consciousness, and caring (Watson, 2018).

The way ANs/ANSs articulate practice informed with anthroposophic thinking and knowledge is exposed in the language they use during therapeutic engagement with patients/individuals and families and when collaborating with nursing colleagues and allied health professionals. Holding (in one’s mind) the picture of the anthroposophic four-fold body when caring (see Section 5.4.3), nursing with the assurance that the spiritual world is an ally (see Section 5.4.3), and an inner connection with spiritual science (see Section 5.4.2) are existential ontological and epistemological expressions of anthroposophic nursing. Inner development is a core requisite of anthroposophic nursing education (Heine, 2020b, 2020c) and is an impactful element throughout the

AN/ANS professional journey (Cooksley, 2021). It extends reflective practice as a primarily cognitive but well-integrated tool in undergraduate nursing curricula and ongoing professional development (Patel & Metersky, 2022). The distinctive development of perception and observation and relationship building between the nurse and the recipient of care in anthroposophic nursing (Heine, 2020c) leads to ANs'/ANSs' expressions of "incorporating all our nonvisceral activity...offering an impetus to the person" that results in "therapeutic situation[s] and brings some transformation" (see Section 5.4.2). A distinct language develops when working with the anthroposophic paradigm that moves beyond the caring act that speaks of tasks and interventions or "purely utilitarian considerations" (Bay, 2020, p. 33), and this necessitates more context and explanation when used in conventional practice areas.

Furthermore, for ANs/ANSs, encounters with patients in clinical practice are "meaningful and not accidental" (see Section 5.5.1). These expressions of human relationships relate to nursing practice, underscored by the notion of a greater purpose at work (spiritual language) and purposeful engagement between nurse and patient. It accentuates the relevance and deeper meaning of an underlying caring culture informed by anthroposophic foundations.

6.4.1 Unseen Values of Nursing Practice

The findings expand on the meaning of "true" holistic care (Therkleson, 2005, p. 43) as demonstrated in a series of successive encounters. When first engaging in the nurse/patient relationship, this was expressed as meeting vs overwhelming (see Section 5.5.2) and progressed to the reassurance that "illness is an important part of someone's life journey" (see Sections 5.4.1, 5.5.1, & 5.6.1). Nuanced interpretations of what holistic care entails for ANs/ANSs extend unseen values in nursing care into practice guided by spiritual integrity (see Sections 5.4.2 & 5.5.1) and spiritual presence (see Sections 5.4.2 & 5.5.1). Similarly to the term holism, "spirituality" in nursing has various meanings and interpretations. While consistently recognised as a critical component of nursing (Martins & Caldeira, 2021; Murgia et al., 2020), especially in the literature on holistic nursing care and as part of the scope of holistic nurses (Burkhardt & Nagai-Jacobson, 2016), there is still confusion between religion and spirituality

(Cooper et al., 2020) with both terms often used interchangeably, especially in nursing (Murgia et al., 2020). In practice, this can lead to the avoidance of aspects of care related to a person's spiritual well-being (Egan et al., 2017). From an anthroposophic perspective, ANs'/ANSs' spiritual paths and professional identities are closely linked and represent a therapeutic triad as the interactions, clinical interventions, and therapeutic encounters are framed and articulated through the 12 Nursing Gestures model. While nurses in conventional settings are cognisant of spirituality, multiple factors have been shown to influence this: education about spirituality and the experience and age of the nurse, as well as the nurse's spiritual or religious beliefs (Cooper et al., 2020, p. 119). The findings confirmed that advanced education in anthroposophic nursing presents a shift for nurses, affecting their personal self-awareness and professional attitude.

Anthroposophic nursing values, whether manifesting in seen or unseen caring actions, are rooted in anthroposophic foundations and vital in articulating practice. A well-known challenge is the evaluation of nursing care beyond the apparent and visible as reflected in tasks, clinical skills, and hands-on actions (Welton & Harper, 2016). Safe nursing skills play a crucial role in demonstrating the effectiveness of nursing interventions. However, if the focus is on a purely materialistic approach, often expressed through quantitative (numeric) measures without further validation of influencing parameters, nursing care may become reductive and inadequate, lacking holistic foundations (Kramer et al., 2022; Welton & Harper, 2016). Often, these invisible skills are based on careful observation on the part of the nurse, guided by relational and humanistic elements (Arman et al., 2008) and characterise a nurse's ability to be present during existential moments for the individual in their care. The values encapsulated in nursing care are frequently unappreciated and ignored in conventional nursing practice, as these are challenging to evaluate using standard measures (Wyatt, 2020). Therefore, measures of caring gestures and expressions influenced and marked by practice articulations extended with spiritual intentions might be even more complex to define (Kramer et al., 2022).

Although the current undergraduate nursing curriculum includes education in observation skills, simulated practice using all senses during nursing assessments, and the relevance and necessity of applying holistic nursing models and emphasises self-reflective practice, much of this becomes challenging when new graduates encounter the realities of nursing (Benner, 2001; Cooper & Ratnayake, 2023; Walton et al., 2018). Extending and enhancing skills that foster holistic caring values is crucial, as nurses play a vital role in mediating between the patient and their surroundings.

The research findings imply that when there is a perceived “difference” in the language used for care and compassion, nursing colleagues and allied health professionals immediately question the knowledge of ANs/ANSs. Based on the participants’ responses, replacing anthroposophic terminology with more widely accepted health terms helped to reconcile the differences. The findings also suggest that some ANs/ANSs pursued postgraduate studies to extend their existing conventional nursing scope and noticed, in the process, an increased confidence in their anthroposophic nursing skills and recognition of their professional voice among peers (see Section 5.6.2).

Historically, nursing has struggled to substantiate its validity among the health professions. Thorne (2016, p. 28) asserted that nursing is “a complex and messy discipline” that has and will have to continue to assert its stance in society, politics, and gender-related discourses. The development of various nursing theories has contributed to nursing’s far more robust professional and academic standing and its emancipation in the 20th and 21st centuries (Mudd et al., 2020). However, the need for additional empirical research to validate the findings of this study and achieve a deeper understanding of how holistic nursing practice is perceived, communicated, and embraced by ANs/ANSs in health structures that lack knowledge of the anthroposophic paradigm is needed. The recent development of international benchmarks for various foundational and advanced anthroposophic nursing pathways will contribute to the visibility and accessibility of anthroposophic nursing education worldwide (WHO, 2023).

6.4.2 Salutogenesis: Symbiosis of Illness and Biography

Nurses who work with anthroposophic principles consider illness to be part of an individual's life journey and embrace a salutogenic approach to health. The data includes accounts of practice experiences interwoven with comments on working with illness in a purposeful and meaningful way as part of biography rather than working against it (see Section 5.4.1). The view ANs/ANSs hold of illness as a milestone (Section 5.4.1) also enables the comprehension and contextualisation of an individual's journey through long-term illness within the broader social context (Sections 5.5.1 & 5.5.2). The findings indicate that acknowledging the importance of the patients' experiences during illness, specifically in end-of-life care and mental health settings, leads to a renewed understanding of holistic well-being and spirituality in their life journey (see Sections 5.4.4, 5.5.1, 5.5.2 & 5.6.1). It is important to note that a salutogenic versus a pathogenic approach is not only a theoretical concept (IFAN, 2022, pp. 3-7; also see Chapters 1 & 2), but is actively incorporated into the practical interventions of anthroposophic nursing therapies (see Section 5.5.2, "sense-making of the woman's journey"; Hasselberg & Heine, 2020; Schier, 2020; Trevelyan, 1997)

The findings demonstrate that there is merit in raising health professionals' understanding of the way illness, especially chronic conditions, may impact self/identity and other health-related outcomes (Shneider et al., 2024). The premise is that each human being is unique (Trevelyan, 1997) and, therefore, nursing care must be aligned with the individual's biographical journey. In addition, achieving health restoration necessitates a broader perspective beyond the scientific aspect. Additionally, Trevelyan (1997) pointed out that losing a sense of purpose in life could potentially result in health problems and suggested that "illness may provide a platform for change to recalibrate the old lifepath with newfound life" (p. 152). Health professionals unfamiliar with anthroposophy might argue that this is a challenging and unusual proposition, especially when working with individuals experiencing a life-limiting and long-term illness or condition. Conventional/mainstream models of care focus on treatment initially, resolving symptoms and, ultimately, cure; however, simultaneously, the adoption of person-centred (McCormack, 2020; McCormack &

McCane, 2006) versus disease-centred models (Cleary & Hungerford, 2018) has changed conventional interventions for long-term and chronic condition care management. While this focus on autonomy and personhood alongside the ecological circumstances of individuals, which include social, cultural, and hereditary factors, has become more accepted in conventional healthcare settings, implementing a consistent approach within mainstream health systems remains challenging. Advocacy, particularly existential advocacy, is necessary for nurses to offer support that aligns with the patient's holistic health needs and values (Grant & Reed, 2024). The lack of commitment to holistic and integrated therapeutic interventions within health structures and fragmented service delivery are significant barriers to providing effective and consistent chronic care (Barreira et al., 2023). Patient advocacy occurs at the staff level, with nurses in a favourable position to navigate and influence healthcare structures (Askerud & Conder, 2016).

ANs/ANSs perceive their caring interventions as all-encompassing, unique opportunities to support patients on their illness journey and stimulate innate healing capacity. The alignment and relationship between biography and illness are unique to anthroposophic healthcare, and the nurse's motivation to reflect on the patient's biographic journey creates empathy towards the patient in their quest for autonomy and meaning making. Work with illness as part of biography (Evans & Rodger, 2017; Glöckler, 2020; Hasselberg & Heine, 2020; Heusser, 2016) is grounded in the spiritual elements of anthroposophy, and contrasts with the expression of "fighting it" or using imagery, for example, as some holistic nursing theories propose (Gulino Schaub & McInnis Burt, 2016). ANs/ANSs are therapeutic mediators and facilitators of a healing and caring impulse (Schier, 2020) which is intentionally nourished by the inner attitude nurses bring to their role (Heine, 2020d). The data showed a shift in the nurses' thinking about practice interventions from managing symptoms primarily to helping patients find equilibrium (see Sections 5.4.1 & 5.4.3). Active, physical nursing interventions (EATs, see Chapter 2) are underscored and supported by intentional attitude, which aligns with previous research (Dahlberg et al., 2016; Ozolins et al., 2015; Ranheim et al., 2010). The focus on the patient's innate healing capacity is part of the anthroposophic nursing culture (Baars et al., 2017) and resonates with the sense

of coherence (SoC) of the salutogenic model. The three components of the SoC, comprehensibility, manageability, and meaningfulness, offer a perspective on health and disease that is individually orientated but simultaneously inclusive of the person's biographical journey, including their family heritage, social connections, and spiritual essence. The practice focus is person-centred; however, by granting the patient (whole being) the freedom, space, and time to respond to the interventions, a conscious shift to an autonomous and empowered patient-led healing journey is created. Moving away from the pathological view that illness is something to remove or fight against, the salutogenic perspective extends into the psychosocial sphere of human resilience (Glöckler, 2020).

6.5 Fundamental Dynamics

The previous sections presented interpretations of both fundamental dynamics of AN practice, as illustrated in **Figure 5**. Spirituality, as a nourishing stream with changing dynamics for caring, is first explored and reflected upon during foundational education in anthroposophic nursing (see Sections 1.3.2 & 5.5.1) and continues to inform practice interventions and caring presence. It is an openly explored key element of anthroposophic nursing education which leads to a profound shift in the approach to practice and an experiential expansion of existing knowledge of anthroposophic foundations.

Paradigmatic nuances of conventional and anthroposophic nursing are intertwined for ANs/ANSs in practice and only become part of the professional discourse when "difference" is spotted by nursing peers or allied professionals unfamiliar with the application of anthroposophical concepts in health. Existential shifts in self-exploration, self-knowledge, and spirituality influence nursing practice and become vital components of therapeutic relationships.

6.5.1 Embodied Practice

A notable finding was that nurses incorporate anthroposophic conceptual frameworks (Chapters 1 & 2) into embodied responses (Section 5.5.1) that inform ANs'/ANSs' decision-making. Case observations and examples from practice solidified these

findings. Although the three- and four-fold representation of human individuality is a pictorial and linear depiction, these are impressions of human existence that become lived experiences for anthroposophic nurses through embodied practice experiences. Examples in the data include “taking yourself on in this journey...and become more of your authentic self; therefore, you’re more available to the other person” (see Section 5.4.3), “carrying inner spiritual orientation consciously” (see Section 5.4.2), and “what’s growing in the process of our time together [patient/person and nurse]...what grows and changes...” (see Section 5.4.4). Essentially, the intentional carrying of the three- and four-fold perception of the human being as a lived and embodied image inspires ANs/ANSs practice.

Embodied practice and experiences are not novel findings in the nursing literature. Draper’s discussion (2014) draws on the epistemological knowledge of embodiment. Her main argument is that nursing needs to reorientate its stance on embodiment— from the perspectives of both nurses and patients— by considering the implications of embodiment in teaching, the lived nursing experience, and future research. Despite ongoing research exploring the relevance of embodiment in nursing (Maykut & Wild, 2019) and allied health professions (Jackson, 2023), it does not appear easy to translate into day-to-day nursing practice. Goethean science proposes that the nurse “explores the phenomenon of the patient with the patient” (Mason, 2014, p. 55), rather than the nurse applying holistic care (models) when entering a therapeutic relationship, as the patient encounters their own lived experiences which can create “dissonance” in a therapeutic relationship.

Embodied knowledge paired with clinical practice experiences becomes a merged picture of a developing anthroposophic nursing identity. Once nurses consciously engage with the anthroposophic paradigm, an inner shift occurs; consequently, this shapes and influences their nursing care. The data illustrated this when nurses stated, “I couldn’t go back—this makes sense—pieces of a puzzle coming together—I found something—I found anthroposophy”.

A lifelong journey on a continuum of being and becoming is part of the inner development that encultures a capacity for inner sensing, which anthroposophic

nurses describe as a conscious “inner knowing”. A prerequisite for this process is the openness to explore and delve into anthroposophy when applied to healthcare. Although anthroposophic nursing is characterised by its spiritual foundations (Bay, 2020; Hasselberg & Heine, 2020; Heine, 2020b; Steiner & Wegman, 1925/1983), mainstream nursing theorists (Benner, 2001; Hardin, 2018; Watson, 1988, 2018) have raised awareness around nursing traits that are quite similar to core elements of anthroposophic nursing practice (for example, empathy, relational practice—meeting the person rather than the patient, being present with the patient). Surprisingly, the terms “moral agency” and “comportment,” despite their connection to human values and virtues, are not often directly linked to the notion of spiritual self-awareness or nursing practice. In contrast, Maykut and Wild (2019) merged concepts of comportment (Roach, 2002/2012) and relational ethics (Berghum, 2002) via the process of entanglement to achieve what they called relational comportment (RC). The authors arrived at a definition that relates well to the findings of this study, namely, “relational comportment is the embodiment of a contemplative journey of being and becoming persons of care by the nurse” (Maykut & Wild, 2019, p. 295).

In this study, participants considered anthroposophy as an applied practice tool to nurture encounters with patients while simultaneously observing the person and the self. Embodied practice based on the anthroposophic paradigm versus the cognitive process of applying a specific holistic model presents a novel platform for a renewed perspective on nurse/patient relationships and meets the patient on their terms, ensuring patient autonomy and validating their experience of illness.

6.6 Implications for Practice in Aotearoa New Zealand

Any caring philosophy and practice applied in a local context has to adapt to the cultural, political, and social requirements of local healthcare provision. This research has explored how registered nurses with additional education in anthroposophic nursing apply this knowledge in their practice. Originally developed by Rudolf Steiner in Europe around a century ago (Martin, 2020), anthroposophic medicine and healthcare are grounded in universal theoretical foundations. However, the practice implications for healthcare professionals working within this integrative and spiritually

extended paradigm can vary significantly between countries. This is particularly true in Aotearoa New Zealand where health structures are still influenced by postcolonial impacts on the health of its Indigenous population.

Aotearoa New Zealand's constitutional past is unique in relation to its obligations to Tāngata Whenua, and all entities under the Crown (including health professionals) are responsible for considering Te Tiriti o Waitangi principles (NCNZ, 2023). Embracing the need to work with diverse values and health beliefs is a pertinent and core element of practising nursing in Aotearoa New Zealand (De Souza, 2015; NCNZ, 2016, 2024; NZNO, 2019; Richardson et al., 2009; Wepa, 2015).

6.6.1 Relevance of Holistic Care in Aotearoa New Zealand

The findings confirm that holistic care entails more than just the application of anthroposophic concepts and foundations; it represents a journey of self-development that emphasises spiritual self-awareness and spiritual integrity. For anthroposophic nurses, holistic care extends to considering an individual's life journey within a broader context encompassing social, cultural, and familial dimensions as well as the meaningfulness of connections between physical health, personal and family biography, life events, and spiritual values.

Spirituality stands out as the most characteristic and defining feature of anthroposophic nursing, connecting worldviews and values concerned with human existence beyond the measurable physical realm. While health professionals operating from a holistic perspective widely accept the existence of spiritual energy, this concept is still met with scepticism or outright denial in many Western societies (Erickson, 2007). When such perspectives on health emerge in practice settings, they are often disputed, relegated to the category of religion, or dismissed as complementary and alternative medicine (CAM) or pseudoscience.

In contrast, universal life forces and spirituality are undisputed core features of health and well-being in non-Western belief systems. This study raises critical questions about why conventional Western approaches to healthcare have largely disregarded or abandoned insights outside the Western worldview (section 5.6.1). Despite the proven

relevance of Indigenous health models, the ongoing neglect of the health beliefs and values of Tāngata Whenua underscores the importance of addressing gaps in holistic practice within Aotearoa New Zealand (Pihama et al., 2023; Reid et al., 2019). The integration of spiritual care into nursing with a focus on nurses' spiritual self-exploration, rather than compartmentalising the meaning and practice of spirituality, aligns with the values expressed in Indigenous health models and deserves better incorporation into mainstream practice (Cooper et al., 2020; McColgan, 2022).

Additionally, the study highlights the disparity between AM and conventional healthcare paradigms and the potential for nurses to foster collaboration between patients and various other healthcare providers, such as CAM practitioners (see Section 5.4.4). Recognising patients as “bridge builders” within the anthroposophic paradigm, especially when integrating anthroposophic interventions into conventional healthcare settings, has been found to positively influence the caring process (Arman et al., 2008, p. 364) and strengthen the practitioner-patient relationship (Ben-Arye et al., 2021).

6.6.2 Working with Tāngata Whenua

The research demonstrates that anthroposophic ideas and frameworks are expressed and situated alongside kawa whakaruruhau and Tāngata Tiriti responsibilities (see Section 5.6.1). It is not being suggested here that adopting an approach grounded in esoteric spiritual knowledge, which was initially developed in Europe, should supplant or interfere with the cultural traditions of Aotearoa New Zealand (see Section 5.6.1).

What the findings suggest, however, is that ANs/ANSs have noted a gap in the current interpretation and practical applications of holistic nursing care in conventional health structures in Aotearoa New Zealand. The data revealed various benefits in advancing conventional/mainstream nursing education through a pathway in anthroposophic nursing, and this is not limited to nursing in specific clinical areas. The focus on spiritually extended nursing care was reported as advantageous in therapeutic relationships but more so during observation, assessment, and the expansion of therapeutic practice interventions (EATs). Extended spiritual care, as it is offered in

anthroposophic nursing, has shown benefits for patients and caring staff from culturally diverse backgrounds (Ben-Arye et al., 2018); however, anthroposophic nursing remains underexplored in the context of Indigenous healthcare provision in Aotearoa New Zealand and internationally. The findings illustrate the participants' personal and professional immersion in spiritual values that foster spiritual and cultural openness and compassion, eliminating the cognitive compartmentalising of different interconnected aspects of health (physical, mental, emotional, spiritual, social, economic, and environmental). This lived spirituality moves away from the intellectual application of spiritual care models to become "care provided spiritually" (McColgan, 2022, p. 19). Understanding holism as the interconnectedness of all human layers and from the perspective of balance (equilibrium) rather than pathology aligns with the Te Ao Māori worldview (Pihama et al., 2023) in which separating physical well-being from emotional or spiritual well-being in healing approaches "contradicts the concept[s] of hauora and mauri ora" (Pihama et al., 2023, p. 36). The findings carefully articulate the affiliation of AM with Indigenous worldviews, Te Ao Māori; for example, both worldviews note subtle connections between human existence and the universe, and there are similarities between Te Whare Tapa Whā and anthroposophic anthropology (see Section 5.6.1).

Indigenous voices have long highlighted that an exclusive reliance on a biomedical model is not in line with the holistic concept of hauora, which considers spirituality an essential aspect of health and well-being (Durie, 1985, 1994; Mark et al., 2017). Western thinking, cultures, and societal norms have moved away from a holistic view (Michaelson et al., 2019) and maintain an exclusive and dominant stance based on the biomedical paradigm (Wilson et al., 2018), which affects Indigenous groups disproportionately. All health professions in Aotearoa New Zealand carry the responsibility to continue to explore ways that can improve comprehension of diverse health beliefs, collaborate with health recipients as autonomous partners and subsequently integrate and apply knowledge that respects and complements Indigenous and other health models as expressed by the recipient of care.

The findings uphold Te Tiriti o Waitangi as a foundational document but also affirm collaboration with Tāngata Whenua as an opportunity requiring more conversation (see Section 5.6.1); recognising and acknowledging the effects of colonisation while challenging and questioning one's worldview is critical for nurses' ongoing professional development in Aotearoa New Zealand (NCNZ, 2016, 2022b). RNs with extended education in anthroposophic foundations and concepts are well-positioned to contribute to the development of holistic care in Aotearoa New Zealand, with its complex facets. Values of holistic health, particularly the normalising of spirituality as part of nurses' approaches to whole-person care, can improve the integration of diverse health beliefs (Cooper et al., 2022) and facilitate therapeutic relationships with Indigenous populations (McColgan, 2022).

6.6.3 Reflections on the Research Question

This research has examined how registered nurses who have completed additional education in anthroposophic nursing inform their practice using the anthroposophic paradigm.

The study's objectives included examining how ANs/ANSs perceived practising from anthroposophic foundations, establishing the barriers and facilitators they encountered, and finally, how working from the anthroposophic paradigm was contextualised and applied to practice. All participating nurses had completed a foundation course in anthroposophic nursing, had more than 20 years of nursing experience, held an APC, and were working in various clinical areas in both islands.

Although the findings confirm that engaging with allied health professionals and nurses who share insight into the anthroposophic paradigm is rewarding and can benefit patient care, it was surprising for the ANs/ANSs that conventional, mainstream services in Aotearoa New Zealand did not recognise or appear open to the contributions that AM as an integrative, multimodal approach has to offer. While RNs are professionally bound to apply holistic models of care here in Aotearoa New Zealand (NCNZ, 2012, 2024; NZNO, 2014, 2018), persistent barriers to and limitations on the application of existing holistic models and explorations of their fit with the requirements of the

population exist (Clendon, 2013; Egan et al., 2017; Egan & Blank, 2021; Pene et al., 2022; Wilson et al., 2018). There is openness to anthroposophic nursing care in areas where dominant biomedical therapies and interventions have reached the end of their capacity to provide treatment options, such as mental health and palliative end-of-life care. In particular, the focus on integrating EATs in oncology settings aligns with other studies (Ben-Arye et al., 2018, 2021; Rutert et al., 2021; Zeugin et al., 2018) and benefits patients and their families and provides job satisfaction for the health professionals involved in their care.

Another finding important for the health context in Aotearoa New Zealand is the salutogenic intent anthroposophic nursing applies to practice. The changes the Labour government implemented in 2022 (Te Whatu Ora, 2024b) are now under review by the new Coalition Government (National/Act/NZ First) and up for change. While all parties have promised the public “better health” (Reti, 2024; Te Whatu Ora, 2022) and to lessen the burden on the health system (Department of the Prime Minister and Cabinet, 2021), the gaps in patient care, lack of access to rural and now urban GPs (The Royal New Zealand College of General Practitioners, 2021), shortages in the nursing workforce (NZNO, 2024) and funding issues for pivotal services remain concerning. Rural communities especially are experiencing increased wait times or additional travel to access PHC services. Nurses remain at the forefront in managing the consequences of these political decisions (Carrier, August 1, 2024) that impact the entire population but disproportionately impact those already affected by existing health inequities. The current shifts in policy will inevitably lead to increased health needs in communities. ANs/ANSs are well-equipped to offer health-promoting strategies to strengthen community resilience, for example, promoting healthcare strategies that support families with young children, providing a salutogenic focus on child development (see Sections 5.4.4 & 5.6.2) and providing education about minor ailments to avoid hospital admissions. Individuals with existing chronic health conditions also benefit from having anthroposophic therapies available in the community (Ritchie, 2001) and experience increased quality of life (Koster et al., 2016, 2020) and improved ability to self-manage (Baars et al., 2017).

6.7 Chapter Summary

This study contributes to the existing research and literature on anthroposophic nursing by offering a deeper understanding of how registered nurses inform their practice with anthroposophic foundations within the healthcare culture in Aotearoa New Zealand. The findings highlight challenges nurses face when working primarily from within a Western allopathic model, and their continuing struggles to achieve a dedicated holistic focus on care. The benefits of completing a foundation course in anthroposophic nursing pointed to two fundamental dynamics: firstly, anthroposophy leads nurses to rethink the physiological functions and the psychosocial and spiritual elements of human existence; and secondly, the nurse/patient relationship and interaction are emphasised, partly influenced by the nurses' questioning and explorations of their own biographies and spiritual existence.

The discussion recontextualised anthroposophic nurses' advanced role and their role perception as exposed in the findings. Moreover, this chapter aimed to uncover where and how the anthroposophic foundations underpin nursing practice specific to Aotearoa New Zealand's unique health context. The distinct and nurtured understanding of holistic values expressed in anthroposophic concepts, particularly the intent to work with body, soul, and spirit, informs the care and interventions of anthroposophic nurses. The fundamental dynamics of anthroposophic knowledge, as depicted in **Figure 5**, emphasise the importance of embodied knowledge and experience. The findings indicate that these factors substantially influence how ANs/ANSs think and act, as reflected in the identified key themes.

The anthroposophic nursing discourse that evolved over the last century aligns with holistic humanistic values in various theoretical nursing models worldwide. Nevertheless, what distinguishes anthroposophic nursing care is the inclusion of tangible manifestations of embodied spirituality through external nursing therapies that are grounded in the 12 Nursing Gestures. Spiritual connections and insights were cautiously expressed by participants, mindful of the biomedical scientific basis of their profession. Despite this, the anthroposophic caring culture becomes an embodied culture, a lived experience, and a worldview interlinked with the individual nurse's

identity. ANs'/ANSs' openness to explore their spiritual and biographical paths leads to spiritual caring versus care underpinned by a spiritual model.

The findings of this study represent a starting point for further exploration that could define an ontological literacy of anthroposophic nursing and the anthroposophic nursing identity in Aotearoa New Zealand. Considering the significant impact the global pandemic posed and is still posing for health systems and the nursing workforce, these findings need to be read in the context of nursing care as it was during the lockdown at the start of the global COVID-19 pandemic.

Chapter 7 Conclusion and Recommendations

The nurse's valuing of the human body in anthroposophic nursing care, his or her attentiveness to touch, use of warmth, cold, air and light to promote healing processes, form a solid bridge between treatment of the body and treatment of the patient's soul and spirit. And this connection is needed more than ever today.

Rolf Heine (*Anthroposophic Nursing Practice*)

7.1 Introduction

This chapter builds upon the discussion and presents targeted recommendations that align with the specific health landscape in Aotearoa New Zealand. I explore implications for education, leadership, and health policy grounded in the findings of this study. I argue that integrating education and knowledge of anthroposophic concepts and frameworks into advanced nursing practice provides contemporary nurses with a well-rounded set of holistic skills. Further education in anthroposophic nursing stimulates practice development and enables nurses to explore patients' existential values through the intentional integration of spirituality. Anthroposophic nursing has become a global movement that extends beyond the European health culture and workforce; the outcomes of this research present a view on the practice of anthroposophic nurses in nonanthroposophic health environments. Based on the findings, I include recommendations to inform the design and development of future research and methodological approaches in anthroposophic nursing. I highlight the study's strengths and limitations and make recommendations that would enhance integrative and collaborative practice.

7.2 Outcomes of this Research: The Future of Anthroposophic Nursing in Aotearoa New Zealand

This study has created new insights into anthroposophic nurses' expertise and approach to holistic nursing in Aotearoa New Zealand. The research project aimed to establish how registered nurses apply and work with knowledge based on the anthroposophic paradigm in day-to-day nursing practice. Although this study focuses

on anthroposophic nurses, the findings may have broader implications for the nursing workforce in Aotearoa New Zealand and facilitate improved awareness of what anthroposophic nursing perceives as “true” holistic care. Additionally, this research establishes insights into the experience of anthroposophic nursing identity when working in a nonanthroposophic health environment. As anthroposophic nursing and healthcare continue to grow across the globe, each sociocultural health setting presents distinct challenges and priorities that will affect the integration of anthroposophic nursing. This study found that anthroposophy has evolved into a way of being for the participating nurses, which emphasises an embodied practice enhanced by its spiritual aspects. The language utilised by ANs/ANSs to describe their nursing approach and practice revealed their inner connection to anthroposophy and spiritual insights into the nature of the human being. The findings of this study show that anthroposophic anthropology could offer valuable extensions to the care provided in Aotearoa New Zealand, as a “true” holistic paradigm encompassing the spiritual plane with its distinct focus on integrating natural substances (Themes 1 & 2; also see Chapters 1 & 2). As noted earlier, models based on social, cultural, spiritual, and person-focused frameworks in Aotearoa New Zealand aim to provide more comprehensive health services for the person, their family/whānau, and the health professionals involved. Achieving meaningful implementation of diverse supports requires a strong emphasis on holistic considerations.

The COVID-19 pandemic has resulted in a heightened awareness of disparities, not only in addressing COVID-19, but in many other health domains. The pandemic has produced a new level of public health consciousness of well-being, spirituality, and social connectivity (Büssing et al., 2020; Officer et al., 2022; Wilberforce Foundation, 2023) and more vocal critiques of services not meeting expectations or the healthcare recipient’s needs. In Aotearoa New Zealand, renewed discussions emerged around a call to reexamining the current undergraduate nursing curriculum by including “more diverse and challenging topics” (Rook et al., 2022, p. 3). These discussions highlighted the variations in nurses’ interpretations of whole-person, holistic care and illustrated the theory-practice gap. In Aotearoa New Zealand, the concept of holistic care is closely connected to Indigenous health models and person-centred care. However, in

different countries, such as the USA, the role of holistic nurses is defined as a specialised field in nursing (AHNA, 2024; Mariano, 2016). The findings here assert that spirituality, as part of all holistic models, is not a separate concept but is an inherent foundational driver of the anthroposophic paradigm. Therefore, in AN/ANS practice, spirituality is a vital component of nursing assessment (anthroposophic anthropology) and is integral to therapeutic relationships and caring interventions.

Additionally, one intention emerging from this research is to highlight where possible bridging could occur (or is already happening) between conventional health services and nurses who work with anthroposophic foundations. The terms “moral courage” and “spiritual integrity” serve as indications of nursing values, representing a duty to provide various means of support and care for individuals. Current research in Aotearoa New Zealand is calling for improved recognition of spiritual values as part of holistic care (Egan & Blank, 2021; Egan et al., 2017; Florence & Mikahere-Hall, 2019; Pene et al., 2022; Pene et al., 2023), and international studies have provided evidence that integrating spirituality into health policy and management has positive effects on populations (Oman & Brown, 2018) and improves the outcomes of nursing care. The findings in this study suggest that anthroposophic concepts applied to nursing may provide a bridge between competing understandings of the place of spirituality in nursing.

7.3 Reflections on Outcomes

As a researcher and anthroposophic nurse, I set out to provide a picture of anthroposophic nursing that would improve understanding of this lesser-known nursing practice in Aotearoa New Zealand. Alongside offering a deeper understanding of anthroposophic nursing, this study found distinctions and similarities to holistic nursing. Holistic caring is significant to ANs/ANSs, and how they perceive, express, and understand holistic care in its manifestations through real-world scenarios provides a depth of knowledge not otherwise imagined.

One of my insights during the writing process related to anthroposophic nurses' efforts to explain the anthroposophic paradigm to other nurses and allied health

professionals. A challenge during this research/explanatory process of reframing, rearticulating, and interpreting anthroposophic concepts and language has been to avoid linear generalisations and mapping and even over-simplification of anthroposophic foundations. One way to mitigate this would be to conduct further empirical studies exploring the interface between conventional and anthroposophically informed nursing practice.

7.4 Strengths and Limitations of the Research

7.4.1 Strengths of this Research

New Insights for Aotearoa New Zealand

This is the first study in Aotearoa New Zealand presenting how RNs inform their practice using knowledge and skills based on anthroposophic concepts. The data revealed various challenges ANs/ANSs experience when working in healthcare structures and clinical areas unfamiliar with anthroposophic nursing and working with integrative healthcare models. ANs/ANSs are cognisant of the pitfalls and therefore cautious when using language specific to anthroposophic concepts and frameworks, as this can cause misperceptions and a reluctance to acknowledge the benefits these approaches might offer particular patient groups. The impact of anthroposophic nurses' spiritual practice and principles contributes to their proficiency in fostering a holistic approach to care that integrates bicultural foundations in Aotearoa New Zealand. Embracing spiritual values in holistic care is a significant factor that guides interventions and influences how healthcare professionals interact with patients.

Wider Implications

Although the findings relate to a relatively small cohort of ANs/ANSs situated in a specific sociocultural and geographic health context, they add to the national and international professional validation of anthroposophic nursing. While the core theoretical concepts of anthroposophic care can be applied to diverse health environments, the specific articulation of how anthroposophic nursing practice facilitates and emphasises cultural safety is of particular relevance to the delivery of nursing care in Aotearoa New Zealand. These new insights may also interest those in

other international health contexts with Indigenous populations and health systems affected by postcolonial constructs. Furthermore, the study's findings may aid future explorations of ways anthroposophic nursing as an integrated and inherently holistic practice could bridge, foster, and strengthen collaborations with Tāngata Whenua when establishing culturally safe dialogue as Tāngata Tiriti and healthcare partners. While the data highlighted commonalities within a broader ecological context that the anthroposophic paradigm and Te Ao Māori might share, arriving at premature assumptions or comparisons without further research would be unwise and culturally inappropriate.

Integrated Nursing Practice

Another strength of the study is the diverse clinical experience and expertise the participants brought to their professional practice (see Section 5.2). The findings show integrated, noncompeting repertoires of knowledge which include both anthroposophic and conventional RN practice. While some participants worked in a limited capacity with the practical therapeutic interventions of anthroposophic healthcare (EAT), three of the six participating ANSs lectured for the Foundation Course in Anthroposophic Nursing at Taruna College, and several had experiences of being self-employed in their capacity as AN/ANS.

Use of ID Generated Novel Insights

The strength of the methodology used was that it allowed a philosophical positioning of nursing identity that is informed and guided by the theoretical foundations of anthroposophy and this also allowed for the inclusion of impactful practice narratives demonstrating professional nursing knowledge expanded with spiritual science. The use of ID ensured that the ontological and epistemological principles rooted in anthroposophy were maintained and applied as theoretical foundations for the practice interpretations. Within the interpretative constructivist paradigm, my philosophical stance as a researcher allowed me to present data that showcased the significance of nursing practice and validated the voices of individual nurses, as well as presenting the professional culture of nursing expanded with anthroposophic insights.

7.4.2 Limitations of this Research

Despite collecting the data during the nationwide COVID-19 lockdown (which began on March 25, 2021, in Aotearoa New Zealand), there is minimal mention of the pandemic's impact on anthroposophic nursing practice. Therefore, the findings of this study might vary if the same participants were interviewed in 2023/24 and may intensify or highlight other facets of care considering the impact of the COVID-19 pandemic on the nursing workforce.

Researcher Subjectivity

As an ANS and RN, I have knowledge and experience running an anthroposophic nursing clinic in the community in Aotearoa New Zealand and working in one of Germany's anthroposophic hospitals (Paracelsus Klinik) from 1999-2000. While it was important to me to provide insight into AN's/ANS's positioning and experiences in the health context away from its origins (Germany/Switzerland) to achieve a picture relevant to the context in Aotearoa, my previous experiences within these distinctly different environments may have subjectively influenced this qualitative study.

Participant numbers

Another limitation is the sample size, which was influenced by the small number of eligible ANs/ANSs practising in Aotearoa New Zealand. From 1998 to the time of participant recruitment in 2021, 84 nurses had completed an anthroposophic nursing education programme in Aotearoa New Zealand and obtained certification as ANs/ANSs. While qualitative studies frequently collect data from smaller cohorts, the limitations inherent in this have been discussed in the literature (Creswell & Poth, 2018; Thorne, 2016). Considering the nature of the research question (Thorne, 2016) and the number of nurses completing education in anthroposophic nursing since 1998, 11 participants constituted a legitimate representative sample.

Health Environment

Further limitations include working with anthroposophic foundations in health structures/services away from their place of origin, in Europe. The impacts nurses experience when working for nonanthroposophic services is an entirely separate topic

that will require more research and, according to the findings here, presents obvious challenges and limitations given the visible features of anthroposophic nursing practice, for example, working with the external anthroposophic therapies (EATs). These may be noticeable in the way participants articulate their professional positioning and knowledge in anthroposophic nursing when engaging with colleagues and allied health professionals. Therefore, the findings in this study may be distinctly different from studies conducted within health environments that are more favourable to and familiar with the integrated anthroposophic medical approach.

7.5 Recommendations: Nursing Education, Practice and Policy

Currently, anthroposophic nursing is not well known in the health landscape in Aotearoa New Zealand. The 11 participants interviewed for this study show that this group of registered nurses, with advanced knowledge in general conventional nursing and anthroposophic healthcare, work in a wide range of clinical areas (see Chapters 1 & 5), indicating a diversity of potential impacts for a broad group of recipients of healthcare based on this integrated, holistic nursing paradigm. The practice areas and specific narratives suggest that anthroposophic nursing can influence current health-promoting strategies across all stages of the life span in Aotearoa New Zealand. The recommendations from this study focus on local practice interventions rather than national policy changes.

7.5.1 Recommendations for Nursing Education and Practice

Include Spiritual Development in Undergraduate Nursing Curriculum

Incorporating spiritual insights into nursing can enhance the theoretical and practical aspects of nursing interventions. Furthermore, embodied knowledge of one's spiritual beliefs in therapeutic encounters with patients can lead to more meaningful and impactful experiences. Spirituality may be fostered in various ways; however, the data in this study shows a connection between the philosophical foundations of anthroposophy and the way nursing identity influences caring interventions articulated as "different" compared to conventional nursing. Other researchers have previously alluded to the notion of "difference" (Arman et al., 2008). An openness to spirituality

seems to influence nurses' personal and professional development and plays a more significant role than anticipated. One recommendation from this study is to emphasise and expand the current teaching in undergraduate nursing programmes on spirituality, offering nursing students additional opportunities for spiritual self-exploration. The topic of spirituality in care is often limited to the principles of therapeutic relationships (empathy, respect, openness to different values and beliefs) or is only included in the theoretical discussion of end-of-life care. It is less likely to be presented as an essential part of the nurse's self-development. Specific papers/courses such as chronic conditions management, community health, and oncology could incorporate modules on spiritual self-development, spiritual care, and biography. Incorporating structured learning on these topics throughout the nursing degree aligns (based on this study's findings) with teaching holistic and Indigenous models of care and person-centred practice, and would additionally assist first-year nursing students in becoming reflective practitioners.

Including Anthroposophic Foundations in the Postgraduate Nursing Curriculum

Since the anthroposophic nursing pathway is accessible here in Aotearoa New Zealand, after completion of the Bachelor of Nursing degree and registration as an RN, a focus on advanced nursing pathways could offer postgraduate nurses practice-integrated papers/courses that build on clinical experiences and encourage self-development based on anthroposophic foundations. These could initially be made available as part of a pilot OR as a singular pathway in connection with the Foundation Course in Anthroposophic Nursing and, if successful, be further developed as an independent postgraduate course. Taking into account the insights from earlier studies (Ben-Arye et al., 2018, 2021; Rutert et al., 2021) and the intrinsic nature of applied anthroposophy for various health professions, it would be worthwhile considering the inclusion of a foundational course on anthroposophic concepts within cross-disciplinary pathways and degrees.

Recent reviews of the Aotearoa New Zealand health system (WAI 2575; MoH, 2024) and current Indigenous voices provide ongoing reminders of gaps in holistic care. These findings show that enhancing nursing practice with anthroposophic concepts

stimulates spiritual self-reflection, broadens existing skills and therapeutic dialogue, and improves nurses' perceived satisfaction with delivering whole-person, holistic care. For ANs/ANSs working in nonanthroposophic services, there is an opportunity to collaborate with nursing colleagues in complex holistic care. Leading by example, which is especially relevant for RNs in advanced nursing roles, can provide opportunities for change and influence nursing culture. Additionally, when patients request anthroposophic therapies, a collective approach can be used by ANs/ANSs to deliver introductory education sessions to their RN colleagues within the clinical area, which can open up space for initial conversations and strategies to improve patient care. A good starting point is presentations providing foundational information about the benefits of anthroposophic external nursing therapies. Based on the research findings, the following practical recommendations could be adopted in individual learning modules to enhance the understanding of anthroposophic nursing amongst RNs and allied health professions. These could include:

Spiritual Self-Reflection in Nursing Practice: Encourage nurses to integrate spiritual insights and anthroposophic concepts into their practice to stimulate self-reflection and broaden their skills. This approach would enhance their ability to engage in therapeutic dialogue and increase their satisfaction with delivering holistic care.

Foster Collaboration Across Nursing Roles: Facilitate collaboration between anthroposophic nurses (ANs/ANSs) and registered nurses (RNs) working in nonanthroposophic services. This could involve sharing knowledge and leading by example to address the complex nature of holistic care, ultimately influencing and improving the overall nursing culture. It could involve collaborative research projects requiring engagement in anthroposophic caring culture and language and learning about the use of the 12 Nursing Gestures model in practice.

Educate on Anthroposophic Therapies: Implement introductory education sessions on external anthroposophic therapies (EATs) for nursing staff. These sessions should provide foundational information on the benefits of these therapies shown in the research, enabling RNs to consider such approaches when requested by patients, thus enhancing overall patient care strategies. It would be important to focus on and

approach RNs in clinical areas and health services which have shown receptivity to anthroposophic nursing foundations and where previous studies have reported benefits, such as registered nurses in palliative and end-of-life care, long-term care, and in PHC and community health.

7.5.2 Leadership within Anthroposophic Nursing in Aotearoa New Zealand

Considering the ongoing health system changes in Aotearoa New Zealand and WHO's stance on developing global benchmarks for AM as an integrative health strategy (2023), anthroposophic nursing has an opportunity to provide leadership and representation. The findings also point to the importance of language/expression and the way the anthroposophic nursing paradigm is articulated in health services and for allied professions unfamiliar with the characteristics of anthroposophic care.

One recommendation (as noted above) would be to strengthen the existing anthroposophic nursing education pathway and develop short workshops/education sessions targeting RNs in clinical areas open to the philosophical foundations of anthroposophy, for example, end-of-life, palliative, and long-term care (LTC).

The establishment of a nursing research group that is part of the Anthroposophic Medicine Research Council (AMRC) global network would offer opportunities for ANs/ANSs to represent Aotearoa New Zealand, exchange practice experiences with ANs/ANSs in other countries, and define areas of anthroposophic nursing research. In non-Western countries, the significance of whole-system medical approaches such as AM is on the rise, with many of these approaches integrating existing conventional biomedical methods with traditional and CAM healing methods from specific cultures (Baars & Hamre, 2017). Conventional biomedical healthcare has limitations for Aotearoa New Zealand's Indigenous population and a wide range of ethnically diverse population groups. The experiences of ANs/ANSs in the healthcare field in Aotearoa New Zealand can provide valuable insights into how to improve responsive nursing practice alongside existing models of care. These insights have significance not only within Aotearoa New Zealand but also on an international scale, owing to the nurses' experiences in diverse sociocultural health contexts.

Enhance Cultural Safety Training: Introduce anthroposophic foundations to training programmes focused on cultural safety for healthcare professionals, emphasising understanding and respecting patients' values and beliefs and addressing the power dynamics between healthcare providers and recipients. This would complement the delivery of culturally safe care across diverse sociocultural contexts and highlight anthroposophic nursing as a caring culture which inherently fosters values of self-reflection and ethically responsive care.

Strengthen Interprofessional Communication: Foster improved communication within multidisciplinary and interprofessional teams, especially during the integration of anthroposophic medicine. Encourage regular meetings and workshops focusing on building cross-cultural relationships and sharing insights to enhance collaborative care efforts.

Encourage Research and Exploration: Support further research and exploratory projects to investigate the impact and application of anthroposophic healthcare in diverse professional and patient populations. Use insights from Aotearoa New Zealand as a foundation to inspire international studies that could lead to more inclusive and effective healthcare practices worldwide.

7.5.3 Leadership and Future Policy

Nurses in advanced practice roles can take on critical roles in policy development by evaluating existing structures and advocating for change that benefits patient care (Mund, 2017). There is scope and opportunity in Aotearoa New Zealand to challenge existing care models and question their validity regarding the delivery of holistic and compassionate care (Robinson et al., 2024). This study's findings assert that pockets of innovation integrating anthroposophic nursing are valuable and worth further exploration.

At this stage, anthroposophic nursing practice is relatively unknown in health services, and increasing awareness of anthroposophic healthcare is a prerequisite for having a voice in policy development. ANs/ANSs in roles with more professional and public exposure can take leadership roles in providing more insight into this integrated

whole-person healing approach. This could occur through lobbying and involvement at professional organisational levels (NZNO, College of Nurses Aotearoa), advocacy at the bedside, conversations with stakeholders (for example, PHC clinics, local communities, palliative and end-of-life care providers) and ongoing engagement with the international anthroposophic nursing community to ensure presence and voice. Education and future research are crucial for determining the status of anthroposophic nursing in both Aotearoa New Zealand and the global context.

WHO's endorsement in 2023 of anthroposophically integrated education can serve as a catalyst for enhanced collaboration with employers and nonanthroposophic healthcare services in Aotearoa New Zealand, assisting in discussions around funding. Providing a range of stand-alone educational modules in anthroposophic nursing could increase interest and be cost-effective while also serving as a starting point for further exploration of the anthroposophic nursing pathway (Foundation Course in Anthroposophic Nursing). External nursing therapies are visible therapeutic interventions that anybody can learn; however, the clinical decision-making to use these interventions requires a robust understanding of the foundations of anthroposophic anthropology as part of the AN/ANS knowledge base and benchmarks (Heine, 2018a; WHO, 2023).

A further recommendation relating to the new health structures and policy developments in Aotearoa New Zealand (Te Whatu Ora, 2024a) is to encourage more nursing presence at various leadership levels (NCNZ, 2022b; Te Whatu Ora, 2023a, Slide 6). The findings suggest that the professional breadth added through AN/ANS education led to more job satisfaction for the nurses by expanding their skills in holistic and integrative care; learning about anthroposophy was noted as a motivator to continue nursing or expand their existing RN scope. Nurses in leadership roles require a broad range of skills, including advocacy for diverse patient groups and collaboration between services. For anthroposophically educated nurses, these skills include health promotion that is patient, whānau and family-centred and is "shifting nursing care closer to home" (NZNO, 2018, p.50). The nurse-led focus on integrating

anthroposophic caring interventions that align with conventional biomedical therapies offers patients choices and self-management strategies.

7.6 Research Related to Practice Settings

RNs must adhere to professional national competency standards, which may vary from one country to another. To date (see Section 3.6), national and international studies linked to anthroposophic nursing practice have, in the first instance, investigated practical (therapeutic) interventions and have focused mainly on the effect of substances used for various EATs. Future research should be situated in various research paradigms to gain a more extensive perspective of the breadth and impact of anthroposophic nursing in Aotearoa New Zealand. Larger samples, focus groups, and an emphasis on specialist nursing areas impacted by anthroposophic nursing would add to this initial scope of data. Additionally, to contrast with this study's findings, study designs involving multidisciplinary anthroposophic healthcare teams would distinguish whether there is variation in the ANs'/ANSs' perceptions of care working in Aotearoa New Zealand. The following sections outline future research recommendations related to the three themes identified in this study.

Theme 1 focused on the integrative practice approach that fostered spiritual connections, serving as a key motivator for nurses. Participants highlighted their journeys of self-development through meditative inner paths, alongside learning and adopting anthroposophic anthropology. Further research is needed to explore the meaning and implications of the esoteric anthroposophic pathway within nursing practice using codesign principles. Such research should examine anthroposophic nursing's value, challenges, and potential misperceptions from the patient's perspective to better understand the factors that attract nurses to anthroposophic healthcare.

As mentioned in the limitations section of this chapter, larger cohort studies should include patients and nurses, possibly using case study methodology to focus on specific aspects of anthroposophic nursing: spirituality, job satisfaction, and meaningfulness in the broader context of interprofessional collaborations. Job satisfaction needs

particular consideration in the context of the current national and international shortage of nursing staff and difficulties with the retention of nurses.

Larger cohort studies would also return a more varied picture of anthroposophic nursing as it is applied in different areas of clinical practice in Aotearoa New Zealand and cast light on how this way of nursing may impact specific patient groups in the long term. Future research should include comparative study designs which contrast mainstream, general nursing practice with anthroposophic nursing.

Larger Cohort Studies:

- Objective: To assess the application of anthroposophic nursing across different clinical settings in Aotearoa New Zealand and its long-term impacts on diverse patient groups
- Method: Conduct large-scale, longitudinal cohort studies involving both patients and nurses. Include surveys capturing dimensions such as spiritual well-being, job satisfaction, and the perceived meaningfulness of care
- Participants: Nurses in anthroposophic and nonanthroposophic settings and patient groups, including those with long-term conditions (LTC), and Indigenous and migrant communities

Theme 2 and subthemes illustrated the participants' interpretations and articulation of how anthroposophic concepts and foundations have impacted their nursing practice. This theme also pointed to the value in nursing actions that may not be visible and tangible but are experienced as impactful gestures. Similarly to Theme 1, spiritual awareness, impulses, and/or growth were infused in these findings regarding the expressions of nursing practice.

Conducting qualitative research to examine how a nurse's spiritual attitude, based on the anthroposophic paradigm, influences the delivery of care could be beneficial. According to research conducted by McColgan (2022) in Canada, nurses' spiritual self-awareness was found to be a critical factor in their collaborations with Indigenous communities. Consequently, the data presented in this research supplement the

current body of knowledge and can be utilised to enhance undergraduate and postgraduate education in Aotearoa New Zealand.

Qualitative Research on Spiritual Influence:

- Objective: To examine how a nurse's spiritual mindset, rooted in anthroposophic paradigms, influences patient care quality and collaborative teamwork
- Method: Conduct qualitative interviews and focus groups with nurses, art and movement therapists, and Indigenous community members, exploring themes of spiritual awareness and collaboration
- Population: Nurses and healthcare providers working in interdisciplinary teams, particularly those engaging with Indigenous populations

Theme 3 added more specific data to the context and positioning of anthroposophic nurses in Aotearoa New Zealand. While advantages have been noted for working within the anthroposophic paradigm to offer interventions based on person-centred values, the data demonstrated the distinct challenges that ANs/ANSs experience when engaging with nonanthroposophic health services.

Research studies evaluating patient experiences in the context of health service delivery in Aotearoa New Zealand would offer insights into how various patient groups validate anthroposophic nursing.

Since this is the first research study exploring anthroposophic nursing care in Aotearoa New Zealand, it can only present a preliminary insight into this way of nursing; further research is essential for more comprehensive analysis and understanding of its potential value for patient groups with complex needs and those affected by inequities, for example, patients with LTCs, migrant, and Indigenous populations.

Comparative Study Designs:

Studies should also include investigations into the effect of anthroposophic nursing on conventional/mainstream nursing practice, especially whether and to what degree

embodied spiritual values may impact nursing care in the cultural contexts of Aotearoa New Zealand.

- Objective: To explore differences in care outcomes and patient satisfaction with conventional nursing practices and those infused with anthroposophic principles
- Method: Implement comparative studies that contrast standard nursing care with anthroposophic approaches. Use quantitative measures to gauge patient outcomes and qualitative interviews for in-depth insights.
- Participants: Patients receiving conventional versus anthroposophic nursing care across various health sectors (for example, palliative care, mental health)

Successive research projects within selected clinical fields (for example, LTC, community health, end-of-life care) could also introduce these fields to the ontological and epistemological stance of anthroposophic nursing and its characteristics while generating a more universally understood integrated caring language. Applying various methodological lenses would add depth to the current knowledge base, confirm or challenge the findings of this and previous studies that include anthroposophic nurses, and extend and shape future pathways for integration into receptive clinical areas.

To ensure a comprehensive evaluation of anthroposophic interprofessional teamwork from the patient's point of view, it would be ideal to involve physicians, art and movement therapists, counsellors, and educators (if a research project includes school children in Waldorf education). This interdisciplinary approach would allow for a broader assessment of the application of anthroposophic concepts. Research evaluating these multilayered insights and experiences of various anthroposophically trained professionals would not only offer a more complex view into this integrative healthcare model as it is practised in Aotearoa New Zealand but also allow a more comprehensive understanding of the nursing role. Considering the current shortages of nurses and GPs, this could be an opportunity to ascertain the value of anthroposophically educated nurse practitioners, especially in clinical areas like palliative, end-of-life care, and mental health.

Collaborative research projects with Tāngata Whenua and Māori health providers evaluating and assessing the use of native flora for external applications in anthroposophic nursing would add insights into how best to support Indigenous communities but also provide further data on how anthroposophic nursing care can improve access to EATs.

Most importantly, research is needed to explore patients' perspectives on anthroposophic nursing care and how it is delivered in Aotearoa New Zealand. A project addressing this could include therapies available through other anthroposophic health professionals in collaboration with the community, via a PHC centre, or one-on-one treatment with an AN/ANS.

7.6.1 International Research

While writing this thesis, an international umbrella group of ANs/ANSs, the Anthroposophic Medicine Research Council (AMRC), was formed. It is currently working on a proposal for an international research project exploring the work of registered nurses working from anthroposophic foundations (AMRC, 2024). One of the considerations will be how anthroposophic knowledge informs nursing practice and how this manifests in health environments unfamiliar with the integrated approach of anthroposophic healthcare. A first draft of the proposal for this research project will be presented at the upcoming international annual conference of the Medical Section at the Goetheanum in Switzerland (September 10-15, 2024). It will open up opportunities for IFAN to support these endeavours as collaborative projects with the aim of generating national and international nursing research goals.

To date, the medical profession has been driving AM research, and one future strategy needs to be joint ventures by national and international anthroposophic nursing groups (IFAN) to develop a set of research questions. Future empirical research in anthroposophic nursing needs to be specifically aimed at defining, positioning and testing anthroposophic nursing with the aim of improving the visibility of its values. As a result, anthroposophic nursing will be better recognized and accepted in conventional healthcare settings that are less familiar with this approach.

7.7 Final Thoughts

While the data in this study will resonate with anyone involved in anthroposophic nursing, the findings present new insights into the professional identity, knowledge, and experiences of anthroposophically educated RNs practising in the Aotearoa New Zealand health context.

With the increasing external demands of climate change and the COVID-19 pandemic and the increasing need for validation of holistic concepts and models of care, the anthroposophic paradigm presents opportunities for nurses for future development. These further professional learnings could encompass a salutogenic approach to patient self-management, incorporating holistic features into health-promotion activities, and improving understanding of a holistic perspective of the human as an entity intricately interlinked with nature and the spiritual world.

The study has uncovered implications for practice, education, and policy; my focus has been on addressing those findings that are most applicable to the present healthcare landscape in Aotearoa New Zealand. Rich data extraction also supported the need for additional and more extensive investigation of a unique nursing model rooted in anthroposophic principles.

While this study provides evidence that ANs/ANSs aim to “translate” the distinct anthroposophic terminology for colleagues and allied health workers to be understood, it also demonstrates an opportunity to use the 12 Nursing Gestures as a universal language to articulate, for example, HOW the anthroposophic paradigm informs practice interventions which could then be integrated into and validated in conventional health settings.

AM's ontological and epistemological foundations have been practised for some decades with a broad range of research and specialised literature; it is time for anthroposophic nursing to articulate its value within the broader healing paradigm.

*Seek the truly practical material life, but
Seek it so that it does not numb you to
The Spirit which is active in it.
Seek the Spirit, but seek it not in passion for the super sensible out of
super sensible egoism
But seek it because you want to apply it selflessly in practical life in
the practical world.
Turn to the ancient principle:
Matter is never without Spirit and Spirit is never without Matter,
In such a way that you say: We will to do all material things in the
Light of the Spirit
And we will so to seek the Light of the Spirit that
It evokes warmth for us in our practical activities.*

(Steiner, 1919a)

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Glossary

AM—anthroposophic medicine, a complex, multimodal and integrative health approach is based on the teachings and insights of Rudolf Steiner (1861-1925), a philosopher, educator, and scientist who founded and developed the philosophy, worldview, and science known as anthroposophy.

Anthroposophic nursing—nursing informed and extended with the foundations and principles of anthroposophy. The full term is used throughout the thesis when related to anthroposophic nursing in general, not an individual AN or ANS.

ANANZ—Anthroposophic Nursing Association NZ

AN—anthroposophic nurse: a registered nurse who has completed a Foundation Course in Anthroposophic Nursing (IFAN, 2022).

ANS—anthroposophic nurse specialist: a registered nurse who has completed a Foundation Course in Anthroposophic Nursing (prerequisite) and completed either the specialist course OR the portfolio pathway (IFAN, 2022). Both pathways require a final exam (practical and theoretical components).

Anthroposophy—Steiner coined the term “anthroposophy” from the Greek *anthropos* (human) and *sophia* (wisdom) to describe and define the “consciousness of one’s true humanity” (Bartelme, 2017; Steiner, 1918). APC—Annual Practising Certificate

Aotearoa—“land of the long white cloud” (Te Reo for New Zealand)

Biomedical—this term is used interchangeably in this thesis with **mainstream** or **conventional** to represent the dominant Western approach to healthcare and health service delivery

CAM—complementary and alternative medicine

CAIM—complementary, alternative, and integrative medicine

EFPAM—European Federation of Patients’ Associations for Anthroposophic Medicine

EFPAM—European Alliance of Initiatives for Applied Anthroposophy

GP—general practitioner, a medical practitioner in the community, “family doctor” physician

Hauora—health in the broadest sense; in Te Ao Māori, this extends to environmental features (rivers, mountains, oceans), well-being, vigour

Hui—meeting, gathering, seminar, workshop

ICANA—International Council for Anthroposophic Nursing Associations

IFAN—International Forum for Anthroposophic Nursing

IVAA—International Federation of Anthroposophic Medical Associations

Kawa whakaruruhau—cultural safety in the context of Māori nursing, as introduced by Dr Irihapeti Ramsden (1990).

Mihi—speech of greeting, acknowledgement, tribute

NCNZ—Nursing Council of New Zealand

NZNO—New Zealand Nurses Organisation

Pākehā—non-Māori New Zealander of European descent

Person-centred care vs patient-centred care: both are often used interchangeably depending on the author's/researcher's philosophical interpretations. The term "person-centred care" was preferred for this research as it focuses on the person as an individual defined by culture, values, and beliefs. The term patient carries connotations of unwellness and pathology but also the notion of a possible power construct at work.

RBO—rhythmical body oiling/rhythmical embrocation (Einreibung): *"...has foundations characteristics of rhythm and lightness. Through the RBO a substance can be applied in a healing manner, appropriate for the human being. It has been developed out of the rhythmical massage movement. The strokes of the RBO are lighter in comparison to the rhythmical massage. We are working on the 'skin surface' without moving or kneading it as with massage."* (Fingado, 2005, p. 9).

PHC—primary healthcare

QAN— Quality of Anthroposophic Nursing Bureau (within IFAN)

Rhythmical massage—a massage developed by Hauschka and Wegman (Hauschka, 1990).

RN—registered nurse. A RN in Aotearoa requires an annual practising certificate (APC) to practice.

Rongoā—medicine, remedy, drug, treatment, cure. "Rongoā Māori"— medicines and treatments originating from Te Ao Māori used in accordance with tikanga

Spiritual science—seeks to extend the principles of natural science—rooted in perception and cognitive reasoning—into the realms of emotion and spirituality. By

exploring consciousness as a fundamental reality, this approach offers a scientific lens through which we can better understand ourselves as human beings and our place in the universe.

Tāngata Tiriti —“people of the Treaty”: all New Zealanders of non-Māori descent living with the rights and obligations of Te Tiriti o Waitangi

Tāngata Whenua—Indigenous peoples of Aotearoa New Zealand

Taonga—treasure, highly-priced possession

Tauīwi—foreigner, non-Māori, colonist

TCIH—traditional, complementary and integrative healthcare

Te Tiriti o Waitangi—also referred to as Te Tiriti. The founding treaty between Māori and the Crown was signed in 1840 and set out broad principles to govern the new nation of Aotearoa New Zealand. Important to note: Te Tiriti refers to the Māori version, and The Treaty to the English version. The documents differ and the terms should not be used interchangeably.

Te Ao Māori—Māori world view

Tikanga—protocol, the customary system of values and practices

Waldorf education/schools, also referred to as **Steiner** education/schools

Wairua—spirituality OR spirit

Whakawhanaungatanga—the fostering and nurturing of relationships
(whanaungatanga)

Whānau—extended family, family group

Whānau Āwhina Plunket—Plunket is a national not-for-profit organization in Aotearoa New Zealand established in 1907 that offers a range of support services for the health, development, and wellbeing of tamariki (children) under five and their whānau (families). Plunket offers the Well Child Tamariki Ora Programme (free health and development checks for children under five), free parenting support (a 24/7 parenting helpline, parent groups, and educational resources). Plunket networks with local community services and advocates for policies that improve child health
(<https://www.plunket.org.nz/plunket/about-plunket/who-we-are/>)

Whenua—earth, land, placenta

Appendix A Third Party Copyright: The Twelve Nursing Gestures



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24/8/2023

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Dear Rolf

I am a Doctoral student/staff member at Auckland University of Technology and am writing a thesis on *Anthroposophic Nursing in Aotearoa/New Zealand - How do anthroposophic registered nurses inform their practice using the anthroposophic paradigm?* for a Doctor of Health Sciences.

I am writing to request permission for the following work, for which I believe you hold the copyright, to be included in my thesis:

I would like to insert a visual presentation of the 12 Nursing Gestures attached to this document. I will refer to the 12 Nursing Gestures in the background and discussion chapter mainly. But there will also be notes made in the recommendations for practice in the conclusion chapter.

A digital copy will be made available online via the University's digital repository [Tuwhera](#). This is an open-access research repository for scholarly work, intended to make research accessible to as wide an audience as possible.

I am seeking from you a non-exclusive licence to include these materials in my thesis. The materials will be fully and correctly referenced.

If you agree, I should be very grateful if you would reply to me via email, or alternatively sign the form below and return a copy to me.

If you do not agree, or if you do not hold the copyright in this work, would you please let me know.

I can most quickly be reached by email at maria.te.huia@aut.ac.nz. Thank you for your assistance. I look forward to hearing from you.

Yours sincerely,

Maria Te Huia

I, Rolf Heine, agree to grant you a non-exclusive licence for an indefinite period to include the above materials, for which I am the copyright owner, in the print and digital copies of your thesis.

Date: August 26th, 2023

Rolf Heine

Appendix B Ethics Approval



Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
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E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

TE WĀHANGA ARONUI
O TAMAKI MAKAU RAU

12 May 2020

Eleanor Holroyd
Faculty of Health and Environmental Sciences

Dear Eleanor

Re Ethics Application: **20/74 Anthroposophic nursing in Aotearoa/New Zealand. How do registered nurses inform their practice using the anthroposophic paradigm**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 12 May 2023.

Non-Standard Conditions of Approval

1. In the Information Sheet please update the Executive Secretary details to Dr Carina Meares.

Non-standard conditions must be completed before commencing your study. Non-standard conditions do not need to be submitted to or reviewed by AUTEC before commencing your study.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the [Auckland University of Technology Code of Conduct for Research](#) and as approved by AUTEC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard and that all the dates on the documents are updated.

AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

Please quote the application number and title on all future correspondence related to this project.

For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through <http://www.aut.ac.nz/research/researchethics>

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: maria.tehuia@wintec.ac.nz; Priya Saravana-Kumar

Appendix C Poster Presentation of Pilot 2018



Antihypertensive Nurse Association of New Zealand
November 2018

First national survey of anthroposophic nurses in Aotearoa/New Zealand

Maria Te Huia - (MHeaSc, PGDipPhC, RN, ANS) - Waikato Institute of Technology
Anthroposophic Nurse Association New Zealand (ANANZ) - Education Committee
November 2018



Wintec
WAIKATO INSTITUTE OF TECHNOLOGY

Introduction/Background

Anthroposophic health care although listed as a complementary and alternative medicine (CAM) approach according to the Ministerial Advisory Committee for Complementary and Alternative Health (MACCAH, 2002-2004) in New Zealand (NZ), is an integrated healing system that has been practised and widely used in Europe. Based on foundations developed by Rudolf Steiner and his Wegman, anthroposophic medicine is a holistic healing approach considering the whole human being, namely the physical, emotional, mental, and spiritual aspects. Anthroposophic approaches will aim not only at the physical complaint but target the whole person, inclusive of emotional, psychological and spiritual aspects. Diagnosis and therapies are therefore based on assessing the individual with a holistic framework and rather than aiming for a cure, the emphasis is on salutogenic strategies, supporting the person's capacity to improve their health through their own healing abilities (Fram & Rogers, 1997; Mithras & Wirth, 2017; Theobald & Theobald, 2016).

Health care professionals practicing with anthroposophic principles use esoteric, scientific foundations and extend their practice with the holistic foundations of anthroposophic health care in NZ anthroposophic nurses (ANs) work in a variety of clinical settings, e.g. in anthroposophic health centres (H. Z. online integrative Medical Centre), primary health practices (Munichner, 2009), in community centres (Framman, 2014), hospice and some of independent practitioners in the community. ANs therefore support the human being through holistic nursing, integrative, complementary, integrative, integrative and integrative work (Theobald, 2006).

Collaboration is an essential part of anthroposophic practice. Through the Trans-Community for Nurses (TCN) and the ANANZ Register of Anthroposophic Nurses (ANR), some of the ANs currently practicing in NZ have gained registration overseas at an Anthroposophic hospital (Germany or Switzerland).

Methodology/Design

A questionnaire (online) - research design was developed in collaboration with the researcher Maria Te Huia and the ANANZ Education Committee (see below) to collect data on the ANs. The questionnaire was sent to all registered ANANZ members for completion. The 13 questions collected demographic information, qualifications and qualitative responses. Qualitative data was gained by asking questions regarding the use of anthroposophic foundations and additional open-ended questions regarding the use of anthroposophic foundations. Identifying possible barriers and facilitators of the application of ANs. An invitation to share any reflective thoughts was included in the survey to gain further insight into the participants' views on ANs. A request for participation in this project was approved by the Waikato Research Department on the 24th of January, 2018.

All nurses on the ANANZ membership data base with associated education in AN that was either completed in New Zealand (NZ) or at an overseas institution were invited to participate. The link to the survey/questionnaire was open from the 9th of April to the 30th of June 2018. Principles of Galen's philosophy (1889) were applied to make beginning connections between the phenomenology of the participant's experiences (lived-experiences) and how these nurses see their clinical practice compared to the mainstream foundations of anthroposophic health care. This is only captured with limited steps here and will need further exploration.

Findings, concl.

It is a concern, the nature of isolation and care research was also noted by those respondents who work as independent practitioners, expressed in terms of challenge regarding time and additional reporting when being self-employed.



Figure 1



Figure 2

Recommendations

A first nationwide survey conducted in NZ has established the ANANZ Education Committee, the beginning of a more extensive analysis of these anthroposophic nurses' practice when utilizing and extending nursing care with anthroposophic foundations. It seems worthwhile to consider health environments marked by an increase in chronic, long-term conditions to consider different phenomenological perspectives when exploring the position of nurses integrating holistic and integrative views on health care mainstream practice (Edwards et al., 2008; Edwards & Egan, 2011; Odom, Holberg & Colberg, 2015; Odom, 2015; Odom, 2015; Odom & Egan, 2015). Colberg and ongoing professional development opportunities were identified from the results that would benefit from further exploration by the ANANZ Education Committee. However the findings from this survey can only present a glimpse into the topics explored, and despite being integrated in health systems in Europe for almost 100 years, anthroposophic health care is not well known in NZ. Overseas literature and research has confirmed the value of integrated health care (Edwards & Egan, 2011; Odom, Holberg & Colberg, 2015; Odom, 2015; Odom & Egan, 2015). Therefore a more explorative inquiry looking ANs and mainstream nursing in NZ, could produce insights that support existing services, patient requests and nursing practice.

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Wintec. (2018). *Wintec*. Waikeato Institute of Technology.

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Findings

The 24 nurses that responded to the survey work in a variety of clinical areas: pediatric (4), postnatal, community services, primary health services, hospital (2) and aged care (1). Gender: 20, AN, AN, with populations ranging with adult and old age, in women and child health and/or are self-employed anthroposophic care either as an independent practitioner or in mainstream, stated a lack of collegial support, not achieved JAC qualification, only offering ANs (1) to travel and family of their full time sometimes use ANs (1) and 27% (n=6) stated always when practicing as a RN (Figure 2).

The participants' responses generated a broad range of experiences and terminology that shows more light on the practice of AN, but also highlight the need for more clarification around how anthroposophic concepts and foundations are expressed, perceived and integrated in encounters with patients.

"It is part of my being-the way I look at the job as a human being and illnesses as a challenge".

"It is great for the first time, it's hard to view them through the lens of AN but then I have to stop and just look and remember I am in mainstream and have to speak mainstream a language in our understanding/foundations field even if I change the language in what I hope would be understandable."

"By seeing the patient as a whole being, I integrate anthroposophic concepts in my assessment of the patient and I use the Anthroposophic practices to achieve reports with my patients."

"Holistic and integrated individualized approach to each person I work with, use functions in annual diabetic checks."

The results reflected a clear knowledge increase after further professional AN development. Nurses stated that their learning was supportive of the pre-existing nursing practice and were used to broader holistic paradigms and added to existing knowledge into the biomedical approach. This is a barrier noted when nurses use CAM also confirmed in the literature (Orkaby & Greenberg, 2015). In contrast to their participants viewed however a lack of opportunities to implement knowledge especially in practice. Although this was mentioned a lack of geographical support systems and confidence in practicing with the acquired knowledge if there were no collegial support in place. So, working in isolation seems

Aims/Objectives

The aim of this survey was to establish an initial understanding of how ANs integrate knowledge based on esoteric and holistic foundations into their research or data collection that supports and informs AN nursing in the NZ health care.

Since research literature shows that nursing is slowly positioned to integrate CAM knowledge (Edwards & Egan, 2011; Odom, 2015; Odom & Egan, 2015; Odom, 2015; Odom & Egan, 2015), it is important to better define this extended nursing practice and the potential barriers for its integration.



Introduction/Background

Anthroposophic health care although listed as a complementary and alternative medicine (CAM) approach according to the Ministerial Advisory Committee for Complementary and Alternative Health (MACCAH, 2002-2004) in New Zealand (NZ), is an integrated healing system that has been practised and widely used in Europe. Based on foundations developed by Rudolf Steiner and his Wegman, anthroposophic medicine is a holistic healing approach considering the whole human being, namely the physical, emotional, mental, and spiritual aspects. Anthroposophic approaches will aim not only at the physical complaint but target the whole person, inclusive of emotional, psychological and spiritual aspects. Diagnosis and therapies are therefore based on assessing the individual with a holistic framework and rather than aiming for a cure, the emphasis is on salutogenic strategies, supporting the person's capacity to improve their health through their own healing abilities (Fram & Rogers, 1997; Mithras & Wirth, 2017; Theobald & Theobald, 2016).

Health care professionals practicing with anthroposophic principles use esoteric, scientific foundations and extend their practice with the holistic foundations of anthroposophic health care in NZ anthroposophic nurses (ANs) work in a variety of clinical settings, e.g. in anthroposophic health centres (H. Z. online integrative Medical Centre), primary health practices (Munichner, 2009), in community centres (Framman, 2014), hospice and some of independent practitioners in the community. ANs therefore support the human being through holistic nursing, integrative, complementary, integrative, integrative and integrative work (Theobald, 2006).

Collaboration is an essential part of anthroposophic practice. Through the Trans-Community for Nurses (TCN) and the ANANZ Register of Anthroposophic Nurses (ANR), some of the ANs currently practicing in NZ have gained registration overseas at an Anthroposophic hospital (Germany or Switzerland).

Methodology/Design

A questionnaire (online) - research design was developed in collaboration with the researcher Maria Te Huia and the ANANZ Education Committee (see below) to collect data on the ANs. The questionnaire was sent to all registered ANANZ members for completion. The 13 questions collected demographic information, qualifications and qualitative responses. Qualitative data was gained by asking questions regarding the use of anthroposophic foundations and additional open-ended questions regarding the use of anthroposophic foundations. Identifying possible barriers and facilitators of the application of ANs. An invitation to share any reflective thoughts was included in the survey to gain further insight into the participants' views on ANs. A request for participation in this project was approved by the Waikato Research Department on the 24th of January, 2018.

All nurses on the ANANZ membership data base with associated education in AN that was either completed in New Zealand (NZ) or at an overseas institution were invited to participate. The link to the survey/questionnaire was open from the 9th of April to the 30th of June 2018. Principles of Galen's philosophy (1889) were applied to make beginning connections between the phenomenology of the participant's experiences (lived-experiences) and how these nurses see their clinical practice compared to the mainstream foundations of anthroposophic health care. This is only captured with limited steps here and will need further exploration.

Findings

The 24 nurses that responded to the survey work in a variety of clinical areas: pediatric (4), postnatal, community services, primary health services, hospital (2) and aged care (1). Gender: 20, AN, AN, with populations ranging with adult and old age, in women and child health and/or are self-employed anthroposophic care either as an independent practitioner or in mainstream, stated a lack of collegial support, not achieved JAC qualification, only offering ANs (1) to travel and family of their full time sometimes use ANs (1) and 27% (n=6) stated always when practicing as a RN (Figure 2).

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Appendix D Email from Sally Thorne

Thorne, Sally <Sally.Thorne@ubc.ca>
Fri 15/11/2019 7:35 AM
To: Maria Te Huia

2 attachments (169 KB) Download all Save all to OneDrive - Wintec

 2004-AnalyticChallengei... 68 KB

 Sandelowski-2011 When... 101 KB

Hello Maria
I do apologize for the delay in responding. I was travelling and your message slide down into my inbox over time. Your topic sounds great – definitely an interpretive description kind of question.

I should let you know that I am not a huge fan of thematic analysis as it is currently being used in applied clinical disciplines. The issue is that the term refers to the most basic form of qualitative (inductive) analysis, essentially looking for common patterns within a data set and reporting them as findings. In our clinical disciplines, we actually need rich and deep and nuanced understandings of phenomena, so that we don't merely recreate what is already known, but engage in studies that will unpack some of the complexities that will usefully inform the work we do in the applied practice field.

A study calling itself thematic analysis is essentially claiming to be looking for recurrent or common patterns. And reporting them as findings. It of course can be well done and useful, or in many instances (as a review of the published literature will confirm), can be a superficial exercise in restating the obvious. Sometimes the authors report their findings in terms of themes and categories (providing the reader with the number of each, as if that is relevant to an understanding). As Margarete Sandelowski wrote in 2007, some words (like theme or category) should be "seen but not written" <https://onlinelibrary.wiley.com/doi/abs/10.1002/nur.20198> In other words, certainly a good scholar will attend to such issues as common themes, and in some instances they may lead to some useful insights, but the best of qualitative scholarship is capable of also including interesting diversities within a data set, and wrestling with interpreting why that might be, in order to come up with findings that actually advance thinking in the field in a meaningful way.

I have attached an older paper that might help (or perhaps it is redundant, since the book expands on it considerably). But I think that thinking about yourself as "working" the data is a good approach in general. And an older paper of Sandelowski that I have also attached may be helpful in that regard.

Hope these thoughts are helpful. And good luck in your study!

SALLY THORNE RN, PHD, FAAN, FCAHS
Editor-in-Chief, *Nursing Inquiry*

Appendix E Literature Table – Empirical Sources⁴

[Nursing views/data](#)

[Patient/family views on nursing practice](#)

Author(s)/Country (where study conducted)	Participants	Title of publication	Methodology/Design	Findings/Discussion linked to AN	Recommendations/ implications linked to AN
<p>Arman, Ranheim, Rehnsfeldt & Wode (2008) Nordic College of Caring Science (Sweden)</p>	16 former patients at an anthroposophic clinic	Anthroposophic healthcare—different and home-like	Phenomenological hermeneutic approach. Gadamer’s philosophy. Main author/researcher: RN	<p>Research aimed to explore whether anthroposophic care has beneficial effects for patients with a history of cancer burnout syndrome.</p> <p>The patient was identified as the bridge builder between integrative and conventional care. Patients found it difficult to describe what anthroposophic care is, but authentic</p>	Key concepts of AN are outlined, as well as the holistic underpinnings of care. AN is described as “directing consciousness when providing care toward the whole person in every caring act.” (p. 358)

⁴ Table includes only sources found based on AUT database search with key terms noted in Chapter 3 & inclusion/exclusion criteria

Author(s)/Country (where study conducted)	Participants	Title of publication	Methodology/Design	Findings/Discussion linked to AN	Recommendations/ implications linked to AN
Ben-Ayre et al. (2021) Journal of Pain and Symptom Management (Israel & Germany)	30 participants (13 nurses , 10 physicians, 6 complementary/ integrative healthcare providers (HCP), 1 psycho-oncologist)	Enhancing palliative care with mindful touch: Impact of a manual and movement therapy training programme in an international multidisciplinary integrative oncology setting	Qualitative content analysis by a sociologist not involved in designing the training programme (pre & post-training evaluation).	encounters with life allowed for connectivity with inner sources (p.364). HCP providers received training in manual movement therapy (AM5 & TCM6). Comments after the course: MMT7 enhances nonverbal communication; bridge- building between therapist & patient. Touch was linked to spiritual understanding and concepts of energy and soul. Also effect on HCP's personal lives.	Future research could include investigating the nature of the change of attitude in professional and clinical presence. Larger cohorts and different health environments. ? Does the use of MMTs increase sensitivity to patient suffering, reduce compassion fatigue and burnout, and facilitate resilience and posttraumatic growth (both personal and professional)?

⁵ AM=Anthroposophic Medicine
⁶ TCM=Traditional Chinese Medicine
⁷ MMT=Manual Movement Therapy

Author(s)/Country (where study conducted)	Participants	Title of publication	Methodology/Design	Findings/Discussion linked to AN	Recommendations/ implications linked to AN
Ben-Ayre et al. (2018) Supportive Care in Cancer (Israel & Germany)	18 German & 14 Israeli healthcare providers (CPs comprising 10 physicians, 12 nurses and paramedical practitioners, & 10 CIM therapists & spiritual CP)	Crossing the death threshold: Experiencing multidisciplinary end-of- life integrative oncology training	Content analysis of participant narratives post 4-month training	Skills learnt in the 3-day training course have value across various cultural settings, enhanced communications and clinical skills. Nurses: calmness & confidence in “providing care up to the end”, “facing own fears”, more open to the dying process.	Further studies (mixed method) pretraining attitudes, knowledge and clinical competence. How does training in EOL (end-of-life) care with AM foundations impact clinical practice in the long term?
Dahlberg, Ranheim & Dahlberg (2016) International Journal of Qualitative Studies on Health and Well-being (Sweden)	16 patients with cancer (rehabilitation unit at an anthroposophic clinic)	Ecological caring— Revisiting the original ideas of caring sciences	Phenomenological and reflective lifeworld research (RLR). Main author/researcher: RN	Ecological care recognises that human existence must be understood within a web of relationships. Tacit knowledge: taken- for-granted approach to “holistic care” is dismantled.	Focus is on the patient rather than the nurse. Effect of nursing practice (limited). AN- therapies outlined and discussed. The patient statements give insight into how care is received. How do these findings fit when

Author(s)/Country (where study conducted)	Participants	Title of publication	Methodology/Design	Findings/Discussion linked to AN	Recommendations/ implications linked to AN
<p>Rutert, Stritter, Eggert, Auge, Laengler, Seifert & Holmberg (2021)</p> <p>Complementary Medicine Research (Germany)</p>	<p>Observations & 12 interviews with parents, doctors, therapists, and nurses across 7.5 months at 2 different anthroposophic hospitals (ICUs).</p>	<p>Development of an integrative care program in a pediatric oncology unit</p>	<p>Grounded theory, semistructured interviews.</p>	<p>Training in AN was needed to develop integrative care: focus on the delivery of integrated care</p> <p>Three essential factors were identified: structure of a ward, communication & information dissemination, time constraints.</p>	<p>explored through the carer's lens in practice?</p> <p>Integrated care needs to be flexible.</p> <p>Time constraints, increased workload.</p> <p>Future research:</p> <p>(1) the applicability to other clinical settings; (2) evaluation of the impact of integrative care on the philosophy and culture of a ward; (3) the impact of a team on the implementation of integrative care; (4) the effects of anthroposophic treatments on time, touch, and affection amongst nurses and patients; and (5) the financial requirements.</p>

Author(s)/Country (where study conducted)	Participants	Title of publication	Methodology/Design	Findings/Discussion linked to AN	Recommendations/ implications linked to AN
Therkleson (2014a) Journal of Holistic Nursing (Australia, NZ)	Case report/clinical presentation (1)	Ginger therapy for osteoarthritis: A typical case.	Clinical case study (1 patient, with ethics approval) conducted by ANS in Aotearoa/NZ	AN: holistic way of thinking, feeling and acting in the world; theoretical concepts rooted in anthroposophic perspectives & integrated into conventional health science	Future research: larger scale cohorts to trial ginger (patch) application
Tröndle, Stritter, Odone, Peron, Ghelman & Seifert (2021) Journal of Alternative and Complementary Medicine (Brazil)	12 interviews: 6 anthroposophically trained nurses, 3 non-ANs clinic nurses, & 3 physicians.	Beyond the standard of care: An exploratory qualitative study of an implemented integrative therapeutic care program in a Brazilian pediatric oncology unit	Semistructured interviews; thematic approach; ethnography	(1) implementation and its effects on daily patient care demonstrated positive patient outcomes; were well accepted with minimal changes in daily activities. (2) nurses are highly motivated due to the beneficial and stress-relieving effects of the application & increased healthcare—	*1 nurse explained they liked the different and more humanistic approach *personal life was impacted – EAT8 use at home with own families *intimate moments through touch – specific to EAT

⁸ EAT=External Anthroposophic Therapies

Author(s)/Country (where study conducted)	Participants	Title of publication	Methodology/Design	Findings/Discussion linked to AN	Recommendations/ implications linked to AN
				<p>provider relationship. (3) lack of time; expansion of the project in the future; strengthen relations between patients, caregivers, and family members. Acceptance in the team after benefits are visible.</p>	<p>*nurses received positive feedback & trust *EAT positive effect on nurses' stress *training parents in EAT *Time constraints</p>
<p>Von Schoen-Angerer et al. (2017) Complementary Therapies in Medicine (Switzerland)</p>	<p>52 parents 43 nurses 6 physicians</p>	<p>Acceptance, satisfaction and cost of an integrative anthroposophic programme for pediatric respiratory diseases in a Swiss teaching hospital: An implementation report</p>	<p>*CSQ-8 – parents *Open-ended questionnaire for staff (nurses & physicians) *Cost-minimisation analysis</p>	<p>Nurses positive: EAT means offering additional treatments; closer comfort contact active participation by parents; pleasure in caring; additional time and education in AM needed.</p>	<p>Integration of complementary medicine was perceived to improve holistic capacity through treating the “whole person”, by filling gaps in existing service delivery, and through increasing treatment options for patient.</p>

Appendix F Literature Table – Grey Sources⁹

Author(s) /Country	Title	Type of publication	Discussion/comments linked to AN	Description of anthroposophic nursing (AN)
Cooksley (2021) Lilipoh Magazine¹⁰ (US)	Returning healing to the nursing profession	Discussion/commentary Author: AN ¹¹	Personal reflective narrative of the education journey to becoming an anthroposophic nurse	Educational path is presented alongside the personal journey & how both can enhance conventional nursing. Complexity of AN approach as an advantage and extension of conventional nursing.
Deckers et al. (2016) Holistic Nursing Practice (Germany)	External nursing applications in the supportive management of prolonged postoperative ileus	Discussion of a case report from AN perspective. Main author: ANS	Case presentation: most descriptive, each substance used is linked to anthroposophic concepts Additional time is required but practical interventions are rewarding for nurses.	Short description of AN in the context of AM as an integrated approach. External applications as part of AN core therapeutic interventions.
Freeman Rock (2014) Kai Tiaki Nursing (Aotearoa/New Zealand)	Taking an anthroposophic approach to care	Discussion/commentary	Describes Hōhepa residential community for people with intellectual disabilities Hawkes Bay, NZ Outlines the role & work of RN	AN is a “hands-on” practice with acute observations. “Specialists at generalist practice”. “Anthroposophic medicine is grounded & practical, especially for home care...range

⁹ Table includes only sources found based on AUT database search with key terms noted in Chapter 3 & inclusion/exclusion criteria

¹⁰ “...LILIPOH is a lifestyle magazine for the growing populace known as ‘culture-creatives,’ folks interested in holistic health, well-being, creativity, spirituality, gardening, education, art, and social health.” (Lilipoh, 1997-2024)

¹¹ AN(s)=Anthroposophic Nurse(s)

			when taking on AN roles. An integrative & holistic approach to care.	of skills...alongside our sound health assessment skills.” (p.36)
Heine (Ed.) (2020) Portal Books (1st edition published in Germany by Salumed in 2017)	Anthroposophic nursing practice. Foundations and indications for everyday caregiving.	Textbook Editor and all contributing authors are Ans/ANSs	Comprehensive textbook for anthroposophic nurses and nurses interested in anthroposophic nursing. Lays out concepts and foundations of anthroposophic nursing practice	Part 1: Methodical-didactical foundation Part 2: Anthroposophy & nursing; ontological & epistemological foundations; biography, practice of self-reflection & meditation; 12 Nursing Gestures Part 3: Elements of nursing practice; EATs, relevance of warmth, rhythm & natural substances Part 4: Specialisations in nursing—case studies from various clinical areas using anthroposophic nursing interventions
Kramer, Schmiesing & von Dach (2021) Journal of Holistic Nursing (US)	Illuminating nursing’s value: The 12 anthroposophic nursing gestures	Discussion/commentary Authors include ANSs	Organisations quantify nursing care; lack of value assigned to patient-nurse encounters. 12 anthroposophic nursing gesture model makes intangible actions tangible while applying a whole-person approach	More research needed: *to refine nursing care values *to establish connection between healing, caring & patient outcomes

<p>Manchester (2009) Kai Tiaki Nursing (Aotearoa/New Zealand)</p>	<p>Nursing the anthroposophical way</p>	<p>Discussion/commentary</p>	<p>Generic info on AN training, ANS (anthroposophic nurse specialist) accreditation process; history of AN in NZ</p>	<p>AN work is described as, “a holistic & therapeutic approach...stimulating the body to ‘heal itself’. A deepening of knowledge on medicinal plants techniques of hydrotherapy, rhythmical body oiling & the pharmaceutical warmth processes.” (p.24)</p>
<p>Seifert & Längler (Eds) (2022), Springer (Germany)</p>	<p>The healing power of touch— Guidelines for nurses and practitioners: External applications in pediatrics</p>	<p>Textbook Authors: AM pediatricians (pediatric clinic for oncology & hematology at the Charité/Universitätsklinikum Berlin, Germany)</p>	<p>Text dedicated to nursing. Focus: EAT, hands-on therapies; for healthcare professionals, therapists & family caregivers interested in supplementing conventional pediatric care with external applications.</p>	<p>Nurses have in-depth understanding of the whole person; the conceptual framework of EATs described & the relevance of holistic understanding for their use. No additional mention of AN/ANS roles.</p>
<p>Sustick (2017), Lilipoh Magazine (US)</p>	<p>The caring profession of anthroposophic nursing</p>	<p>Narrative/reflection Author is ANS</p>	<p>Short description of the use of the medium of “warmth” in AN practice. Limited contextualising to AN concepts</p>	<p>Step-by-step explanation of footbaths; three therapeutic substances noted & their applications</p>

<p>Therkleson (2005), The Australian Journal of Holistic Nursing (Aotearoa/New Zealand)</p>	<p>Anthroposophical nursing</p>	<p>Discussion/commentary Author: ANS</p>	<p>Extensive discussion on nursing external therapies. Four clinical vignettes included (which are discussed in detail) Profiles in nursing practice (2006).</p>	<p>AN is well explained from the standpoint of an ANS working in Aotearoa/New Zealand. Spiritual aspects & inner meditative work of AN role are described & discussed.</p>
<p>Therkleson & Stronach (2015), Journal of Holistic Nursing (Aotearoa/New Zealand)</p>	<p>Broken heart syndrome – A typical case</p>	<p>Discussion/commentary Author: ANS</p>	<p>AN treatments for an 82-year-old woman described & discussed. Rationale for each nursing intervention is presented & linked to the anthroposophic four-fold picture of the human being.</p>	<p>AN described as a holistic approach to support physical, emotional, mental spiritual, & social aspects of a person. Although “treatments are directed to the physical body they work on restoring life vitality & emotional imbalance with warmth & conscious caring” (p. 346).</p>
<p>Trevelyan (1997), Complementary Therapies in Nursing & Midwifery (Great Britain)</p>	<p>Anthroposophical medicine: A nursing perspective</p>	<p>Interview/commentary Author: ANS Interviewee: AN</p>	<p>This paper includes an interview with Frances Bay. Outline of AN practice &</p>	<p>A description of what anthroposophic nursing is from the perspective of an AN. Very limited & lacks reference to updated research (source is 27 years old).</p>

			therapeutic approaches.	
Varriale (2019), Lilipoh Magazine (USA)	Anthroposophic, palliative nursing	Discussion/commentary Author: ANS	Article describes the role of the palliative care nurse working from anthroposophic foundations. Care plans include art, music, speech, colour therapies & eurythmy (a form of movement therapy).	AN brings “valuable insights & skills that enhance the effectiveness & expand the repertoire of care.” (p.12). Nurses are well versed in concepts of health & illness, healthcare systems, treatments & therapies...they are able to collaborate with the interdisciplinary team to create a holistic, individualised patient-centred plan of care.” (p.15). Teaches the “patient & their families how to self-manage, hence enhancing autonomy...Inner attitude or gesture of the nurse important in AN” (pp.15-17)

Appendix G Participant Information Sheet



Participant Information Sheet

Date Information Sheet produced: 12.05.2020

Thank you for your interest in this research project. Please read carefully through the information provided before you give permission to participate.

Project Title

20/74 Anthroposophic Nursing in Aotearoa/New Zealand – How do anthroposophic registered nurses inform their practice using the anthroposophic paradigm?

An Invitation

I would like to invite you to participate in my DHSc (Doctor of Health Science) research which seeks to explore and articulate the work anthroposophic nurses do when integrating knowledge and nursing therapies into their clinical practice. While studies are emerging that evaluate anthroposophic nursing therapies from the patient's perspective, there is no research to this point that illuminates the work of registered nurses informed with the anthroposophic human picture and worldview.

My own experiences as an anthroposophic nurse over the past 18 years have influenced and are informing this path of inquiry. I have completed the postgraduate training to become an anthroposophic nurse at an anthroposophic hospital in Germany, worked in New Zealand (NZ) in private practice as an anthroposophic nurse and have been employed by a not-for-profit organisation to integrate anthroposophic nursing care for women suffering from stress, depression and anxiety. This journey has continuously confirmed for me the validity of nursing informed by the anthroposophic paradigm but also at the same time questioned why this way of nursing has not been further researched and studied at a scholarly level.

A special thank you to Weleda Charitable Trust who have supported my studies so far through the nursing scholarship fund. I have also been able to access my allocated professional development fund with my current employer Waikato Institute of Technology (Wintec).

What is the purpose of this research?

Anthroposophic health care and medicine is an integrative, multimodal treatment system (Kienle et al., 2013) based on the foundations of a holistic view of the human being. This healing approach has been practised for over a century by doctors, nurses, and other allied health professions. In New Zealand (NZ) the Taruna College in Havelock North has offered postgraduate education in anthroposophic nursing to registered nurses since 2002. However, despite around 60 nurses completing this program, not much is known in NZ about this way of nursing. The primary aim of this study will be to understand better the role of anthroposophic nursing and how nurses articulate working from the anthroposophic paradigm in NZ.

The findings of this research may be used for academic publications and presentations in NZ and internationally.

How was I identified, and why am I being invited to participate in this research?

Invited are all registered nurses (with a current annual practising certificate) who have completed a postgraduate qualification to become an anthroposophic nurse and/or anthroposophic nurse specialist and are practising in NZ. Eligible participants might be working in hospitals, community or primary health care settings and/or in private practice (self-employed). Registered nurses with anthroposophic nursing training NOT currently employed in a role specifically related to anthroposophic health care will be included.

Invitational emails will be sent out by the ANANZ-coordinator Shelley Bignell via the ANANZ email list alongside the Participant Information Sheet and the Consent Form. If you are aware of an anthroposophic nurse not on the membership list and interested in participating, please feel free to forward this information with my contact details.

How do I agree to participate in this research?

Your participation in this research is voluntary and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you decide to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, the removal of your data may not be possible.

If you decide to participate in this research, please complete the consent form attached to this email/information and email it back to the researcher. Maria will contact you and arrange a time suitable to conduct an interview (maria.tehuia@wintec.ac.nz OR 027 3560405).

If you are part of the first-line responder workforce during the current Covid-19 pandemic, would like to participate but are limited due to shift work commitments, please contact me, and we can arrange a time that suits your time schedule. Also, the suggested interview time can be reduced to 30 minutes to 1 hour.

What will happen in this research?

The interview (due to the current COVID-19 pandemic these will be conducted via Zoom or phone instead of face-to-face) will be approximately 1 – 1.5 hrs long and I will be asking you a few questions relating to your knowledge and practice as a registered nurse who informs their practice with anthroposophic foundations and/or your work as an anthroposophic nurse. Before the actual interview, I will invite you to a pre-meeting so I can talk you through some of the Zoom platform features if you are unfamiliar with this online tool. During this pre-meeting, you will also have the opportunity to ask any questions about the study. The interviews will be audio and video recorded, so please be aware you are in a space that allows for privacy, and you are undisturbed for the duration of the interview. Any background noise or other people entering the room will be on the recording and might impact on confidentiality and privacy. Only the audio recording will be stored, and I will delete the video recording after the interview.

In case of a phone interview, I will call you twice. One call to take verbal consent and the other phone call will be the interview. Both will be recorded but stored separately to protect privacy.

The interview will be transcribed verbatim (word-by-word) in the first instance by myself. A confidentiality agreement will be completed if a transcriber has to be employed for this task before they have access to the data. After collating this information, data will be analysed and written up as part of my thesis. The data collected will be used for this research ONLY. If required, the researcher or yourself can request a follow-up interview clarifying and/or adding to the initial interview responses.

Here is a selection of [interview questions](#) the researcher might ask you:

How would you explain anthroposophic nursing to a colleague?

Can you give me an example from your practise where you think you have used your knowledge in anthroposophic nursing?

Can you describe your feelings/responses/thoughts when you work with the anthroposophic paradigm in your clinical area?

In what way do you see this way of nursing affecting the recipient of care?

How do you, as a nurse, feel about integrating/working with anthroposophic knowledge?

Which anthroposophic nursing therapies have you been using in your practice?

Tell me about your experience working as an anthroposophic nurse specialist in private practice (if applicable).

How do your colleagues respond when you say you are an anthroposophic nurse?

How will my privacy be protected?

All information gathered from the interview will be treated as confidential. No identifying personal or organisational information will be used in any publication of the data. However, since the group of anthroposophic nurses/nurse specialist is small in NZ, individual participants might be aware of comments made by some of their anthroposophic nursing colleagues in the study and this could limit confidentiality. Interviews will be recorded and transcribed by myself as the primary researcher. All information will be accessible only to myself and both my supervisors (please see details below) and will be securely stored. Recorded interviews via the Zoom platform will be deleted from the Zoom Cloud after they are downloaded onto an external hard drive. Your consent will be stored separately from your interview recording. At the end of the study, personal information will be destroyed immediately except that, as required by the University's research policy, any raw data on which the results of the project depend will be retained in secure storage for six (6) years, after which it will be destroyed.

Should I invite all participants of the study to a presentation of the findings, I will notify each participant beforehand of the possibility that others attending the event may realise that they were interviewed for this project as well.

Before any presentation of the results within the ANANZ community, participants will be notified

Please note: the researcher is a member of the ANANZ and on the ANANZ Education Committee hence might be known to the participants.

No patient health information will be disclosed and solicited for this study.

Will I receive feedback on the results of this research?

A summary of your transcribed responses given during the interview will be provided to you, and you can decide if you want to retrieve or change comments made. Also, if you would like a follow-up interview with the researcher, please be in touch.

What are the benefits of this research?

You will be contributing to increasing the knowledge and practice of anthroposophic nursing, specifically relating to the NZ health context. After the completion of my Doctoral thesis, the findings will be disseminated within the local and international anthroposophic nursing community.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Professor Eleanor Holroyd, Eleanor.holroyd@aut.ac.nz, (09) 921 9999 ext. 5298.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEK, Dr Carina Meares, ethics@aut.ac.nz, 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Maria Te Huia (researcher) – Maria.tehuia@wintec.ac.nz
Prof. Eleanor Holroyd (primary supervisor) – Eleanor.holroyd@aut.ac.nz
Dr Priya Saravanakumar (secondary supervisor) – Priya.saravanakumar@aut.ac.nz

Researcher Contact Details:

Maria Te Huia (MHealSc, PGDipPHC, PGCertTT, Anthroposophic nurse specialist)
Mobile: 027 3560405
Work: 07 834 8800 ext. 8753, email: Maria.tehuia@wintec.ac.nz

Project Supervisor Contact Details:

Primary supervisor: Professor Eleanor Holroyd
Mobile: 021 721 143
Work: 09 921 9999 ext. 5298, email: Eleanor.holroyd@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on 12th May 2020; AUTEK Reference number: 20/74

Appendix H Consent Form



Consent Form

Project title: 20/74 Anthroposophic Nursing in Aotearoa/New Zealand – How do anthroposophic registered nurses inform their practice using the anthroposophic paradigm?

Project Supervisor: Professor Eleanor Holroyd

Researcher: Maria Te Huia

- I have read and understood the information provided about this research project in the Information Sheet dated 12.05.2020.
- I have had an opportunity to ask questions and to have them answered.
- I understand that notes will be taken during the interviews, they will be audio/video recorded (Zoom) and transcribed.
- I understand that during COVID-19 and social isolation regulations, the interviews will be conducted via Zoom. Only the audio recordings will be stored; the video recording will be deleted after downloaded. All data will be deleted from the Zoom Cloud after stored in external/password-protected hard drive.
- I understand that a follow-up interview (30 min) can be requested by the researcher or the participant.
- I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- I understand that if I withdraw from the study, then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, the removal of my data may not be possible.
- I agree to take part in this research.
- I wish to receive a summary of the research findings (please tick one): Yes No

Please note consent has to be stored separately from your interview data; hence here are some options on how you can return the form to me :

- You can sign it electronically and email it back to me (maria.tehuia@wintec.ac.nz)
- print it off, sign it, then scan it and email it back to me
- print it off sign it and take a photograph that you can email back to me
- copy/paste the consent form into an email to me and add a sentence indicating your agreement (please make sure this is sent from your email address, and you are stating your full name on the email)
- in the case of a phone interview, I will conduct a separate call to take verbal consent only and record this

Participant's signature:

Participant's name:

Participant's Contact Details (if appropriate):

.....
.....
.....
.....

Date:

*Approved by the Auckland University of Technology Ethics Committee on 12th May 2020;
AUTEK Reference number: 20/74*

Note: The Participant should retain a copy of this form.

Appendix I Invitational Email

Invitational email

Dear colleagues

My name is Maria Te Huia, and I am a registered nurse, an anthroposophic nurse specialist and have been living and working in NZ for the past 27 years. My background in nursing includes medical/surgical, acute nursing (ICU), occupational health nursing, community and primary health nursing, gerontological nursing, and working in rehabilitation (TBI and MH). Since 2011, I have been working for Wintec (Waikato Institute of Technology) as a lecturer and clinical tutor in the Bachelor of Nursing programme. I have worked in a variety of clinical settings in Germany, Switzerland and NZ. I am also a reflexologist registered with the RNZ (Reflexology NZ).

After completing my postgraduate education to become an anthroposophic nurse (AN) working at the Paracelsus Klinik in Germany in 2000, I have been running a private practice, completed the requirements to achieve ANS registration and was part of a multidisciplinary team for an NGO here in the Waikato integrating complementary and alternative therapy approaches.

Engaging with a variety of individuals and communities has highlighted to me the relevance and currency of integrative health care over the years. In particular, the value of anthroposophic nursing. After completing my research project for the Master of Health Science in 2015, I noticed the lack of studies completed on anthroposophic nurses worldwide. Holding knowledge and practical experience in applying the three and four-fold human picture, external therapies and the development of an inner path when practising as an anthroposophic nurse is influencing our approach to patient care. Various conversations with some of you, anthroposophic nursing colleagues from overseas, registered nurses interested in anthroposophic nursing and practitioners working with other integrated approaches, led me to embark on this current scholarly journey. While continuing my work as a full-time lecturer at Wintec (Hamilton), I have been enrolled as a Doctor of Health Science-student at AUT since mid-2018.

With this email now, I would like to invite you to participate in my Doctoral research. The study will aim to explore how registered nurses with additional education in anthroposophic nursing (AN or ANS), integrate anthroposophic foundations into their clinical practice.

I am looking at interviewing (due to COVID-19 these will have to be Zoom or phone interviews instead of face-to-face) 10-12 anthroposophic nurses who have completed postgraduate education to become an AN or ANS, have an annual practising certificate and are currently working in NZ. I intend to have all interviews completed by the end of 2020.

If you are interested in my research or have more questions about the study, please get in touch with me via email or phone.

Contact details: maria.tehuia@wintec.ac.nz

Mobile: 027 35604050

I am looking forward to hearing from you!

Warm regards

Maria Te Huia

Invitational email to Shelley

20/05/2020

Appendix J Interview Question Guide (Initial)

Interview questions:

How would you explain anthroposophic nursing to a colleague?

*Can you give me an example from your practice where you think you used your anthroposophic nursing knowledge? **What does 'integration' mean for you? How is 'integration' reflected in your practice?***

Can you describe your feelings/responses/thoughts when you work with the anthroposophic paradigm in your clinical area?

*In what way do you see this way of nursing affecting the recipient of care? **What does this way of nursing add to conventional nursing practice?***

How do you feel about integrating/working with anthroposophic knowledge as a registered nurse?

Which anthroposophic nursing therapies have you been using in your practice?

Tell me about your experience working as an anthroposophic nurse specialist in private practice (if applicable).

How do your colleagues respond when you say you are an anthroposophic nurse?

Follow-up - questions:

I heard you say.....could you clarify this?

You have mentioned earliercan you further expand on how this is visible in your nursing practice?

You use the term 'external therapies' when you stated....., what did you mean by that?

Are you able to talk a bit more about?

If you had to explain this to a nurse unfamiliar with anthroposophic nursing, how would you do that?

Reviewed interview questions with rationale:

1. Before we go into the practice of anthroposophic nursing, can you give me a brief introduction to your journey leading into this way of nursing? How and why did you become interested in anthroposophic healthcare/nursing/medicine?

Rationale:

Get a contextual understanding of why nurses embarked on this path. Establish who had previous engagement with anthroposophy and was stimulated to go into this way of nursing from this direction **OR** was stimulated to look for an approach alongside mainstream nursing.

2. How long did you practice as a nurse before you started your postgraduate education in AN?

For some relevant:

How much time has passed since you completed your initial education in AN and your anthroposophic nurse specialist (ANS) qualification?

Rationale:

Establish motivators & barriers that might have evolved through the journey of becoming qualified to practice as an AN/ANS.

3. What was the most important thing you learned when completing the education diploma **OR** advancing to becoming an ANS (if applicable)?

Rationale:

Give the participant the opportunity of a reflective moment at the end of the interview.

Appendix K Interview Question Guide (Follow up)

Revised interview question

Research question:

Anthroposophic nursing in Aotearoa/New Zealand - How do anthroposophically educated registered nurses inform their practice using the anthroposophic paradigm?

Original interview questions

How would you explain anthroposophic nursing to a colleague?

Can you give me an example from your practice where you think you used your anthroposophic nursing knowledge?

Can you describe your feelings/responses/thoughts when you work with the anthroposophic paradigm in your clinical area?

In what way do you see this way of nursing affecting the recipient of care?

As a nurse, how do you feel about integrating/working with anthroposophic knowledge?

Which anthroposophic nursing therapies have you been using in your practice?

Tell me about your experience working as an anthroposophic nurse specialist in private practice (if applicable).

How do your colleagues respond when you say you are an anthroposophic nurse?

Follow-up - questions:

I heard you say.....could you clarify this?

You have mentioned earliercan you further expand on how this is visible in your nursing practice?

You use the term 'external therapies' when you stated....., what did you mean by that?

Are you able to talk a bit more about

How would you explain this to a nurse who is not familiar with anthroposophic nursing?

Appendix L Template Interview Data

Interviews and data collection for Anthroposophic nursing in Aotearoa/New Zealand – How do anthroposophically registered nurses inform their practice using the anthroposophic paradigm? Interview 4

<u>stories/sentences/paragraph</u>	<u>Issues/phenomena/showing itself</u>	<u>My thoughts/interpretations</u>	<u>Codes/subthemes/themes</u>
<p>M: [00:12:14] Hmm, ok. I'd like to go back to the Māori patients when you said there was quite, ahm, when you said, you saw quite a few Māori patients for treatments.</p> <p>█ We...our clinic, we had the highest percentage in the █ for nurse-led clinics. Yup.</p> <p>M: [00:12:32] Why do you think that was?</p> <p>M: [00:12:36] Ahmmm....what people told us was that what we were doing really aligned with their own personal and spiritual values, that it wasn't like a tension or working against that. They felt that the plant-based medicines that we used a lot in our substances, the way we worked, the way we assessed the time</p>	<p>she mentioned 'returning Māori patients' Individual people and then their whole whānau would come, became well-known</p> <p>The health clinic (nurse-led) had the highest percentage of Māori patients at the time.</p> <p>This reflects a level of trust, culturally responsive engagement between nursing and mana whenua. Higher percentage of Māori population in this geographical area of NZ.</p> <p>Patients stated that AN aligns with their own person values and spiritual beliefs</p> <p>Patients used the terms 'no tension' and 'having to work against something' This 'comfort' was substantiated by the use of plant-based medicines, how assessment was conducted, time that was spend with each person</p> <p>AN conducted case studies exposing AN comments from patient that they felt AN enable them to become more autonomous – self-managing –</p>	<p>Nurse-led clinic at █ had received a PHO Business Innovations Award</p> <p>Interesting that this was to support in particular Māori patients – so there is a clear correlation between the Indigenous health paradigm and the AN approach to therapies, health concepts and patient relationship.</p> <p>This has gone otherwise fairly un-noticed in the wider PHC health professional community and was geographically defined</p> <p>Positive experiences with the AN clinic was spread within the local Māori community and organically sustained the clinic with referrals. Word by mouth referrals are based on trust and narratives from whānau/friends</p> <p>It is not a given that referrals within the AN are the most frequent ones</p> <p>(practice liaison occurs more frequently when there is no practice nurse with AN knowledge and practical training)</p> <p>Collaboration and referrals between a Waldorf School in the area and a practicing AN are more common which reflect the close relationship between education and health</p>	<p>Returning Māori patients</p> <p>Referrals frequently word by mouth</p> <p>AN approach successful with Māori patients</p> <p>Some collaboration with AN doctors</p>

21/10/2020
28/2/2021 updating & completing 3rd column

M. Te Huia

<p>process that we had around things was really helpful. I mean. Ahmmm...you know, there were some really remarkable case studies came out of that time of people's experiences and where they had felt that working with this modality enabled them to become more autonomous in their own health journey, and more able to integrate the stressors of their life and their life in a better way. I mean, it was very widespread from people with, you know, gambling addictions, to people with eating disorders, to people who revealed abuse experiences. You know, it was a very wide, wide-ranging as well as diabetes, as gall bladder pain, as high blood pressure, blablablablab.....</p> <p>M: Himm....(acknowledging). Can you tell me a little bit about something, you know, when you say this aligned very well with how Māori perceived....what did you say exactly? [00:14:12] I don't want to put words into your</p>	<p>allowed place for tino rangatiratanga – improved the coping with life stressors. Eating disorders, gambling addiction, abuse (all areas with high needs in contemporary statistics – NZ Health Survey). Wide range of health conditions: diabetes, high BP, gall stones</p> <p>Personal encounters and the spiritual experience of treatments seemed to represent an 'authentic experience' for Māori patients. Being part of an experience vs, something happening to them (active vs passive participation in therapy) – for all not only Māori</p>	<p>Close relationships between health services working with AN within the same geographical area can contribute to saturation of community awareness. It is however often assumed that AM practitioners know of each other and therefore can make referrals OR suggest another AM therapeutic approach for patients.</p> <p>Knowledge of health inequalities within a population are pivotal when establishing any health clinic/service in the past more than in the contemporary health landscape these services were often established without the consultation of those most in need in a population.</p> <p>Knowledge of culturally safe and responsive practices has been well circulated since Ramsden (1992) introduce the concept of cultural safety to the health professional community. Despite ongoing attempts to integrate culturally safe care in all aspects of health provision, there are still significant disparities between Māori and non-Māori health outcomes. The current inquiry into structural racism reflected in the WAI 2575 (https://www.health.govt.nz/out-work/populations/maori-health/wai-2575-health-services-and-outcomes-kaupapa-inquiry)</p>	<p><i>Referral by AM doctors to AN linked to relational engagement/knowing of and about each other</i></p> <p><i>Links between Waiohio school AN therapies – teachers or school doctor referring</i></p> <p><i>Not every anthroposophic orientated practitioner knows others in the area</i></p> <p><i>High numbers of Māori patients for AN clinic</i></p> <p><i>AN therapies aligned with Māori personal & spiritual values (feedback from patients/clients)</i></p>
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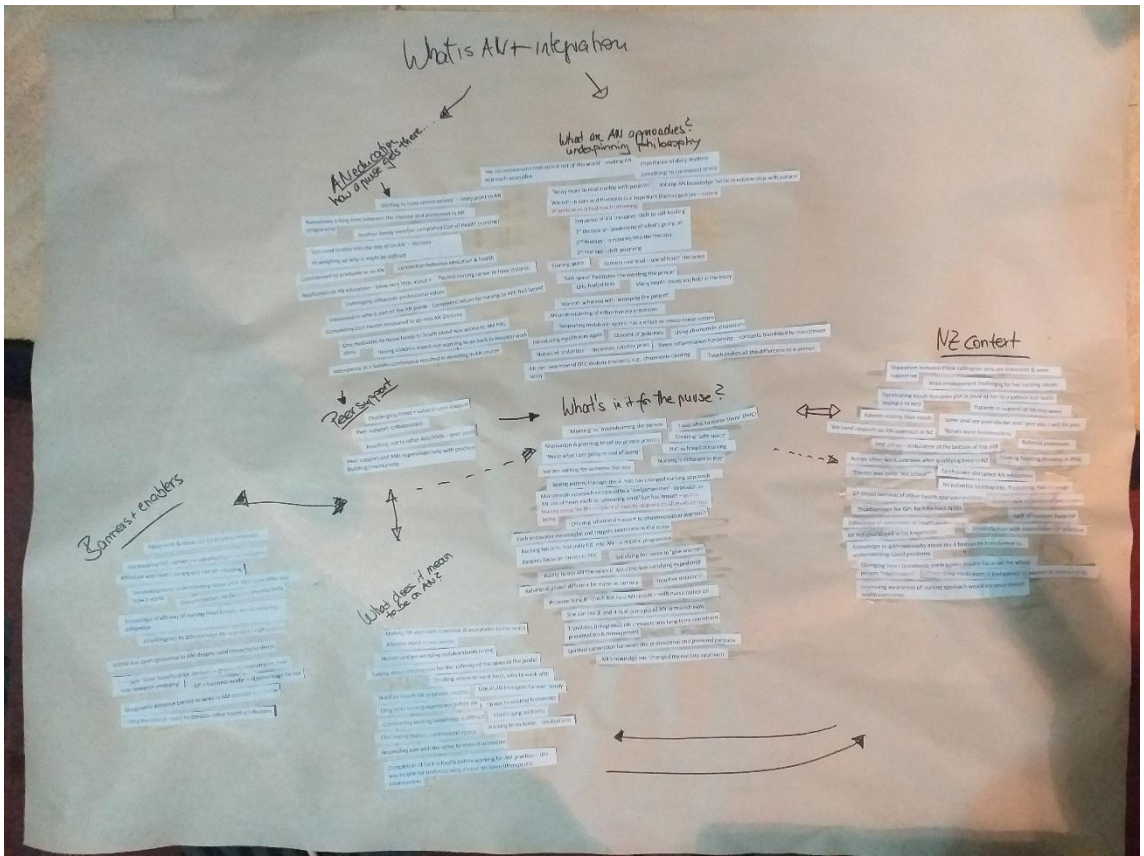
M. Te Huia

<p>mouth that it aligned well with the...you didn't use the word worldview, but it aligned well with....</p> <p>■ Yeah....it was the personal and spiritual experience. I think they I think it was kind of like it was all an authentic experience that they could be part of rather than happening to them. Well, not just for Māori, of course, but for everyone. But I think that many of them talked about being disillusioned with the allopathic healthcare system and that they were not able to be seen as their whole selves.....or that they felt they were being perceived as a problem to be solved rather than a person on their own life journey.</p> <p>M: Yeah, yeah. That's interesting. You know, there is often, ahmm....</p>	<p>AN paradigm provides something that allopathic health care doesn't or cannot do</p> <p>Ability to see one's 'whole self'</p> <p>Patient is disillusioned in the allopathic system</p> <p>Patients feel being a problem to be solved vs a person on their own life journey</p>	<p>Structural and individual barriers (health professionals) were perceived as not present or as something that was not required 'to work against'</p> <p>Meeting health needs of Indigenous populations also includes to not make assumptions that all Māori want Rongoā Māori to support themselves. Access by Māori to CAM therapies has been noted in the Ministry of Health inquiry in 2004 on</p> <ul style="list-style-type: none"> • who uses CAM • what CAM modalities are available in NZ • who offers CAM <p>A current literature review published in BMJ 2021 (Liu et al., 2021 added to endnote) has now begun to collect more data on the frequency and use of CAM in NZ.</p> <p>Interesting to notice is the seamless acceptance of diversity in values and beliefs, inviting patients to grow their way of being in the world – tino rangatiratanga as a way to live Māori identity was upheld.</p> <p>Conducting case studies is essential when establishing evidence working with a modality different to that of mainstream. Māori patients accessing the nurse-led clinic reported that receiving care from an AN perspective enabled them to live a better life and integrate existing stressor better (salutogenesis).</p>	<p>No tension between the health service provided (AN therapies) – 'Māori didn't have to work against that tension'</p> <p>Plant based medicines/substances & process of therapies aligned with Māori worldview/expectations</p> <p>Case studies conducted with Māori patients reflected and enabled "...to be more autonomous in their own health journey, and more able to integrate the stressors of their life and their life in a better way."</p> <p>Broad range of health issues for Māori accessing the WHCC</p> <p>Seeing self differs when accessing AN therapies vs mainstream health care</p>
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28/2/2021 updating & completing 3rd column

M. Te Huia

Appendix M Poster Development, Mapping



Appendix N Notes Supervision/Reflections

