Nurses historically have used the medical model to assess and intervene when individuals move transitionally into and out of the role of patients with cancer. Although assessing for clinical depression or other medical model designations is appropriate, using this as the sole model for helping patients with cancer emerge from their illness experiences and into the role of survivorship may rob them of the opportunity to actively use the illness for spiritual growth and self-actualization. The transition process is classified into three distinct stages: endings, the neutral zone, and beginnings. Each is characterized by its own unique qualities and challenges. Jungian metaphors and archetypes also can be used to evoke powerful images that help survivors find depth of meaning in their suffering and enhance healing. Nurses often are in ideal positions to create such healing experiences by helping survivors recognize “shadow” emotional experiences stemming from the recovery process, accepting the emotions as normal transitional phenomena, and using them to develop compassion for others. Individuals, therefore, are presented with opportunities to imagine newly emerging life purposes that far exceed their identification as survivors.

At a Glance
- As patients emerge from active treatment and move into survivorship, they may feel lost and find mainstreaming—a return to a new and different normal—challenging.
- Explaining to survivors that experiences after treatment are predictable transitions can help them navigate each stage.
- Using metaphor and archetypal language can help survivors use the illness experience as an opportunity to grow and eventually provide service to others.

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Deprofessionalizing (i.e., a reduction in the amount of caregiving behavior), although representing progress toward the resumption of health, can be experienced as social abandonment as the healthcare team members who were adopted as an extended family during a critical life crisis eventually fade into the backdrop of the survivor’s life. Such intimate relationships, forged during intense periods of time, have great impact on survivors and their families. Letting the relationships go and resuming some semblance of normalcy creates an unexpected and an unanticipated loss.

Facing life-threatening illness is an identity-transforming phenomenon. Survivors emerging from the rigors of treatment often begin questioning the meaning of the illness event in their lives; what the point of their survival is; what is emerging as a new life purpose; what helps them laugh, learn, grow; and what makes them heal (LeShan, 1994). Much of the literature on survivorship links adjustment issues after treatment to post-traumatic stress disorder (Cordova & Rykowski, 1993; Deimling, Kahana, Bowman, & Schaefer, 2002). Symptoms, such as reliving certain traumatizing treatments, nightmares, fearfulness, insomnia, and difficulties resuming normal relationships, may conspire to complicate the transition from patient to survivor if not addressed during counseling.

Identity transformations, although necessary, often are painful and can complicate adherence to surveillance regimens after treatment. Healthcare providers who supervise the transition of patients from active treatment to survivorship may not perceive that role change as significant. One survivor reported to the author that, when he tried to talk about his experience with his surgeon, he was told to “lighten up. You’re still alive, aren’t you?” Survivors can benefit from understanding that what is happening to them is a predictable part of the mainstreaming (i.e., a return to a new and different normal) that comes with transition.

The purpose of this article is to present a conceptual framework using Bridges’ (2004) Transitions Theory and metaphorical archetypal imagery that might sensitize nurses to the existential plight of survivors (Goodman, Schlossberg, & Anderson, 2006). Awareness can help nurses develop therapeutic responses to remarks that may seem dismal, obscure, morbid, or lacking in clarity.

Transitions Theory Framework

Bridges’ (2004) work on the nature of transitions offers a road map by which to navigate most major life changes. The framework breaks most transitions into three predictable stages: endings, the neutral zone, and beginnings. Using the concepts to explain what the survivor is describing can reduce some of the anxiety associated with moving through such changes.

Survivors and their families might harbor unrealistic expectations about how quickly the recovery should occur. Psychological adjustments may lag behind physical recovery.

Endings

Any transition implies the letting go of old relationships, forms, methods, and roles, even if the nature of the transition is perceived as positive (a promotion, marriage, or completing treatment for cancer). All transitions imply leaving the familiar and suggest a sense of loss or grief.

Survivors can feel lost and confused by the sudden cessation of a treatment regimen. They may be pronounced “cancer-free” or have “no evidence of disease,” but rarely are they told that they are cured. Physically, although still recovering strength and dealing with residual quality-of-life issues, survivors and their families might harbor unrealistic expectations about how quickly the recovery should occur. Psychological adjustments may lag behind physical recovery. Fatigue may camouflage depression or sadness and beleaguered immune systems may not readily bounce back. Patients often wonder why they feel that way when they were so looking forward to completing treatment. This stage may be characterized by disengagement, lack of connection to a previous identity, disenchantment, and disorientation (Bridges, 2004).

The biggest difficulty of the ending stage may be the resistance to shedding the old role. Although the role of a patient with cancer is, by necessity, a painful one, it also becomes familiar and a survivor may have difficulty relinquishing it. Myss (1996) has written extensively about survivors who hang on to their woundedness (i.e., the perpetual attachment to one’s identity as a patient with cancer leading to an inability to make a complete transition). Some patients with cancer do not want “to get off their lifeboat when they reach the opposite shore. Instead, they have made a transitional phase of their lives into their full-time lifestyle” (Myss, pp. 213). True compassion expressed toward those individuals “is the strength to honor another’s suffering while bringing power back into one’s life” (Myss, pp. 213–214).

For support group leaders, Myss (1996) suggested that survivors be encouraged to create rituals during which they call back their spirit and release the negative influence of their wounds. That frees them to make use of the wisdom gained from their illness experience to move ahead with their lives. Asking “what will you do with your pain?” guides survivors to be intentional about the completion of their healing transition so that they become not merely survivors, but people who at one time had a cancer experience. That does not minimize the significance of the experience in their lives but, rather, uses it for the highest good. After all, if a survivor attends a cancer support group for years after a successful remission, what does it say about the effectiveness of the group?

Normalizing feelings of sadness, anger, and other grief symptoms can help survivors view the ending stage as one of healing and consolidation. Cautioning survivors to look for improvement in quality-of-life symptoms in 30-day increments may help them to see their recovery in more realistic terms. Transcending personal suffering allows survivors to see the pain of others, cultivates empathy, and has the potential to assist survivors to become more expansive (Platek, 2008).

Neutral Zone

The second stage of transition is the neutral zone, which is characterized by a sense of confusion, chaos, and anxiety. If endings represent leaving a familiar shore and swimming out
to sea, the neutral zone represents treading water in the middle of the sea with no land in sight, either from where the swimmer began or to where the swimmer is headed. The neutral zone feels relentless from its inherent lack of structure, typified by a personal identity crisis. Survivors often express feelings of being lost. Some relationships and careers do not carry the meaning they once did. Illness can change values and priorities. Unfortunately, nothing on the horizon seems to have replaced familiar identity signposts yet, and survivors often express feelings of being adrift—no longer a patient with cancer but not feeling back to normal either. Trying to rush through the neutral zone creates discomfort, anxiety, and panic (Bridges, 2004).

The primary intervention during the neutral zone stage is the cultivation of silence and the intuitive investigation of the emerging identity (e.g., journaling, meditation, the use of ritual). Balancing regular periods of solitary time with time spent restoring a social network can help survivors feel supported. They need to be assured that their feelings are normal and that the new identity will emerge when it is ready (Bridges, 2004).

**New Beginning**

When the survivor is ready to make a new beginning, the final stage of the transition, the opportunity will present itself. The survivor is constantly surrounded by opportunities to make a new beginning; however, until the survivor has done the work associated with the first two stages of the transition, opportunities may not be recognized, and therefore, not acted on (Bridges, 2004).

The Chinese symbol for crisis is made up of two characters. The first is the symbol for danger, which survivors have no trouble identifying with. The second is the symbol for opportunity. Nurses often are in positions to assist survivors in looking for opportunities that may not be readily apparent to them. Nurses can ask questions such as

- Do certain relationships and activities from the past still give your life meaning?
- Who or what makes you laugh? How might you integrate this into your life now?
- What new skills might you be interested in developing now that you are at this point in your life?
- Have there been things that you have always wanted to try but felt reluctant to do?

By supporting survivors’ explorations, nurses also must be willing to resist the urge to “fix” survivors and not prematurely rush them through the stages. Nurses should honor the transition process. New beginnings often are characterized by remarks such as “a new chapter in my life began when . . .” Survivors may feel drawn to a new direction or life purpose (LeShan, 1994) and start exploring new relationships, projects, and skills. As a result, the new identity begins to emerge.

**Illness as a Spiritual Journey**

Shinoda-Bolen (1996) hypothesized that viewing a life-threatening illness as a spiritual journey allows survivors to create a more meaningful treatment experience, giving survivors a better ability to bear inherent suffering. Survivors often return to their communities transformed by the illness experience. Returning to the mainstream is fraught with self-doubt, including threat to survival embodied in the fear of recurrence and a perceived lost mastery over previous cognitive and physical skills.

Quest stories of illness imply that the teller has been given something by the experience, usually some insight that must be passed on to others. The final stage is the return. The teller returns as one who is no longer ill but remains marked by the illness . . . mythic heroism is evidenced not by force of arms but by perseverance. The paradigmatic hero is not some Hercules wrestling and slugging his way through opponents, but rather the Bodhisattva, the compassionate being who vows to return to Earth to share enlightenment with others (Frank, 1995, pp. 118–119).

Frank (1995) suggested that the “personal issue of telling stories about illness is to give voice to the body so that the changed body can become once again familiar in these stories” (p. 2). Stories told by survivors have a dual meaning: to work out their own changing identities and to guide others who follow. Service “can take many forms, but for the person who is seriously ill, a primary possibility for service is storytelling as an act of witness” (Frank, p. 40). Frank suggested that stories not only repair the damage that illness has wrought in survivors’ lives, but that they also provide road maps to new destinations. This road map becomes the basis for Transitions Theory (Bridges, 2004).

When survivors pay attention to their own suffering, they are more likely to pay attention to the suffering of others and, therefore, transform personal angst into gratitude and generosity of spirit. Critical to the survivor’s journey is the ability to tolerate dark emotions, such as uncertainty, fear, and despair, and to mine them for their eventual transformational qualities as a persona emerges after treatment. Personal suffering is redeemed in this way and can be borne more meaningfully.

Honoring the dark feelings of the journey means learning how to soothe, using intentional breathing, and cultivating an attitude of gratitude despite the misfortunes survivors have experienced. Teaching the three basic skills (attending to feelings, befriending feelings, and surrendering to the suffering) developed by psychotherapist and author Miriam Greenspan, M. Ed, LMCH, can help survivors move through the dark journeys (Platek, 2008).

**Attending to Feelings**

Attending to feelings, whether pleasant or not, allows the dark feelings to be present rather than denying or fighting them. Nurses should ask survivors to name the dark feelings and not judge them as being good or bad, but simply present (Platek, 2008).

**Befriending Feelings**

The second skill, befriending feelings, teaches survivors how to tolerate and accept their feelings by breathing through them, similar to how a woman in labor is taught to breathe through contractions. The grief process gives birth to a new identity of self. Breathing, relaxation exercises, meditation, and prayer all are examples of strategies designed to help individuals emerge from inherently distressing periods (Platek, 2008).

**Surrendering to the Suffering**

The third skill is the actual surrendering to the suffering, which evokes wisdom, compassion, and courage (Platek, 2008).
Greenspan suggested to survivors: “Don’t let go of emotions, let go of ego. The emotions then let go of themselves” (Platek, p. 7). Healing results from the dark emotions flowing through an individual, rather than getting stuck. Spiritual leaders often have encouraged followers to remember that the sentiment behind “thy will, not mine, be done,” often is the breakthrough

behind “thy will, not mine, be done,” often is the breakthrough that he currently is facing. Robert is intolerant of his medical care, impatient with what he perceives to be a lack of progress, and incredulous that his physicians consider his current status a success story. The nurse attending to the palliative care of his physical wounds also responds to the existential subtext of his transition. He presents for a series of outpatient therapy sessions.

Nurse: I know everything has been difficult, but what would you say has been the most challenging aspect of this whole experience for you?

Robert: Well, at this point, I feel kind of dismissed by the hospital people. I am supposed to be well enough to just resume my life now that they consider me cancer free. But I still have issues with fatigue, sleeping, not being able to eat by mouth at all yet . . . some nausea still. I feel like I just got released back into the wild from having been in some kind of forced captivity, but I am not up to it.

Robert: I am not the most patient guy around. Still, I really don’t know where to go from here. Someone told me that I would find a new normal, whatever that means, but I feel like I am waiting around for something to hit me.

Nurse: You sound overwhelmed. I am also wondering if you might be a bit unrealistic about how long the healing process will take.

Robert: I am not the most patient guy around. Still, I really don’t know where to go from here. Someone told me that I would find a new normal, whatever that means, but I feel like I am waiting around for something to hit me.

Nurse: Do you think you are depressed?

Robert: I have been depressed before in my life. I don’t feel the same as I did then.

Nurse: How is this different?

Robert: I just feel sad, you know? I was really at the top of my game when all this happened. I guess I should be grateful—I don’t have to worry about money or little kids like other people do. But when I look at the future, I don’t see anything waiting there for me.

Robert: No, but that is really all I know. The rest just scares me.

Nurse: What scares you the most?

Robert: Aside from this recurring?

Nurse: Well, that is a big fear. How are you living with that one?

Robert: I know it can happen but I am not dwelling on it.

Nurse: Glad to hear it. Some patients have told me that they viewed the cancer treatment as a descent into hell.

Robert: That sounds about right.

Nurse: Your own personal hell is about wandering around in your neutral zone. It is a humbling experience.

Robert: Well how do I get out?

Nurse: This isn’t the first transition you’ve ever been in before, is it?

Robert: No, but it feels like the worst one.

Nurse: They all do at the time and that is what makes them transitions. We feel so unprepared for them. We get to the end by mastering them. Then it just feels like life. And of course, when we are in the middle of them, we do feel like we are in hell. When you have been in hell before, Robert, what helped you the most?

Robert: My wife helped me a lot through the last couple ones. She just listened. Also, I started working out, and that seemed to help me sleep better at the time. I am not much for support groups and that sort of thing but I started to do some reading by myself and that seemed to help.

Robert: I think I am in the middle. I don’t have a clue about where I am going. I just want things to be the way they were before all this started.

Nurse: Do you still feel that is possible?

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Nurse: I wonder if there is a way to resurrect those resources to help you with the next chapter.

Robert: Well, I don’t see anything looming on the horizon just yet.

Nurse: Well, the operative word there is “yet.” Whether you see it yet or not, it is out there. Would it be okay if I put you in touch with another person I know who has been through a similar experience? I think the two of you would hit it off really well. You have a lot in common and he is way ahead of you down the path.

Nurse: I think you will have to wait to get to the end of the movie and find out for yourself.

Robert, a 57-year-old lawyer/entrepreneur, is five months out from a head and neck resection followed by radiation and chemotherapy. Robert is hard-pressed to come to terms with the quality-of-life issues that he currently is facing. Robert is intolerant of his medical care, impatient with what he perceives to be a lack of progress, and incredulous that his physicians consider his current status a success story. The nurse attending to the palliative care of his physical wounds also responds to the existential subtext of his transition. He presents for a series of outpatient therapy sessions.

Robert: I know everything has been difficult, but what would you say has been the most challenging aspect of this whole experience for you?

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Robert: That would be all right.

Robert: I have a lot of confidence in your ability to move forward on this journey. You have to make yourself the hero of your own movie. It takes a lot of courage to persevere. And who knows, you might find yourself using your previous talents and skills in a whole new way for a whole new purpose.

Robert: Like what?

Robert: Like what?
of emotional experiences. Learning that emotions felt during survivorship are all normal human experiences, and that they can learn to live with them, gives survivors freedom to move on with courage.

Greenspan indicated that the worst form of despair happens when survivors believe that the pain was purposeless (Platek, 2008). “Despair can be a powerful path to the sacred and to a kind of illumination that doesn’t come when we bypass the darkness” (Platek, p. 9). Finding a purpose becomes hard to do if survivors numb their pain through psychopharmacologic means. The medical model sees all unpleasant emotional experiences as pathology, rather than the essential human plight of suffering. Obviously, if a survivor is suicidal, additional treatment options may be required. However, nurses are encouraged to avoid using the medical model prematurely and unnecessarily (see Figure 1).

**Use of Metaphor and Archetype as Transition Tools**

Shinoda-Bolen (1996) suggested applying the Jungian techniques of metaphor and archetype to the experience of life-threatening illness to help an individual not only survive an illness but to transcend it. A metaphor is a symbol suggesting a likeness or analogy between ideas. An archetype is a primordial image that has universal resonance for people, an inherited representation of an idea that is derived from the experience of the race as a whole and is present in the unconscious mind of the individual. For example, the wounded healer is an archetype of an individual who has had a healing ability triggered or expanded by the experience of suffering. Examples are found in many different cultures, so it meets the criteria of an archetype (Shinoda-Bolen). An example of an archetype may be when a nurse compares the survivor’s plight to that of Moses and the Israelites, who spent 40 years wandering in the desert before finding the promised land. Of course, metaphors are only useful if they are familiar to the patient. Strong metaphors can enrich survivors’ experiences by elevating them to believe that no experience, no matter how painful, is lost or wasted.

**Cultural Issues**

Greenspan suggested American culture lacks the mythology to guide survivors through the painful and perilous journeys of their dark emotions (Platek, 2008). The general population in the United States suffers from high rates of depression, anxiety, and addiction, but, according to Greenspan, has no sense of the sacred possibilities of illnesses. Instead of gods or goddesses, Americans rely on a medical culture. Suffering is considered pathology, and the answer to suffering is pharmacology (Platek). Instead of Kali (an Indian deity of death and rebirth), Americans turn to antidepressants. Frank (1995) noted that what “is needed, specifically in clinical work and more generally in interpersonal relations, is an enhanced tolerance for chaos as a part of a life story. [That] modernity has a hard time accepting, even provisionally, that life sometimes is horrible. The attendant denial of chaos only makes its horrors worse” (p. 6). Greenspan described American culture as one that makes no room for normal existential experiences, such as grief and despair, but instead medicalizes them and insists on providing pills to anesthetize and disinfect them from being perceived as personal failures (Platek, 2008).

Rituals can help survivors open up to their grief and help bring about an understanding of the human condition by expanding their compassion and enabling them to identify with the suffering of others. For example, one survivor was helped by the suggestion to light a candle every time she was confronted with something new that overwhelmed her ability to cope. The survivor confided to the author of this article that, at first, she felt that her candle always seemed to be lit. However, the survivor began to notice that it was lit less often as her confidence increased and her journey progressed.

Shinoda-Bolen (1996) suggested that experiences that force people to contend with the prospect of their mortality, whether they take place in concentration camps or in cancer clinics, evoke identity changes. In Frankl’s (1945) *Man’s Search for Meaning: An Introduction to Logotherapy*, concentration camp guards stripped prisoners of the outer trappings of their personal identities, including hair, clothing, and other belongings. Identification numbers were tattooed on arms, stripping individuals of their names.
For anyone facing diagnosis of a life-threatening illness, the journey to the hospital can have similar metaphoric trappings. Personal belongings are left at home or taken away from the patient. Certain treatments cause hair loss. Patient identification numbers are attached to the wrist. For the patient, the process begins the stripping away of “who I was” and starts the creation of “who I am now.”

Once patients with cancer have crossed the illness threshold with the diagnosis, they meet challenges never before encountered. That may plunge patients into psychospiritual crisis. Patients feel separated from all that was once normal and are thrust into foreign worlds filled with new languages (medical terminology), environment (hospital setting), and strangers (healthcare team) (Weisman & Worden, 1976–1977).

Encouraging the use of metaphorical language to describe each juncture in the transition from patient to survivor helps survivors hold themselves larger, to reach for the soul meaning of the illness experience and, therefore, bear it more effectively. The use of ritual (e.g., journaling or painting to evoke meaning, healing circles, prayer) all have a sustaining effect. Luke Skywalker, a hero from the Star Wars films, is a strong metaphor for the survivor-nurse relationship. Just as Obi Wan Kenobi provided guidance for Skywalker during his journey, a nurse teaches survivors the understanding they need to overcome the maze of illness, treatment, and recovery.

Nurses can play a major role in the archetypal drama by providing the survivor with a metaphorical road map (Bushkin, 1993), confidence in the inherent dignity of the journey, and the assurance of therapeutic presence, no matter what the outcome. Suggesting that survivors are the heroes of their life stories, identifying healthcare providers and other cancer survivors as teachers, and assisting survivors to view the cancer treatment as an epic journey, all elevate the illness experience. If nurses feel unprepared to undertake such counseling, then referrals to appropriate therapists may be helpful.

As an individual begins to transition from patient to survivor, he or she also returns to the mainstream. However, the treatment has transformed the survivor’s identity, and the survivor does not return as the same person. This transition may occur over a period of time after initial treatment ends. Confronting mortality can profoundly change values, priorities, skills, and life purpose.

Summary

Using the medical model to assess and intervene when patients with cancer are troubled by the transition into survivorship can rob them of the opportunity to actively use the illness for spiritual growth and self-actualization. Nurses can encourage more existential work by using the Transitions Theory and archetypal metaphors. Applying such principles can help survivors navigate the rigors of transition by using symbols to expand concepts of self, not despite the illness, but as a result of it.

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