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Innovations in Theory Development for the Nursing Discipline Volume 1

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Innovations in Theory Development for the Nursing Discipline

Volume 1

Gloria Browning  
Barbara Cheuvront  
Angela DelGrande  
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Stephanie Lynch  
Karen Lottis  

Trinette Radasa  
Lourdes Ticas  
Laura Marsh  
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FOREWORD

For the final assignment in this class on theory development, I asked these creative nursing PhD students to either adapt or extend an existing midrange theory. However, the desired vision of this extension would far exceed something to sit gathering dust in a file cabinet or electronic storage space! Instead, the students chose to focus their work on research, practice, educational, or administrative applications critical to their evolution as nurse scientists. It is my view that scholarly achievement in the nursing discipline should accomplish three things: (1) it should in some way inform, improve, or advance our practice, in whatever setting or manner is significant for the individual; (2) it should demonstrate the essential linkage between the conceptual/theoretical and the operational, so that readers can appreciate the value and necessity of both dimensions; and (3) it should in some way ignite curiosity and passion about the reason the theory or model exists. I believe the examples offered by this set of writers succeed in all three domains. The following papers represent great hope for the future of nursing knowledge, and we offer them as evidence to interested readers at any level who want to know why theory matters, how it relates to actual practice, and why the voices of reflective nurses at all levels of educational attainment are needed to advance our thinking and unfolding in the context of all health professions.

Sincerely,

Jennifer B. Averill, PhD, RN, Instructor
Dedications

We dedicate this monograph to all of those who have touched and changed our lives in every single possible way. We offer a special dedication to our professors, and fellow PHD students who diligently and willingly share their knowledge and expertise, and to all of our families who have been an endless source of patience, support, and encouragement. Finally, we would like to extend our gratitude to our patients and their families for giving us a reason to ask questions, seek answers, and overall, for making us want to become better practitioners, educators and scholars.

Lourdes Ticas, RN, MSN, APRN, BC

Acknowledgements

Going through the doctoral program in nursing has been a challenging task for most of us but through lots of support and encouragement, we hope to continue to stay the course. We would like to offer a very special thank you to Dr. Jennifer Averill, for developing the foreword for our first monograph, and most of all, for her guidance, support, expertise, and for sharing with us her passions as a nurse, educator, leader and researcher.

Thank you to classmates who gave their time and special talents to putting the final touches to this monograph:

Barbara Cheuvront for developing the cover and table of contents.

Karen Lottis for the introduction.

Lourdes Ticas for the final compilation of the manuscript, dedications and acknowledgements.

Stephanie Lynch, Trinette Radasa, Sandra McLelland and Laura Marsh for editing of the final paper submissions.
Introduction

The request for a book on theory development demanded a new level of exploration from each of us. As a cohort, we have discovered the multitude of ways that theory augments not only nursing practice but also the profession as a whole. For several of us, this is just the beginning of a career in scholarship that seeks to integrate multiple theories into meaningful and functional components of holistic care.

While our backgrounds and specialties are diverse, what is singular between all of us is the drive to advance nursing scholarship in fresh and vital ways. The theories chosen for this book range from educational, to collaborative and client-centered, and reflect the wide array of interests and foci with which we practice and intend to develop further.

Gloria Browning, a nursing professor at a University located in West Tennessee, with a professional background in Medical Surgical and Community Health nursing. Gloria has an interest in health promotion from a transcultural perspective, and has expanded Pender's Health Promotion Theory to include educational tools provided in ones’ own native language.

Barbara Cheuvront, an instructor at a university with a professional background in obstetrics, has an interest in simulation and specifically the debriefing process. Barb also has an interest in the incorporation of culture into the clinical setting and expanding upon Mercer’s theory of Becoming a Mother to include transcultural themes and a specific educational pocket tool.

Angela DelGrande, a perinatal clinical nurse specialist who has embarked on a new career as a psychiatric nurse also expanded upon Mercer’s Becoming a Mother theory from the perspective of depression in mothers of toddlers. Her focus is on the negative effect maternal depression associated with a maladaptive role transition may have on the social, emotional and cognitive behavior toddlers.

Unchalee Ice, a staff nurse working in an acute care setting in the cardiology unit, with nursing background in midwifery, medical- surgical, labor and delivery, oncology, neurology and rehabilitation, has a personal interest in transcultural nursing. She also extends Kolcaba’s Comfort Theory, with the development of a holistic model of Thai women’s health beliefs and behaviors regarding cervical cancer screening. This model can be used in the research proposed to explore health concepts, cultural beliefs, attitudes and practices for health promotion such as Pap smear screening of diverse cultural groups.

Stephanie Lynch, MSN, PMH-NP continues along a psychiatric focus in the development of the Theory of Interpersonal Relations, while modifying this for use outside of psychiatric populations as well. Peplau taught nurses that to help our patients we must establish a mutual respectful, relationship. This connection is made between nurse-nurse, nurse-physician, and nurse-patient.

Several of us are interested in chronic diseases and client-centered care, and have developed models along these lines. Karen Lottis, a Family Nurse Practitioner working in a rural, northern New Mexico community explored the Theory of Experiencing Transitions, with
development of transcultural and lived experience aspects as these relate to change in chronic illnesses.

Sandra McClelland, a Family Nurse Practitioner with an interest in increasing adherence/compliance to treatment prescription, focused on the integration of Motivational Interviewing with the Tidal Model Theory as this relates to client-centered approaches to chronic disease states.

Trinette Radasa, a medical-surgical clinical nurse specialist and clinical instructor for an undergraduate nursing program, with a special interest in the Mexican-American diabetic population, has extended the Chronic Care Model, and integrated this with the use of community promotoras. Trinette would like to further explore the importance of using promotoras to bridge the communication gap between the Mexican-American diabetic population along the US-Mexico border, all the while applying the Chronic Care Model to practice.

Lourdes Ticas, a Family Nurse Practitioner working with elderly and chronically ill individuals living in a long term setting, has deepened Pamela Reed’s Theory of Self-Transcendence as this relates to chronic illnesses. The extended theory includes the concepts of inner strength, personal transformations and reconstructive identity to describe coping strategies and life experiences of older adults and individuals with chronic illnesses. Lourdes’ future research interest is in inner strength, coping and adaptation skills among the elderly and chronically ill residents in long term care settings.

Moving back into the realm of technology, Laura Marsh, Program Administrator for the University of New Mexico’s Project ECHO (Extension for Community Healthcare Outcomes) provides links between Benner’s From Novice to Expert, the ECHO model, and telehealth. The goal is to utilize telehealth technology to bridge the translation of best practice standards through the integration of new knowledge and application to nursing practice.

Following the inter-collegial theme, Cynthia Nuttall, RN, MSN, MPA, a nurse administrator whose research focus is on recruitment and retention of registered nurses, has an important model for Interprofessional Collaboration. This paper proposes a modification of Vygotsky's Sociocultural Theory of Learning through integration of Learning Theory. The aim of this integration is to develop a comprehensive theoretical approach to conceptualization of the important factors of interprofessional collaboration and their inter-relations.

It is obvious throughout the book that while each of us writes with distinct approaches and frameworks, our vision and passion for the future of nursing is united. The development and expansion of these theories is just the beginning. We invite discussion, thought and discourse on the ideas that have been presented in this book – those that work, and those that do not. Our world is continually changing, and it is our desire that scholarship and the profession of nursing evolve in creative and innovative ways to meet the needs of those we serve.

Karen Lottis, RN, MSN, APRN, BC
Chapter One
Pender ‘s Health Promotion Theory from a Transcultural Perspective

Gloria Browning, MS, RN

Health promotion is presently receiving increased attention regarding the prominent role it plays in the health care field. Health promotion has many benefits, and such benefits consist of living a healthier lifestyle. An increasing emphasis on the prevention of disease and health promotion, along with my interest, established the choice of this model. A healthy lifestyle goes beyond the prevention of disease to incorporate a more subjective feeling of wellness. Nurses, as well as many other health care professionals, are interested in learning more about helping their clients, families, and communities to improve their lives. In order to seek ways to bring greater longevity and a form of higher quality of life, nurses must focus on interventions that will enhance not only health, but also quality of life. Health promotion is a concept suited to the needs and interests of nurses and their clients.

Introduction

Health promotion is receiving increased attention regarding the prominent role it now plays in the health care professions. High costs in health care reflect a shift in the emphasis of care to the prevention of disease, rather than treatment of disease. The relationship between health promotion and disease prevention has been explored since the concept was established by Florence Nightingale (Nightingale, 2006; Frenn & Malin, 1998). More recently, global attention to health behavior and individuals’ lifestyles has turned the spotlight on quality of life, rather than the duration of survival. Quality of life has become the focus of recent health promotion research interest.

The World Health Organization (WHO) states that health promotion includes healthy lifestyles, health services, and supportive environments for health (WHO, 2007). According to Easom (2003), more attention has been focused on the quality of life during recent years with special concerns for longevity of life. Buijs, Ross-Kerr, Cousins, and Wilson (2003) described health promotion programs as having the potential to ameliorate or postpone declines in health associated with aging, which would then increase quality and longevity of life. Health promotion has been identified as an intervention with important payoffs in terms of cost saving and quality of life (Ruffing-Rahal, 1991).
Purpose/Rationale/Description

The purpose of this paper is to analyze, critique, and formulate an extension of Pender’s Health Promotion Model. With an interest in the health promotion field, I chose Pender’s Health Promotion Model (HPM). Pender proposed that some individuals develop life styles and patterns of behavior which are aimed at the attainment of higher level wellness and positive health states, not just the avoidance of illness. One’s personal definition of health has a role to play in the extent to which that person is willing to make a change in lifestyle in order to achieve wellness. People who define health as the absence of illness are less likely to adopt health promoting behaviors than those who view health as an optimum state of total well-being (Pender, 2006). An understanding of how the client values health and health promoting behaviors does help predict who will be more successful at making any necessary lifestyle changes. Health promotion sparks my interest in exploring varied health behaviors and health promotion beliefs from a diverse population of clients.

Background/Historical Perspective/Development

Nola Pender first published her Health Promotion Model (HPM) in Health Promotion in Nursing Practice in 1982. The model is one of the predominant models of health promotion in nursing. In Pender’s HPM, determinants of health promoting lifestyle are divided into cognitive-perceptual factors, modifying factors, and likelihood of action. These factors are important components for health, perceived control of health, definition of health, perceived status of health, and perceived barriers and benefits to health promoting behavior. Modifying factors include demographics, biological, interpersonal, situational, and behavioral factors (Wang, 2001; Walker & Avant, 2005; Sitzman & Eichelberger, 2004).

Originally, the model was proposed as a foundation of why individuals engage in health seeking behaviors. The HPM’s foundation is based on the definition of health that one believes, and focuses on the person as a whole person, as well as the positive aspects of health. The HPM represents a theoretical perspective in that it explores the factors and relationships that enhance health promoting behavior and actions, thus leading to improved health and quality of life.

The HPM was developed as a framework for predicting health behaviors. The model seeks to explain individual characteristics and experiences, as well as how behavior-specific cognition and affect influence these behavioral outcomes. Health promoting behaviors are a desired outcome when providing client care and education. Health promoting behaviors may be defined as actions toward attaining positive health outcomes, such as well being, personal fulfillment, and quality living (Tomey & Alligood, 1998; Srof & Velsor-Friedrich, 2006). Pender (1990) defined health as a positive, comprehensive, and humanistic component. Pender does not make disease the principal focus of health. Her definition of health includes the whole person, the lifestyle one lives, strengths, resiliency, potentials, and capabilities (Gillis, 1993). Simmons (1990) explored the HPM as a framework for identifying and explaining sequential
patterns among variables which influence the decision making, performance and included outcomes of health promoting lifestyles.

Pender’s model is based on theories of human behavior: the theory of reasoned action, the theory of planned behavior, and social cognitive theory (Pender, 1990). Peterson & Bredow (2004) discussed three theories of health behavior with the first, reasoned action, originally based on Ajzen’s and Fishbein’s works. To summarize, the theory explained that the major determinant of behavior is the individual’s intent for that behavior. This means that the individual is more likely to perform a certain behavior if the outcome is desirable. The second theory is an extension from the first, reasoned theory. Reasoned theory suggested that the individual will more than likely perform a behavior if he/she believes there is control in the situation. The third theory is Bandura’s social cognitive theory which is self efficacy. Self efficacy is the confidence an individual has in her ability to successfully carry out an action. The third theory proposes that the greater the individual’s self efficacy, the more likely the person will perform the behavior with success. Pender agrees in that if an individual has high perceived competence in a certain behavior, then the results suggest that the individual will perform the behavior with success.

Pender (2006) defined major concepts and definitions related to health promotion as:

1) Importance of health- individuals who value health are more likely to seek it.

2) Perceived control of health- individual’s perception of his own ability to change his health can motivate his desire for health.

3) Perceived self efficacy- individual’s strong belief that a behavior is possible can influence the occurrence of the behavior.

4) Definition of health- individual’s definition of what health means, ranging from absence of disease to high level well being, can influence what behavior changes will be attempted.

5) Perceived health status- current state of feeling well or feeling ill can determine likelihood that health promoting behaviors will be initiated.

6) Perceived benefits of behavior- individuals may be more inclined to begin or continue health promoting behaviors if the outcome is desired.

7) Perceived barriers to health promotion behaviors- individual’s belief that an activity or behavior is difficult may influence the intent to engage in it.

Pender (2006) revised the HPM in 1996. The revised model describes the interaction between individual characteristics and past experiences with behavior-specific cognitions and affect (subjective feeling states about the behavior). These characteristics/experiences along with cognitions/affect influence an individual’s commitment to a plan of action for engaging behaviors directed toward attaining positive health outcomes. Individual characteristics include past experiences with the same or similar behaviors. These previous experiences directly or indirectly influence behavior. Personal characteristics include physical or physiologic states such as age, gender, or body mass. Personal characteristics also may include psychological states such as perceived health status, self-esteem, motivation, or definition of health (Pender, 1990).

The HPM serves the function of identifying concepts relevant to health promoting
behaviors. The model includes multiple concepts and relationships. However, some concepts are more prominent than others for specific health behaviors. This model does not provide assistance in selecting which concepts are appropriate for specific behaviors. The researcher who uses this model must select concepts based on previous research regarding a specific behavior (Peterson & Bredow, 2004). Walker and Avant (2005) noted that the HPM is composed of clearly specified causal paths. The ordering of the concepts is clear, with modifying or background factors having a causal impact on cognitive perceptual factors, which in turn, affect participation in particular health promoting behaviors.

Considering major assumptions, health is seen as a positive high level state. The individual is seen as having a drive toward health. The person is an individual and the focus for the model. Each person is expressed by a unique pattern of cognitive-perceptual and modifying factors. Specific theoretical assumptions are not indicated by Pender, yet the model represents interrelationships between cognitive-perceptual factors that influence the occurrence of health promoting behaviors.

The HPM was generated through the use of existing research to contribute substantive knowledge. The HPM is a conceptual model since its goal is to integrate what is known about health promoting behavior to generate questions for further testing. The HPM is a tool for research, since dozens of reports have been published using the model to emphasize the importance of individual assessment of factors believed to influence health behavior change.

The HPM has proven to be a primary and popular resource with health promotion activities in nursing. The concept of health promotion is popular in practice. Personal responsibility for one’s own health care has become more prominent in the past decade. In contrast to practice, the use of health promotion has not been as well established in nursing education. Health promotion is currently placed behind illness care in clinical education. The model continues to be refined and tested for its ability to explain factor relationships among the variables that influence health behavior changes (Pender, 2006).

King (1994) defined health promotion as a multidisciplinary function and nurses currently face strong incentives to adopt a collaborative approach with other disciplines. Nursing must first embrace and then further develop the concepts of health, wellness, and client from the nursing perspective. When the developed concepts are accepted, in theory and in practice, nursing will more fully grasp and influence the collaborative nature that health promotion requires.

Sitzman & Eichelberger (2004) explored the assumptions that form the foundation of a theory by clarifying the meaning of the theory. These authors suggest that Pender’s HPM is based on these following assumptions:

1) Individuals seek to create conditions of living so they may express their unique human potential.

2) Individuals have the ability to reflect self awareness.

3) Individuals value growth in directions as positive and attempt to achieve a balance between change and stability.
4) Individuals seek to regulate their own behavior.

5) Individuals interact with their environments and with themselves over time.

6) Self-initiated reconfiguration of person-environment is essential to behavior change.

7) Health professionals constitute a part of the interpersonal environment, throughout their life spans.

The HPM has been applied in a variety of settings, including schools, workplaces, rehabilitation centers, and ambulatory treatment centers. It has been used in studying a wide variety of health behaviors, including exercise and nutrition patterns. The model has a limited history of application in culturally diverse groups (Peterson & Bredow, 2004). Due to lack of application in culturally diverse groups, I would like to extend Pender’s HPM and focus on communication issues across cultural groups. Communication is the means by which a culture is transmitted and preserved and it is a process by which we convey meaning in order to have a shared understanding. Communication involves intrapersonal and interpersonal skills such as listening, observing, and speaking. Communicating with individuals from another culture can be one of the most challenging aspects of providing care and health education (Yee & Weaver, 1994).

**Revision of Pender’s HPM**

**Introduction of Own Ideas**

A person’s beliefs about health are influenced by his or her culture, experiences with health and illness, and exposure to health promotion. Using Pender’s HPM, I would like to expand in the area of communication, interpreted in this paper as the native language of the individual. Language is probably the most salient demographic difference among diverse groups, so knowledge of language spoken is an important key feature in the delivery of health promotion programs. Research with the Hispanic population is growing, but deficient, partially a result of lack of valid and reliable instruments available in the Spanish language. Because only one-half of the Hispanic population speaks English fluently and even fewer are able to read and write English, adequate Spanish-language instruments need to be developed for research involving this population (Carlson, 2000). Grammatical structural differences between English and Spanish increase the difficulty of translating instruments. To ensure a conceptually equivalent instrument, careful attention must be noted to the translation process.

**Rationale for Own Ideas**

In order to provide safe and adequate health care for diverse culturally diverse individuals, health care professionals must overcome linguistic and cultural barriers. I feel that the use of bilingual providers, bilingual community health workers, interpreters, and translated written materials must be accessible and appropriate. As we know, communication goes through numerous filters when a person interacts with someone whom he or she perceives as different. Some of those filters are related to culture, gender, education, age and experiences. When messages move through these filters, they may change because the actual communication cues are interpreted according to a person’s own cultural values and beliefs. This change may lead to misperceptions and misinterpretations. I realize that translation of an existing instrument, such as
Pender’s, into another language would require more than a simple translation of words and requires extensive developmental research to produce a conceptually and culturally equivalent form of the instrument. As for the use of interpreters, it is better to use an interpreter than a translator. Translators simply restate the words from one language to another. An interpreter decodes the words and provides the meaning behind the message. Even with written healthcare information such as leaflets, there are still translation problems. In using the interpreter, the nurse should be present to observe body language and gestures. To reinforce learning, most health care providers prefer to give the client written information. Besides reinforcement, this information serves as a reference guide. Finding appropriate health information for clients from a different culture can be challenging.

Strategies to overcome linguistic and cultural barriers would make it possible to have bilingual health care professionals to communicate effectively with these clients. There is a constraint to this approach, due to a lack of trained health care professionals who are bilingual. Another option is, of course, the use of interpreters to bridge the language gaps. The cost of using professional interpreters would be a financial concern for many researchers. Translated forms, documents, and health education materials would play a tremendous role in increasing access to health care. Of course, these materials would need to be tested for cultural appropriateness.

To ensure the best possible health outcomes, it is important to know the various cultures of our patients and to ask respectful and nonjudgmental questions rather than making assumptions. The manner in which a person presents for care; their style of communication, access to medical services and the type of services available; the level of trust placed in the medical system, including acceptance of a diagnosis; adherence to treatment plans; and, ultimately, the outcome of medical encounters, are all examples of the effects of culture on health concerns.

Some additional ideas for communicating with non-English speaking clients, would be to avoid the use of relatives who may distort information or not be objective, also important to remember social class differences between the interpreter and the client that may result in the interpreter’s not reporting information that he or she perceives as superstitious or unimportant, and provide time for translation and interpretation.

Without the cultural component in Pender’s HPM, not only is language an issue, but the ability to care and treat clients in need of health care is in question. Caring and treating clients from other cultural backgrounds, including people who do not speak English as their native language is a challenge for health care professionals.

The macro aspects of this model focus on the concepts of family, person, community, and effective communication. On the micro level, the model should have areas common in culture interconnected with health implications. Areas should include:

1) High risk behaviors such as smoking or alcohol.
2) Nutrition such as meaning of food and rituals.
3) Death and death rituals.
4) Health care promotion such as traditional practices and remedies.
5) Communication such as dominant language.

**Interventions**

Examples of specific interventions in the context of this extended/revised model include:

- Video presentations in the client’s native language.
- Computer programs, especially simple user-friendly programs such as the touch screen versions.
- Recorded messages in the native language of the clients.
- Pamphlets, booklets, and other visual aids in native language of clients.

As the nurse one should:

1) Discover and remain aware of own cultural biases and prejudices.
2) Show genuine interest in the client.
3) Give attention to communication modes such as use of personal space.
4) Maintain a holistic view of health, health promotion, and healing.
5) Analysis one’s own cultural background and heritage.

**Conclusions & Implications**

The HPM is very clear and simple to understand. Relationships among the various factors in each set are linked somewhat however the relationships require further clarification. The model includes a very simple and self-explanatory diagram (see page 18) that shows associations between two set of factors utilized with this model, which is middle range in scope. It is highly generalized for the adult populations. Further research is under way for the applicability of the model to be used for children aged 10-16 years of age. Support for this model through testing is provided by Pender as a framework for health promotion. Health promotion has been identified as a goal, above and beyond disease prevention. All aspects of the environment, including personal and social, were explored to clarify nursing’s role in delivering health promotion to all ages (Peterson & Bredow, 2004).

The HPM, many nurses are faced with choosing from a variety of models. This particular model is appealing to most nurses because it offers a holistic and humanistic view that is congruent with most nurses’ own philosophy of health and nursing. The model reflects a belief that individuals are capable of personal change, and is more than treatment and prevention of disease. Clients are able to express their unique human potential. The HPM has been used successfully in numerous research studies, and does have a body of
literature that supports its use. The phenomena addressed by the model are intimate to nurses, and most nurses will require very minimal learning of terms and concepts used. This model is very straightforward and easy to understand, as stated previously.

The HPM may be used in diverse settings such as schools, rehabilitation centers, workplaces, and ambulatory treatment facilities. The model may be used with a variety of health behaviors such as nutrition and exercise, and is well suited for most clients. Pender’s HPM proposes a structured process for assessing and addressing needs for health behaviors. The model is based on combined nursing and behavioral health approaches meant to assist clients in making positive health behavioral changes. Pender’s model provides immediate principles to guide nurses in addressing this issue.

Pender proposed the HPM to assist nurses in helping clients achieve improved health and a better quality of life. The model is based on established theories of human behavior, including the theory of reasoned action, the theory of planned behavior, and social cognitive theory. The HPM has a variety of client characteristics and cognitive affective factors to combine with demands and preferences. However, the model was found to have a limited history of application in culturally diverse groups (Peterson & Bredow, 2004). Nurses who understand and value the clients of designated cultures are able to promote positive changes in healthcare practices. Valuing diversity in health care enhances the delivery and effectiveness of care. Health care providers should develop an open style of communication, be receptive to learning from multicultural clients, and promote multicultural relationships.

Clients must be active participants in interpreting assessment data and in planning care. Each individual has in place a system of health care practices compatible with the client’s cultural orientation. Clients need to carry out health behaviors in way that fit their cultural beliefs, preferences, and current levels of knowledge. The client’s sense of cultural pride should be reinforced during the health promotion process.
Pender's Health Promotion Model

Figure 1: Revised HPM (Browning, 2007).
References


Chapter Two
Mercer’s Becoming a Mother with Transcultural Perspective

Barbara Cheuvront MS, RN

The purpose of this paper is to expand upon Mercer’s theory of becoming a mother to include the cultural implications of becoming a mother through the development of an educational tool to aid students in providing culturally congruent care to new mothers and families. This paper will focus on the second stage of the process of becoming a mother. The theory of becoming a mother is expanded in this paper to include cultural competence as it specifically relates to the development of a woman into the role of becoming a mother. It is important for the student and nurse to incorporate the culture and belief system into the provision of care for the woman and her family.

Becoming a Mother and the Cultural Considerations

Introduction

The mystery of the relationship between a mother and child is difficult to explain or define. The ways that a woman defines herself as a mother are as varied as the number of women that exist in the world. Yet, the relationship between a woman and her child is important for the mother in determining her role and for the child as the relationship develops. Mercer (1995) developed the theory of maternal role attainment based on the earlier works of Rubin. Defining the role of a mother and becoming a mother begins with the initial diagnosis of pregnancy. The role is a continuous adjustment as the woman progresses through the stages of pregnancy, birth and the development of the child into adulthood. A woman’s role as a mother continues to evolve with the possible addition of grandchildren. To determine and support a woman become a mother is important for a nurse in supporting a woman during pregnancy, birth, postpartum and the growing up years of the child. Therefore, not only is the examination of the role of a mother applicable to the obstetric nurse, but also to the pediatric nurse and the general nurse as the woman ages and the roles change. Culture is an additional aspect of supporting the transition of a woman to the role of becoming a mother.

Culture is an integral part of the health and well-being of every patient. The inclusion of culture and the belief system of a patient is a part of the holistic care of the patient. The cultural belief system of a patient and her family has the potential to impact patient safety and outcomes if the designed intervention does not account for the unique cultural beliefs of each patient. Servonsky and Gibbons (2005) define cultural competency as:

a broad and complex developmental process that includes an understanding of one’s own culture, values, and beliefs; the awareness and acceptance of cultural differences among groups; and the recognition that diverse groups have their own way of communicating, behaving, problem solving, and interrupting health and illness (p. 52).
The development of cultural competence is an evolving process and not viewed as a goal achieved through a series of tests or courses. Academia and practice are both environments that foster or hinder the development of cultural competence in the health care setting and patient interactions. Mercer’s (2004) theory of the process of a woman becoming a mother is only one segment of cultural competence.

Background and Literature Review

Rubin (1970) explored the cognitive style associated with pregnancy from the moment of diagnosis to the last month. Rubin (1970) specifically examined the stages a woman moves through during the pregnancy in preparation for the arrival of her child. Mercer (1995) expanded the theory of maternal role attainment (MRA). The stages and variables impacting the process of defined and refined in the literature. Mercer (2004) suggested the terms MRA be replaced with the term becoming a mother (BAM) as a response to the fact that a woman’s development as a mother does not stop after the child is born and during the first year. BAM continues into the later years of life when a woman may become a grandmother. As a child goes through the different stages of development, so does a mother, and this necessitates adaptations, changes and adjustments in the role of the mother. Rubin (1970) discusses the changes occurring in a woman from the time of a diagnosis of pregnancy until the time of birth. Rubin discusses the changes occurring during each trimester physically and emotionally as a mother prepares to become a mother. However, the topic of culture is missing in the writings of Rubin. Rubin’s discussion supports the belief of Mercer (2004) that becoming a mother is a more appropriate term in the development of a mother’s role. Mercer does briefly discuss the cultural implications during the development of a mother’s role. Rubin (1975) discusses the important role of the nurse during the hospital stay of the mother and infant in supporting the transition of a woman into the role of mother. Shorter stays in the hospital do not support the interventions of the nurse to support the transition. Mercer (2006) specifically discusses the interventions that are effective in supporting the acceptance of a woman as a mother. The interventions need to be as unique as the woman and the infant to support a good outcome, and part of the uniqueness is culture.

Mercer (2006) identifies the stages of the process of becoming a mother as (a) commitment, attachment, and preparation for an infant during pregnancy; (b) acquaintance with and increasing attachment to the infant, learning how to care for the infant, and physical restoration during the early weeks following birth; (c) moving toward a new normal the first 4 months; and (d) achievement of a maternal identity around 4 months (p.649).

Mercer (2004) discusses movement through the stages as specific to each woman and yet universal to the process of becoming a mother and defining the role as related to a woman’s experience and support environment. The importance of the father as a support in becoming a mother is examined in the more recent literature. However, a father’s role is sometimes specific to the culture of the family.

Cultural Implications

The process of becoming a mother (BAM) defined by Mercer (2004) is an accepted middle-range theory applicable to various areas of nursing including obstetrical nursing,
pediatric nursing and women’s health, as a woman’s role as a mother changes throughout her lifetime. There are also cultural implications for the process of becoming a mother as the culture of the mother impacts the view of the process of becoming a mother. Gray and Thomas (2006) define cultural competence as “the term used in nursing education to address the skill and content needed to provide care with consideration for various cultural facts associated with a given individual” (p. 79). It is important for a nurse to actively seek knowledge of cultures, but the knowledge serves as a foundation for further investigation through interactions with patients from different cultures.

**Literature Review**

There are traditions and rituals associated with birth and often related to the culture of the mother and family. These traditions and rituals are not necessarily obvious to the healthcare provider. Therefore, the development of cultural awareness is imperative to providing culturally congruent care to a mother and family. BAM is one component of providing support and appropriate nursing interventions in the obstetrical environment. The cultural implications of BAM is discussed briefly in the literature, but the traditions and rituals of birth are addressed more extensively in the literature, as are the discussion of culture in the role of the mother and attachment to the infant.

Lemon (2006) discusses the health care beliefs of the Amish in an obstetrical setting and specifically the belief that “babies are a welcomed gift in the Amish culture and are viewed as a gift from God” (p. 56). During the last five weeks of pregnancy, Lemon (2006) discusses the practice in the Amish culture of utilizing a mixture of herbs that are designed to “tone and calm the uterus, quiet the nerves, ease pain, and help make labor easier and on time” (p. 56). It is important that the health care provider be aware of the herbal mixture and the potential for any drug interactions. According to Lemon (2006), the formula consists of red raspberry leaves, butcher’s broom root, black cohosh root, dong quai root, and squaw vine root. Birth is considered an event of the community and not just the family.

Brathwaite and Williams (2004) discussed the birth experience in the Chinese culture and discussed the belief that “children are the wealth of a family” (p. 751). Specific restricted practices during pregnancy of the women interviewed were: “not lifting or reaching for objects over the head; not handling scissors on the bed; not attending funerals or sad occasions; not wearing black or white; and not eating certain foods” (p. 751). Many of the dietary restrictions relate to the yin and yang philosophy that “defines all aspects of the universe as involving opposite yet interdependent forces” (p. 751). The practice of remaining warm after birth is an extension of the yin and yang philosophy, and it is the belief that the woman not be cold after birth. A special diet after birth also includes ginger and pork feet because these foods are believed to remove any remnants of the placenta and bring the body back into balance. The first month after birth is a time of confinement, and rest is supported by a female member of the family that comes into the home to take over all household chores and the preparation of food. It is also important that compliments referring to the new baby as beautiful are considered taboo and the belief is that bragging will cause “the gods to take the baby away” (p. 752).

Callister et al. (2007) discusses the birth traditions of Russian women in Russia and the implications for care in the United States. As in many cultures, pregnancy and birth are times of isolation in order to protect the mother and child from the “evil eye.” Callister et al. (2007) indicate that traditional Russian customs during labor are that the mother “unbraided her hair,
untied her clothing, and removed rings, with the untying and unbraiding being symbolic of releasing the unborn child from the mother’s womb” (p. 20). As in the Chinese culture the first 40 days after birth is unique and Russian women are considered “unclean and vulnerable for the first 40 days until being blessed by the priest” (p. 20). As in the Chinese culture, the Russian woman is supported by the maternal or paternal grandmother and stays with the new family for the first month after birth. Fathers may or may not be present during labor. Pain medication during labor was not supported by the Chinese or Russian culture because of the belief that the medication would harm the unborn child.

Choudhry (1997) describes the Indian woman’s view of pregnancy “as a normal physiologic phenomenon that does not require any intervention by health care professionals” (p. 534). In the Indian culture, care of the pregnant woman is provided by “elder women of the family and/or community” (Choudhry, 1997, p. 534). Dietary considerations during pregnancy include a balance of “hot” and “cold” foods and the general guideline that “hot” foods are considered harmful during the period of pregnancy (Choudhry, 1997). As in previously discussed cultures, the postpartum period lasting 40 days is a time of confinement due to the perceived vulnerability of the mother and the newborn is cared for by a midwife of women of the family (Choudhry, 1997). The involvement of the father is usually limited during the immediate postpartum period.

Martinez-Schallmoser, Macmullen, and Telleen (2005) point out that social support in the Hispanic community is valued and may extend beyond relatives to friends. As in other cultures, the prenatal period is viewed as a period of vulnerability for the woman and the unborn child. The involvement of the father is dependent on the perception of the father as the “successful sole provider” ((Martinez-Schallmoser et al., 2005, p. 756)

Current impact

As the patient population becomes more diverse in the twenty-first century it is critical that nurses are educated to understand and develop an awareness of the different cultures encountered in health care settings. It is important that the education begin as a part of the nursing curricula in academia, and therefore, an integral component of future nurses’ practice. A cultural awareness begins with an awareness of one’s own culture. Cultural awareness is one step in the process of obtaining cultural competence. It is important to recognize the impact of culture on the health and well-being of a patient. To incorporate the patient’s culture into the treatment, interventions and care of a patient supports the compliance of treatment and ultimately the health of the patient. To ignore the culture of a patient is to ignore the core of the person and an essential component of the healing process. The knowledge needed to care for the many cultures present in the health care setting is overwhelming. However, it is imperative that nurses possess an awareness and understanding of the impact of culture in the provision of care to the patient and family.

Culture is also a critical component in the progress of a mother through the stages of becoming a mother as defined by Mercer (1995). Mercer (2006) states “A mother’s progress through the stages in becoming a mother is influenced by her life experiences, creativity, and her infant’s unique characteristics” (p. 650). It is important that the nurse participate in an interactive dialogue to determine the best means of supporting a mother in the transition to becoming a mother and “An important part of any dialogue is hearing and understanding the meaning of
what the mother is saying and how the mother is affected by her account” (Mercer, 2006, p. 650).

Becoming a mother as developed by Mercer (1995) is a process that begins in pregnancy and continues throughout the life of a woman. Becoming a mother is not isolated from culture, just as any health issue is not isolated from culture. It is therefore imperative that today’s nurse develop a level of cultural competence related to the process of a woman becoming a mother. It is critical that each nurse have a clear understanding of her own culture to develop a self-cultural awareness, in order to move into a development of cultural competency related to a woman becoming a mother.

Application to practice and education

Obstetrics and the care of women and newborns is only one segment of nursing that should address the cultural implications of care. Developing teaching strategies that support the development of cultural awareness and cultural competence support the provision of culturally congruent care in the obstetrical environment. It is important to provide cultural information to students to discourage stereotyping of any culture or ethnic group. It is therefore important to educate students in ways that support a dialogue with patients concerning cultural care. As Cutilli (2006) discusses the importance of regarding the patient education of a culturally diverse population, “The education provided in a manner that is meaningful and useful for patients and their family” and “The nurse must understand how the patient’s culture impacts the maintenance or the recovery of health” (p. 218). The development of a tool utilized in the academic setting to provide a foundation and support an interactive dialogue with women and families of diverse backgrounds supports the development of cultural awareness. It is important to provide students with a tool that is useable in the academic and clinical setting in order to support the development of cultural awareness and competence. It is not feasible for a person to possess a complete understanding of every culture involved in the health care setting. As Kleiman, Frederickson, and Lundy (2004) state, “Familiarity with some culturally binding attributes of a particular culture does not necessarily lead to acceptance and trust by patients or their relatives” (p. 251). In addition, they state:

An ‘objective’ cultural view of the patient may lead the nurse to erroneously act in what he or she believes to be a culturally competent manner toward the patient. However, being an objective observer and ‘student’ of a particular culture does not necessarily lead to an understanding of the patient’s individual acculturation. This is an important point since the nurse’s presumed familiarity with a patient’s culture and beliefs may be interpreted as offensive and disrespectful, thus distancing the nurse from the patient and hindering, rather than helping, the implementation of the care plan (p. 251).

It is therefore critical that the nurse dialogue with the patient and their family concerning the specific cultural needs of the patient to provide culturally congruent care.

Four areas have been identified by the author to support the care of the woman becoming a mother. The first area is language and includes questions and observations of the patient and family related to written language, spoken language, non verbal language, interaction with the infant (verbal and non verbal), and the level of noise of the words spoken to the mother and the
infant. The second area identified by the author is diet and includes questions and observations related to special liquids used during pregnancy, labor and the postpartum period; special food restrictions, foods to support labor and foods to support recovery; herbal supplements during pregnancy, labor, and the postpartum recovery period; and breastfeeding or infant feeding traditions. The third area identified is the family and includes questions and observations related to the support family during pregnancy, labor and the postpartum period; the spiritual family during pregnancy, labor and the postpartum period; and the presence of specified individuals in the labor room, the postpartum unit, and the postpartum period at home.

The last area identified is the infant and includes questions and observations made concerning the attachment or bonding period; the care of the infant by the mother, grandmother, female member of the family or community and the father’s involvement; the naming of the infant; the dressing of the infant; and the bathing of the infant. It is important to note that stereotypes be avoided based on the ethnicity of a patient and family without a specific dialogue of the cultural group the patient identifies. It is also critical that the nurse have an awareness of the impact of acculturation on the traditions of the woman in the process of becoming a mother. A woman may decide to follow some traditions and rituals of her culture and not others. No assumptions of care based on the perceived culture should be made without a dialogue between the nurse and the patient.

Development of Tool
The tool developed is a tool that is compact, easily taught and used in the clinical and academic setting (Appendix A). Chinn and Kramer (2004) define the factors important when reflecting upon a theory as the clarity, the simplicity, the accessibility, the generality, and the importance of the theory. The author chose to apply the same factors to the development of the cultural communication tool. The tool can be adapted depending on the environment in which the nurse practices and specifically developed at this point for use in academia. The tool includes four primary areas of cultural awareness – language, diet, and interaction with the infant and family. Utilization of the tool can occur during all the stages of becoming a mother as defined by Mercer (2004).

The first step in the process of becoming a mother identified by Mercer (2004) is the “commitment, attachment, and preparation (pregnancy)” (p. 231). The cultural implications during this first step involve a dialogue concerning the traditions and rituals associated with the prenatal period and the attitude toward birth in a specific culture. Knowledge concerning any dietary restrictions or taboos during the prenatal period is important for the health care provider to determine if any alterations are necessary in the standardized care of the pregnant woman. Involvement of the family and social support are often specific to a culture. Involvement during the period from pregnancy to the time after birth may involve not only family, but also community members and spiritual community members.

Development of an Environment to Use the Tool
Mercer addressed culture as a component of the theory of a woman, BAM. However, it is critical as the world becomes smaller through access to travel and the increased access to technology and the World Wide Web. It is a logical adjunct to the stages of Mercer’s theory of BAM in the midst of the diversity of healthcare to add a generic communication cueing tool to supplement the care of a woman at each stage of the transition. The birth process is unique to each woman within the culture that she identifies or associates as her primary cultural group. The tool developed is
compact and serves as a communication tool that associates with the previously identified stages that Mercer identifies.

The utilization of the tool in an obstetric skills lab culminating in the use in three high-fidelity simulation scenarios supports the learning process of the student and allows the opportunity to become familiar with the tool and the language of the tool. The obstetrics skills lab involves six hours of total lab time occurring over four days in one and one half hour lab times on each day. A fifth lab occurs in the simulation center involving participation in a high-fidelity simulation scenario related to pregnancy or the postpartum period and is designed to expose the student to the complications of pregnancy or the postpartum period. An informal discussion of culture previously occurred in the simulation experience. The tool provides a formalized means of incorporating the discussion of culture into the simulation experience.

Presenting the students with case scenarios during the skills lab provide a foundation for a discussion of cultural implications during the care of the woman as she transitions from pregnancy to becoming a mother. The tool serves as a prompt for the type of questions and assessment in determining culturally congruent care. During pregnancy, it is important to ask questions related to diet restrictions, taboos, activity restrictions, and the general attitude toward pregnancy and childbirth. The student has the opportunity to role play the types of communication styles that facilitate a sharing of information between a patient and the nurse. It is also critical that the student and nurse learn the correct manner of documenting cultural information that impacts the care of the patient and the family.

In addition, the tool serves as a foundation for observations of the interaction between the mother and the infant after birth. It is important for the student to understand that communication with the infant involves touch, voice, and space and all of these are specific to the culture. Assumptions based on the involvement of the mother in the care of the newborn without assessing the cultural norms potentially leads to a determination that the mother is not bonding with the infant. However, in cultures such as the Indian culture, the care of the newborn is completed by the maternal or paternal grandmother and not necessarily the mother.

**Conclusion and Implications**

Providing culturally congruent care to a new mother and her family helps to support the process of becoming a mother in a culturally sensitive manner. Providing culturally congruent care not only supports the process of becoming a mother, but also aids in the development of care that supports the culture of the patient, the family and the newborn. The development of the attached tool for students in academic and clinical settings provides support for the student dealing with patients from diverse backgrounds. It is important that students are exposed to a means of communicating with patients and families to determine culturally congruent care. A segment of nursing rich with cultural implications is the process of a woman becoming a mother from the time of the diagnosis of pregnancy to the period after birth and throughout the life span. Just as Mercer (2004) has continued to refine and examine her original theory of maternal role attainment into the term of becoming a mother, the attached cultural communication tool demands continued refinement and adjustments. The tool is compact and can be formatted to be carried in the pocket for a nurse to use in academia or practice. It serves as an adjunct to the well established theory of Mercer (2004) and the stages a woman experiences in Becoming a Mother.
References


Appendix A

Revised BAM Model (Cheuvront, 2007)
Chapter Three

Mercer’s Becoming a Mother with a Focus on Depression in Mothers of Toddlers

Angela DelGrande, MSN, RN

“Motherhood brings as much joy as ever, but it still brings boredom, exhaustion, and sorrow too. Nothing else ever will make you as happy or as sad, as proud or as tired, for nothing is quite as hard as helping a person develop his own individuality especially while you struggle to keep your own.”

Marguerite Kelly and Elia Parsons

The time period for the majority of research on the presentation and effects of postpartum depression (PPD) on the mother-child dyad is centered between birth and the first 12 month postpartum. Studies do exist with regard to maternal depression beyond the first year, but the emphasis is mainly on how the maternal psychopathology impacts the development of the toddler through adolescence. Deconstruction of maternal depression and its effect on child development from the context of maternal role transition has not been readily explored. The aim of this discussion is to extend Mercer’s theory, Becoming a Mother (BAM), based on revisions to her original theory, Maternal Role Attainment (MRA) to explore how the process of becoming a mother of a toddler is influenced by the presence of maternal depression. The historical development of MRA and its evolution into BAM will be reviewed followed by a literature review on the norms of toddler development, the prevalence of depression in mothers of young children and the impact it has on toddler development. The BAM framework will be used to elucidate the impact that maternal depression may have on role transition with specific regard to distortions of maternal self-confidence, maternal competence and maternal-toddler attachment. Potential intervention strategies and nursing implications aimed at minimizing the negative impact of depression on the maternal-toddler dyad and promoting more effective parenting behaviors for mothers in this high-risk population will also be highlighted.

Introduction

Becoming a mother is one of the most profound life transitions women can experience because of the degree of role change that occurs in a relatively short amount of time after the birth of a child. However, this transition does not end with achievement of the maternal role in the first year. In order to positively influence growth and development as the infant matures into a toddler, the mother must change the way she nurtures her child, which could be considered yet another role transition (Mercer, 1995). The majority of research on maternal role transition/attainment is focused on how the process unfolds in the first year postpartum, but becomes sparse after that time period as attention is placed instead on how mothering critically impacts the cognitive and behavioral development as infants as they become toddlers. Research on maternal role issues in the first year postpartum support a significant association between role strain or conflict, ensuing maternal distress and maladaptive mothering behaviors, and the development of maternal depressive symptoms (Horowitz, Damato, Duffy, & Solon, 2005;
McLennan, Kotelchuck, & Cho, 2001). A significant relationship also exists regarding how maternal depression can negatively impact both infants and toddlers to the extent that maladaptive behavioral traits and cognitive delays emerge (Lyons-Ruth, Wolfe, & Lyubchik, 2000; McLennan et al., 2001). Use of Mercer’s maternal role transition theory, BAM, as a framework for exploration of how mothers adapt as their infants develop into toddlers, may shed light on a possible mechanism for the development or persistence of maternal depression during this time.

Mercer’s (1981, 1985a, 1995) initial theory of maternal role attainment (MRA) provided a framework for understanding the complex psychological process that women undergo during pregnancy and the first year postpartum as they adapt to their role as mother. Mercer (1985a) defined MRA (consisting of the stages of anticipation, formal/role-taking, informal/role-taking and personal role/identity) as “a process in which the mother achieves competence in the role and integrates the mothering behaviors into her established role set, so that she is comfortable with her identity as a mother” (p. 198). In recent years Mercer revisited her theory and proposed that it be re-examined and revised to reflect the process as a continuum over time as opposed to an endpoint, inferred by the use of the word attainment (Meighan, 2006; Mercer, 2004). Mercer concluded that “Although the last stage in MRA is achievement of maternal identity, the dynamic transformation and evolvement of the woman’s persona are not captured by MRA [and it] does not include the continued expansion of the self as a mother” (2004, p. 231). Mercer (2004) proposed using a lifespan approach to find out how women evolve as mothers in response to their own developmental growth, as well as that of their children, and developed her revised theory, BAM. The four stages of BAM are: (a) commitment, attachment and preparation (pregnancy); (b) acquaintance, learning and physical restoration (the first 2 weeks postpartum); (c) moving toward a new normal 2nd week to 4 months postpartum); and (d) achievement of maternal identity (approximately 4 months postpartum). Mercer contended that the achievement period for the last three stages is highly variable and can overlap significantly. Mercer posited that “The process of BAM should be studied in transitions such as becoming a mother of a school-aged child, an adolescent, an adult, or becoming a grandmother. How does the process differ as a woman expands her maternal self?”(2004, p. 231).

The prospect of viewing the maternal role as one that is evolutionary over time provides an opportunity to explore maternal role transition from a variety of contexts that may not have been considered in the past. The aim of this discussion is to extend Mercer’s BAM theory to explore the process of transition toward becoming a mother of a toddler and find out how maternal depression may impact this process.

BAM/MRA: Background and Historical Perspective

MRA Theory development

A discussion of BAM would be remiss without reviewing the development and validation of MRA. Mercer (1981) began her extensive research on MRA by asking the question “What factors occurring during the first year of motherhood have the greatest impact on maternal role
Multiple key maternal and infant variables or factors, identified via a review of the literature, were focused upon in her initial study which included maternal age, impact of social stress, the type and availability of a support system, self-concept/personality traits, infant temperament and infant illness. A quantitative, longitudinal methodological design using multiple regression and cross-sectional analysis was developed incorporating a theoretical framework created by Mercer which was developed using concepts from both Rubin’s maternal role attainment theory, and sociological interactionist role acquisition theory along with literature on the influence of infant traits and development on maternal-infant interactions (Meighan, 2006; Mercer, 1981). Mercer (1985a) defined MRA as “a process in which the mother achieves competence in the role and integrates the mothering behaviors into her established role set, so that she is comfortable with her identity as a mother” (p. 198). This process of becoming comfortable and competent in maternal role consists of four phases beginning with anticipation which occurs in pregnancy, during which time role expectations are formed. Shortly following birth, the new mother enters the formal/role-taking stage in which she looks toward professionals and others she considered knowledgeable for guidance in mothering tasks. As she becomes more comfortable in the role, the mother enters the informal/role-taking stage in which she begins to structure the role based on her own experiences and goals. Finally, the personal role/identity stage is reached in which she becomes secure, comfortable and confident in her role and identity as a mother. Mercer (1985a; 2004) suggested that this last stage could be achieved from one to nine months postpartum, with a typical course of 4 months, but emphasized that it was not a linear process due to the influence by both infant and maternal variables, including the socio-cultural context of the maternal environment, degree of role strain and social/partner support.

Mercer conducted a series of studies to validate her MRA theory and to identify significant maternal infant variables that influence this process. In her primary study, Mercer (1985a) divided primiparas into three age groups (15-19 years; 20-29 years; 30-42 years) and followed them through the first year postpartum (e.g. data collected at 1, 4, 8 and 12 months after birth) to identify the impact of age on the process of MRA, when it was most commonly achieved and the effect that maternal role strain had on MRA. She discovered that some experiences were age-specific, while others transcended age to affect all three groups similarly. Mercer found that 64% of participants achieved self-perceived internalization of the maternal role by 4 months postpartum, and the majority (85%) reached this point by 9 months postpartum, with only 4% reporting that they still had not achieved internalization by one year postpartum. Infant behavior, social support and previous experience caring for infants were found to be mediating factors in this process. The process of MRA was found to be positively or negatively affected at any time during the first year postpartum by the mother’s relationship with her infant, her family and social supports, and her self-confidence with certain observations universal to all three groups.

First, the MRA trajectory did not follow a linear pattern upward with maternal experience over time. Secondly, a decline in both self-reported and observed maternal competence behaviors and maternal role gratification (with less positive feelings toward the infant) was observed between 8-12 months postpartum corresponding with a slight increase in role strain. Mercer posited that this was due to coping with the challenges of caring for an increasingly active infant. Limitations of the study included: 1) the omission of demographics regarding work status, which prevented a comparison of MRA between women who worked versus those who did not during
the first year postpartum; 2) aged related cultural and educational population bias and, 3) an 18% attrition rate with a homogenous composition (unmarried, less educated with a less integrated personality).

Subsequent analysis of the above study revealed that maternal role gratification measured at 8 months postpartum was positively correlated with decreased maternal age across all three age groups and negatively correlated with higher levels of education in the oldest age group. The most significant correlation between increased role strain and decreased maternal gratification occurred in the 20-29 year old age group (Mercer, 1985b). Mercer posited that the decrease in gratification in the older group might signal a discrepancy between work/education and maternal role satisfaction while role strain in the younger group stemmed from lack of partner and social support.

Mercer and Ferketich (1994) studied predictors of maternal role competence at 1, 4 and 8 months postpartum by antenatal risk status (low vs. high), and although they did not find significant differences in the maternal competence between the two groups, they did find that the overall level of competency was highest between 4-8 months postpartum, which supported Mercer’s original results that role internalization occurred most often by 4 months postpartum. Self-esteem and perception of role mastery were constant predictors for both groups which “supports the notion that a woman’s acceptance of her overall self-image and her perceived control over life events are central to taking on the maternal role” (p. 42). Self-esteem was also the most consistent predictor of maternal role competence in both experienced and inexperienced mothers (Mercer & Ferketich, 1995).

**BAM Theory Development**

According to Mercer, Nichols and Doyle (1989) transitions are defined as “turning points, a point of reference from which a person’s life course takes a new direction requiring adaptation or change in restructuring behaviors and roles appropriate to the new direction”(p.2). In the first stage of BAM, the mother commits to the pregnancy by exhibiting health promoting behaviors aimed at providing an optimal fetal environment and begins her attachment to the fetus by fantasizing about her role as mother (Mercer, 2004; 2006; Mercer & Walker, 2006). In a meta-analysis of 9 qualitative studies on maternal role transition, Nelson (2003) discovered that the first step in the process was development of a commitment to become a mother, characterized by deciding to become pregnant or accepting an unplanned pregnancy followed by improved health behaviors and planning ahead in preparation for the birth experience. Similar findings were found in maternal role transition research on first-time mothers over age 35 (Carolan, 2005) and African American mothers of higher socio-economic and educational status (Sawyer, 1999). Although pregnant adolescents experienced increased challenges due to their age, socioeconomic status and lack of social support, limited research supports that for some teens, pregnancy was a time to improve their self-identity and lifestyle in an effort to become responsible mothers (Lesser, Koniak-Griffin, & Anderson, 1999).

The remaining BAM stages occur in the postpartum period and consist of a short period of physical restoration followed by the transition toward becoming a mother, with a culmination in the achievement of the maternal role which occurs at approximately 4 months (Mercer, 2004; 2006; Mercer & Walker, 2006). Rogan, Shmied, Barclay, Everitt, & Wyllie (1997) conducted a longitudinal grounded theory analysis of first-time mothering experiences for fifty-five women to explore how this transition impacted their lives, with a specific focus on how the realities of
mothering compared to the expectations of mothering held during pregnancy. The authors found that the process was a continuum starting with the initial phase; *this isn’t my life anymore*, as the realization occurs that a new life norm is being created which led to feeling *unready* for the new, unknown role. The characteristics of both phases were similar to Mercer’s BAM phase of* moving toward a new normal*. The final phase, *in a certain tune*, was characterized by finding ways to work out this unknown new life and role which had similarities to Mercer’s last BAM phase, *achievement of maternal identity*. In keeping with Mercer’s (1995) conclusions, the authors found that stage trajectory was non-linear, but instead moved within a role transition continuum. Infant behavior, social support and previous experience caring for infants were found to be mediating factors in this process. The authors coincidently called this theoretical framework *becoming a mother*. Carolan (2005) also found primiparas over the age of 35 also experienced maternal identity development in stages. The first four months postpartum were characterized by the stages of *the nightmare of early mothering*, which occurs in the first four weeks postpartum, and *struggle and ambivalence* which occurs between 1-4 months postpartum. Internalization of the maternal role started at approximately 4 months postpartum, with mothers describing the concept of *finding my own way* of becoming a mother. The last stage, *feeling like a mother*, occurred between 4-6 months postpartum and was characterized by “a general understanding of the magnitude of the maternal role and a changing appreciation of what it meant to be a mother” (p. 778), which is congruent with Mercer’s last stage of maternal identity achievement.

Three key components are identified as indicative of a successful maternal role transition: maternal self-confidence, a sense of role competence and a sense of maternal-infant attachment (Mercer, 2006; Mercer & Walker, 2006). Several maternal and infant variables are identified as having either a positive or a negative influence on these role components. Maternal variables that may be particularly relevant to the current discussion include life stressors, external support, spousal relationship, personality traits, core self-concept, role strain, level of anxiety, and depressive symptoms (Coleman & Karraker; 2003; Meighan, 2006; Mercer, 2004, Mercer & Walker, 2006). Infant variables include responsiveness toward mother and general temperament (Martin, Clements, & Crnic, 2002; Mercer, 2004, Mercer & Walker, 2006).

Mercer and Walker (2006) created a model of BAM to depict how external environmental factors influence the trajectory of maternal transition and infant development at three different levels (see Figure 1). First social support and maternal-infant care guidelines are provided to both the mother and father by their immediate environment of *family and friends*. This more intimate environment is embedded within the *community* environment which offers parental resources and health care services which in turn is encompassed by the *society-at-large* environment which “provides aid to families, transmits cultural consistencies, and establishes law affecting family life” (p. 569). Mercer posits that this model may be useful as a means of developing interventions to promote an optimal environment for becoming a mother.
Own Ideas and Extension of Theory

**BAM and Toddlerhood: Impact of Maternal Depression**

In order to extend BAM to explore maternal transitions that occur outside the first postpartum year, certain aspects of each stage must be reframed and used within the context of the life period in question (see Figure 2). With respect to this discussion the first stage is more appropriately viewed from the context of how a mother prepares for the marked changes that will occur as her infant develops into a toddler (Paulson, Dauber, & Leiferman, 2006). Does she read books on toddler development and care? Does she begin to baby-proof the household in anticipation of her child’s new found ability to ambulate? Is she preparing herself for the parental frustration that often occurs in response to toddler behaviors that emerge as the developmental stage of gaining autonomy unfolds? The second stage, which represents a time of acquaintance with the newborn and physical recovery, is unique to the early postpartum period, which in this author’s opinion does not lend itself to being used within the context of maternal transition during toddlerhood. The third stage, moving toward a new normal, is well-suited for exploration of maternal transition during this developmental period because the role that had been attained the first postpartum year may change quite rapidly after the baby surpasses 12 months of age. During this time of moving toward a new normal, maternal adaptation of daily life patterns and parenting skills must occur at some level to meet the emotional, social and physical needs of the toddler (Coleman & Karraker, 2003). The final stage, achievement of a new identity as the mother of a toddler, occurs when the mother has successfully navigated her way through the changes and challenges to the point that “the mother feels self-confident and competent in her mothering and expresses love for and pleasurable interacting with her [toddler]” (Mercer & Walker, 2006, p.569).
Transition to Toddlerhood

The toddler years occur from the first through the third year of life. The toddler’s developmental goal during this time is to gain autonomy and independence from the parents or caregiver. Gross and fine motor skills advance rapidly, enabling many children to walk independently by 18 months of age, and language acquisition begins to occur at a rapid pace (Coleman & Karraker, 2003; Colson & Dworkin, 1977). As the toddler gains mobility he is able to have greater independent interaction with his environment (see Figure 3.). This quest for autonomy, combined with increased motor skills, can lead to daily struggles within the maternal-toddler dyad which is frequently manifested by the toddler having temper tantrums and whining if he does not get his way (Coleman & Karraker, 2003). Although frustrating to parents, these daily struggles are part of the developmental process of learning how to control impulses, and the ability to master this developmental step is dependent upon secure attachment to the parents (Martin, Clements, & Crnic, 2002). The innate temperament of the toddler, maternal behavioral expectations for the toddler and the mother’s parenting style act synergistically to influence the developmental process as well. Discordance among these three variables can trigger feelings of stress and conflict in the mother and behavioral issues in the toddler which may undermine maternal feelings of enjoyment with regard to the maternal-child interaction (Martin, Clements, & Crnic, 2002).
Maternal Depression and Effect on Child Development

The rate of depression experienced by women is twice that of men, with a peak incidence occurring during the child-bearing years between ages 18-44 (Sichel, 2000). The incidence of PPD is estimated at between 10-13% in the United States (Beck, 2001; O’Harra, 1995) and may be as high as 20% (Matthey, Barnett, Howie & Kavanagh, 2002; Sichel & Driscoll, 1999). Presentation of PPD can vary and is better viewed as a continuum of symptoms ranging from subclinical dysphoria to severe depression (Clemmens, Watson Driscoll, & Tetano Beck, 2004; Nonacs, 2005; Ugarriza, 2002). Common descriptors of PPD by women include feelings of being overwhelmed, hopelessness and sadness, experiencing periods of anxiety and irritability, with an ongoing undercurrent of being tense, having difficulty concentrating and poor sleep (Beck & Indman, 2005; Nonacs, 2005; Sichel, 2000). The onset is typically within the first 4 weeks postpartum and is often thought to be limited to between 6 and 12 months after birth but, research supports that PPD can present months after birth and linger up to three years (Goodman, 2003; Horowitz et al. Damato, Duffy, & Solon, 2005). The prevalence of maternal depression in the first year after birth is well documented; however, a consistent prevalence range has not been as strongly established. McLennan et al., Kotelchuck and Cho (2001) sought to determine the prevalence and persistence of depression among mothers of young children by analyzing data obtained from two large data bases, the 1988 National Maternal Health and Infant Survey (NMHIS) and the 1991 Longitudinal Follow-up Survey (LF) which were derived from the National Center for Health Statistics data bank. The authors only used data from mothers of young children who completed the Center for Epidemiologic Studies-Depression Scale (CES-D) (Radloff, 1977 as cited in McLennan et al. Kotelchuck & Cho, 2001) as part of both surveys. Data collection occurred at a mean of 17 months postpartum (Time 1) for the NMHIS survey and 35 months (Time 2) for the LF survey (n = 7537). The authors found that 24% of mothers at Time 1 and 17% at Time 2 reported elevated depressive symptoms (CES-D ≥ 16) while 12.1% and 7.8% of mothers reported highly elevated scores (CES-D >22) respectively. Thirty-five percent of women who had elevated scores at Time 1 also had elevated scores at Time 2 indicating that the persistence of depressive symptoms was moderately stable. Pascoe, Stolfi, and Ormond (2006) found a 20% prevalence rate of depressive symptomatology among mothers of toddlers. In another longitudinal study on maternal depression prevalence during the first 18 months postpartum for a cohort of healthy black women with varied socioeconomic status, the overall prevalence for a high CES-D score (>16) at 18 months postpartum was 14.7% (Beeghly et al., 2003). Horowitz and Goodman (2004) found that 36% of women who had elevated depression scores at 2-4 weeks postpartum continued to have depressive symptoms 2 years after birth. Further research suggests that the degree of maternal depression or depressive symptomatology experienced may not be as influential on toddler development as the chronicity or persistence over time (Goodman & Gotlib, 1999; Lyons-Ruth et al., Wolfe, & Lyubchik, 2000). The instability of depressive symptoms over time (Luoma et al., 2001) and the timing of initial exposure to maternal depression (Essex, Klein, Miech, & Smider, 2001) may also be factors in child outcome.

Although research on prevalence rates varies widely, at least 12-14% of mothers experience depressive symptoms after 12 months postpartum. This is significant because
evidence suggests that maternal depression creates a negative impact on the cognitive and behavioral development from infancy through adolescence (Essex et al., Klein, Miech, & Smider, 2001; Hay, 1997). Lyons-Ruth et al. Wolfe and Lyubchik (2000) conducted a literature review to summarize the correlates between parental depression and impaired developmental outcomes for children beginning in the first year of life. The authors found that children of depressed mothers had greater impairment of social, behavioral and academic skills from infancy through adolescence compared to non-depressed mothers. Specifically, children of depressed mothers may be more prone to having issues with problem-solving, deficits in social skills, demonstrate less active and explanatory play, display increased negative affect toward peers, poor emotion-regulation strategies, lower self-esteem and not surprisingly an increased risk for developing psychopathological conditions. Toddlers of depressed mothers tend to respond more aversively to peers displaying sad affect, exhibit compromised cognitive development, difficulty using maternal contact to decrease their stress responses (Lyons-Ruth et al. Wolfe & Lyubchik, 2000) and exhibit heightened levels of anxiety in response to mildly stressful situations (Goodman & Gotlib, 1999). The effects of maternal depression may also interfere with the development of positive social self-assertion strategies toward their peers and adults (Dietz, Donahue Jennings & Abrew, 2005). Dawson et al. (2003) synthesized their current research on atypical brain activity of infants and toddlers of depressed mothers with that of other researchers and found that these children tended to exhibit decreased frontal lobe activity when compared to those of non-depressed mothers. According to the authors “EEG studies of infants, children, and adults have shown that, during the expression of ‘approach’ emotions, such as joy and interest, the left frontal region is more activated, whereas during the expression of ‘withdrawl’ emotions, such as sadness, the right frontal region is more activated” (p. 1158). A generalized decrease in frontal activity was associated with increased aggressive and the tendency for an increase in tantrums.

**BAM and Toddlerhood: Maternal Depression Effects**

Maternal depression by itself may not be the defining variable which negatively impacts child development. Instead depression may be a mediator or moderator for maladaptive maternal responses to the developmental behaviors exhibited by toddlers, which in turn triggers exaggerated or maladaptive behavioral responses and sub-optimal cognitive and social maturation in the toddler (Essex et al.; Klein, Miech, & Smider, 2001; Goodman & Gotlib, 1999; Lyons Ruth et al., Wolfe & Lyubchik, 2000; Martin et al, Clements, & Crnic, 2002; Paulson et al., Dauber, & Leiferman, 2006) It is within this context that maternal depression and its effect on the process of becoming a mother of a toddler will be explored. In keeping with BAM, the process of integration of the role as the mother of a toddler is achieved through maternal feelings of competency and self-confidence in parenting and caretaking along with a positive sense of attachment and love toward the toddler. This author posits that maternal depression may pose a challenge to the mastery of the three primary BAM components, thus creating issues with the process of role transition and an increased potential for maternal role strain similar to that observed during the first year postpartum.

Negative perceptions of maternal self-confidence and a self-perceived lack of competence are commonly identified as risk factors for the development of postpartum depression (Beck, 2001; Goodman, 2003; Horowitz et al., Damato, Duffy, & Solon, 2005). These characteristics can also emerge in response to negative maternal-child dyad interactions
and suboptimal, ineffective parenting strategies that develop due to maternal depression (Horowitz et al., Damato, Duffy, & Solon, 2005; Lyons Ruth et al., Wolfe & Lyubchik, 2000). Lyons Ruth et al., Wolfe and Lyubchik (2000) found that when compared with mothers who were non-depressed, mothers with depressive symptoms had increased negative interactions and exhibited more negative parenting behaviors toward their children (age 3) including yelling, spanking and increased feelings of annoyance. Mothers with depressive symptoms were less likely to create an environment conducive to the development of positive social and cognitive behavioral strategies such as providing a predictable, less stressful daily living environment for their children (Leiferman, Ollendick, Kunkel, & Christie, 2005) or interacting with toddlers consistently using positive enrichment activities such as reading, telling stories or singing songs (Paulson et al., Dauber, and Leiferman, 2006).

Maternal-toddler attachment is also negatively influenced by the presence of maternal depression. Infants and preschoolers of depressed mothers were more likely to exhibit disorganized, less coherent attachment behaviors and attachment insecurity within the maternal-child dyad (Teti, Gelfand, Messinger, & Isabella, 1995). These findings were supported by Cicchetti, Rogosch and Toth (1998), who found that toddlers with depressed mothers exhibited significantly more insecurity within the dyad which was not accounted for by additional social contextual risks such as family conflict, marital discord, higher stress levels and lower social support levels commonly identified in families with depressed parents. In a study to ascertain maternal emotions in response to both positive and negative toddler affect, Martin et al., Clements and Crnic (2002) found that an increase in negative maternal emotion was inversely associated with a decrease in positive toddler affect. The authors also found that mothers who responded in this manner were more likely to exhibit less sensitive, more disorganized and disruptive parenting behaviors (Martin et al., Clements, & Crnic, 2002).

In summary, the process of becoming a mother of a toddler can be negatively impacted by maternal depression present after the first year postpartum. In mothers of toddlers who are depressed, the BAM components of maternal self-confidence, competence and maternal-child attachments may become distorted leading to a maladaptive integration of the mothering role. Maladaptive mothering secondary to depression can be detrimental to the social, cognitive and behavioral development of toddlers and may have long-range implications for disruption of the developmental process from infancy through adolescence. Possible intervention strategies to improve the outcomes for this high-risk population will be presented in the nursing implications section of this discussion.

**Nursing Implications and Conclusions**

**Intervention Strategies**

Mercer (2006) contends that three levels (family and friends, community and society at large) of environmental variables have the potential to promote or inhibit the process of BAM (see Figure 1). This environmental model can be used as a framework for development of intervention strategies for nursing aimed at minimizing the negative impact of depression on the maternal-toddler dyad and to promote more effective parenting behaviors for mothers in this high-risk population.
Consideration of how a mother’s family and friends influence the process of BAM should be taken into account during the development of interventions strategies, keeping in mind that for some mothers, interaction with family and friends may not be readily available or desired. Researchers have found that maternal isolation and a sense of loneliness may occur in response to maternal role transition (Rogan, et al. 1997; Hartrick, 1997) and mothers may diminish contact with people they had been closest with prior to giving birth (Hartrick, 1997). Conflicting views on the effect of postpartum support of female family members and friends have been identified with some mothers describing that this support was a great help while others felt a sense of inadequacy and distress because they required help at all (Choi, Henshaw, Baker & Tree, 2005). In addition, interventions strategies should not be aimed solely toward the depressed mother, but developed using a family-oriented approach which appropriately incorporates all members of the mothers immediate family (i.e. spouse/significant other and additional children) (Lyons-Ruth et al., Wolfe, & Lyubchik, 2000, Mercer, 2006).

The provision of focused education for mothers, families and health care professionals on the risk factors, prevalence, presentation and effects of maternal depression is one example of how Community intervention strategies that may positively impact the process of BAM. Interventions such as this are particularly relevant to public health nursing. This is an important community health issue for several reasons. Despite an increased emphasis in screening for postpartum depression in the last several years, most women do not report postpartum depressive symptoms to their health care providers thus, remaining undiagnosed and untreated (Nonacs, 2005). Many providers are unaware that postpartum depression can start several months after birth and linger on past one year postpartum, and only screen for depression in the first several weeks after birth (Goodman, 2003). The ability to do ongoing screening is also hampered by the fact that most women have their last obstetric examination at approximately six weeks postpartum and while screening for depression during subsequent well-baby visits is on the rise, it is not the norm (Chaudron, Szilagyi, Kitzman, Wadkins, & Conwell, 2004). Educational strategies designed to improve upon these issues for both the lay population and health care professionals may positively impact the short and long-term mental health and behavioral outcomes for both the mother and the child (Lyons-Ruth et al., Wolfe, & Lyubchik, 2000).

Finally, intervention strategies that emanate from the society at large may center on recognizing the importance of funding further research aimed at expanding the knowledge base related to issues and outcomes specific to mothers of young children who are depressed. Nursing research findings on this subject matter may be a catalyst for the development of health care policy targeted at alleviating the shortage of appropriate mental health services and clinical expertise for this specialized high-risk population (Lyons-Ruth et al., Wolfe, & Lyubchik, 2000).

Research interests

The expansion of Mercer’s BAM theory to explore the effect of depression on the process of becoming a mother of a toddler ties in with the personal research interests of this author, which center on the exploration of the relationship between maternal role incongruence and the onset or persistence of maternal depression at 12 months postpartum. The preparation for and development of this discussion generated new knowledge regarding how maternal depression impacts both parenting behavior and child development and created a strong understanding of the BAM process as a whole. It also strengthened the assertion that studying the effects of depression on this population may provide valuable information which could lead to clinical
intervention strategies that may positively impact the outcome for this high-risk maternal-child dyad.

References


Chapter Four
Extension of Midrange Comfort Theory

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Theory derivation is an efficient strategy in developing new theories. In addition, theory derivation is a useful method to represent a set of related concepts in a structural way. The Walker and Avant (2005) theory derivation method will be utilized to extend/modify Kolcaba’s Comfort Theory (1994, 2001). The following process of essential activities will be discussed and include (a) being mindful of the level of theory development in your field and evaluating the usefulness of new theory development, (b) reading extensively in nursing and related disciplines or other fields for ideas, (c) choosing a parent theory to use in derivation, (d) identifying the structure and content from the parent theory that you will use, (e) developing and redefining new statements or concepts from the structure or content of parent theory (Walker & Avant, 2005). Subsequently, after the theory is extended, a discussion in relation to my proposed research is assembled, implications and contributions to nursing are delineated, and lastly an analogy is presented.

Extension of Midrange Comfort Theory

Introduction

The midrange nursing theory selected for the extension is the Comfort Theory (CT). Comfort Theory will be utilized as the parent model and will be extended from the original published application to the population of Thai women’s health beliefs and behaviors regarding cervical cancer screening. The Journal of Advanced Nursing published the original Comfort Theory in 1994. In 2001, a subsequent article provided an expansion of the theory to include institutional integrity. Kolcaba is the author of the theory.

Walker and Avant (2005) stated that theory derivation is a valuable strategy used to develop new theories. Theory extension or derivation is a method of moving existing knowledge from one area of study to another. Walker and Avant (2005) identified the following activities as essential processes of theory derivation. These include (a) to be mindful of theory development and evaluate the usefulness of theory development, (b) to read extensively in nursing or related disciplines or other fields for ideas, (c) to choose a parent theory to use in derivation, (d) to identify the structure or content of the parent theory that will be used, (e) to develop or redefine new statement or concepts from the structure or content of the parent theory.

In this paper, a synthesis and discussion of the original theory will occur. Concepts, definitions, and statements which are relevant to Thai women’s health beliefs and behaviors regarding cervical cancer will be identified and derived. Subsequently, after the theory is extended, a discussion in relation to my proposed research is presented, implications and contributions to nursing are delineated, and lastly an analogy is presented.
Relationship of Comfort Theory to Phenomenon of Research Interest

Cervical cancer is the leading cause of cancer mortality, morbidity, and cancer death among women in developing countries such as Thailand, Vietnam and Cambodia (Jirojwong & Manderson, 2001; MacFarland, 2003; Winkler, Bingham, Coffey, & Handwerker, 2007). Regular Pap smear screening is an important preventive method that can assist with early detection of early stages of cervical cancer, thus reducing the disease mortality rate. Smith, Phillips and Price (2001) asserted that the researchers estimate the death rate from cervical cancer can be reduced by 37% to 60% if women were to participate in routine Pap smear screening.

Jirojwong and Manderson (2001) conducted a cross sectional study, utilized a survey and ethnographic methods to identify social, cultural and personal factors influencing the use of cervical cancer screening or Pap smear tests and self-breast examination among Thai migrant women in Brisbane, Australia. The researchers found that only 53% of Thai women who lived in Brisbane, Australia had ever had Pap smear tests. This finding was similar for other Southeast Asian groups. The study result indicated low use of cervical cancer screening services, which is contrary to the researchers hypothesizing that Thai women were more likely to be exposed to the cervical cancer screening in Thailand.

MacFarland (2003) conducted a study on knowledge and perceptions of cervical and Pap smear screening in Botswana, Africa. She found that knowledge of cervical cancer and Pap smear screening was inadequate among minority women. In addition to the knowledge deficit, Smith et al. (2001) found that feeling of embarrassment, use of traditional medicine, self healing, decision making, and cultural beliefs play a significant role among racial and ethnic groups.

It is crucial for health care providers to understand the patients’ values, beliefs and knowledge of disease processes. Understanding Thai women’s perceptions of health, values and beliefs will lead to more appropriate disease prevention, and therefore enhance health care services to this group of people (Jongudomkarn & West, 2004).

Comfort theory is holistic, humanistic, and based on patients’ needs. To date, the author notes that careful review of the literature indicates no study has explored cultural and social contexts related to the use of cervical cancer screening among this population in the United States. In order to better understand Thai women’s health beliefs and behaviors regarding cervical cancer screening, CT will be explored and an extension proposed for use in this population. The original article, Evolution of the Mid Range Theory of Comfort for Outcomes Research, analyzed the concepts of comfort and defined a framework that linked components and articulated the stages of theory development, criteria for adequacy of midrange theory and utilization of the midrange theory of comfort. The resultant theory was a product of the construction of different methods for theory development applied during different stages of theory development (Kolcaba, 2001). This paper will utilize the original articles and will derive the theory into one in that will attempt to explore Thai women’s health beliefs and behaviors regarding Pap smear tests.
Historical Background of Comfort Theory

Kolcaba developed the original CT in 1994, and then adapted CT in 2001 for outcomes research. Kolcaba (2001) reasoned that CT was evaluated and adapted for outcomes research and for preparing the nursing discipline to meet the challenges of the rapidly changing health care environment of the 21st century.

The theory developed as a result of the developmental stages of the midrange theory of comfort. These include the theory’s philosophic orientation, and its inductive, deductive, and retroductive reasoning. Kolcaba stated that the purpose of CT was to postulate among patients’ needs, nursing interventions, comfort, and subsequent outcomes. From these relationships, a theory of comfort was derived (Kolcaba, 1994).

Kolcaba (1994) primarily developed CT as a patient-centered theory. Kolcaba discovered the strengthening aspect of comfort as being central to nursing through her initial analysis of the concept of comfort. Kolcaba (1994, 2001) defined three types of comfort: (a) relief is the experience of having a specific comfort need met, (b) ease is the state of calm or contentment, (c) renewal. Later the term was changed to transcendence, which is the state in which one can rise above problems or discomfort.

Kolcaba (1994, 2001) further identified that these types of comfort occur in four contexts of experience: physical, psychospiritual, sociocultural and environmental. There are two dimensions to Kolcaba’s (1994) CT. The first dimension consists of three states: relief, ease, and transcendence. The second dimension is the context of comfort, which derived from holism: physical, psychospiritual, social, and environmental components. Kolcaba arranged the two dimensions (three states and four contexts) in a two dimensional grid resulting in 12 facets of comfort. Kolcaba derived a taxonomic structure for the concept of comfort (Figure A1). Kolcaba (1994, 2001) derived these concepts from an extensive review of nursing literature on holism. Kolcaba (1994) utilized an intra-actional perspective as a theoretical framework to develop a theory of comfort as “a positive outcome of nursing care” (p. 1178).

Kolcaba (1994) provided the basic assumptions underpinning CT and these assumptions are in tune with an intra-actional perspective, which means an individual’s components of holism are related. In addition, the components of a whole person response are assessed thoroughly. Kolcaba (1994) stated “intra” designates within, and comfort is a result that is comprised of many aspects that are related within the domain of the construct. In addition, Kolcaba (2004) further stated “assumptions are a theorist’s point of view about reality” (p. 259). The assumptions are set forward to let the reader know the theorist’s sources. Kolcaba (2004) identified the basic assumptions of CT to include:

(a) Human beings have holistic responses to complex stimuli; (b) comfort is a desirable holistic outcome that is germane to the discipline of nursing; and (c) human beings strive to meet, or to have met, their basic comfort needs; (d) comfort is more than the absence of pain, anxiety, and other physical discomfort (p. 259).

The Theorist

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Adults, a baccalaureate course utilizing Acute Care for Elders (ACE) Principles and Comfort Theory. Dr. Kolcaba teaches at graduate and PhD levels, focusing on nursing research, theoretical nursing, gerontology, end of life and long term care prevention, comfort studies, instrument development, and magnet status. Dr. Kolcaba is also active in volunteer activities. She is the founder and coordinator of her local parish nurse program. Dr. Kolcaba has published extensively on the patient outcome of holistic comfort. She has an award winning website called “The Comfort Line.” Dr. Kolcaba holds numerous awards and honors (University of Akron, n.d.).

Applications and Usages of Comfort Theory

The Comfort Theory is being applied in various settings for education, practice, research and administration, since the human needs for comfort appears to be universal. The Comfort Theory is being tested and taught at the University of Akron, College of Nursing in Akron, OH. CT is still quite new but it is gaining popularity and being increasingly recognized by students who are selecting a framework for their studies such as labor and delivery (Koehn, 2000), hospice (Novak, Kolcaba, Steiner, & Dowd, 2001), urinary incontinence study (Dowd, Kolcaba, & Steiner, 2000), geriatric orthopedics (Panno, Kolcaba, & Holder, 2000), perioperative nursing (Kolcaba, & Wilson, 2002; Wilson & Kolcaba, 2004), pediatrics (Kolcaba & DiMarco, 2005), and nursing administration (Kolcaba, Tilton, & Drouin, 2006).

Critique of Comfort Theory

Clarity

The evaluation of CT will be based on the description of the theory in relationship to its clarity, consistency, simplicity/complexity, and tautology/teleology. Kolcaba developed CT from its conception as the root of her practice, through the development of methods to measure the concept emerged comfort questionnaire instruments, and is presently being applied in practice, education, research and administration and subsequently has developed the taxonomic structures of comfort (Dowd, 2006). In terms of clarity, Kolcaba’s explication of theory is easy to read and understand. In subsequent articles, Kolcaba applied the theory to specific practice settings using understandable academic language. All research concepts are clearly defined theoretically and operationally. The clarity of CT further enhances understanding by the diagram presentations of the theory (figure D1).

Consistency

CT is based on holistic thinking needs. CT empowers the patient to seek and engage in health-seeking behaviors. The Comfort Theory has demonstrated a high degree of congruency among its different structures and components. In addition, the definitions of concepts and the assumptions fit the theory. As previously mentioned, CT has been tested in various practice settings such as in studies of women with breast cancer (Kolcaba & Fox, 1999), patients with urinary incontinence (Dowd et al., 2000), and hospice comfort of family members of dying hospice patients (Novak et al., 2000).

Simplicity/Complexity
The main thrust of CT is the focus of the nursing practice on patients’ needs whether is in acute care, long term care or primary care settings. In addition, CT is simple because it is specific to nursing. CT aims to go back to basic nursing care and the traditional mission of nursing. CT meets the requirements of complexity because its multiples relationships among single variables or the complexity of single variables are addressed.

Tautology/Teleology

Kolcaba has developed concept of comfort from a full array of approaches. These approaches include qualitative and empirical works. Through her qualitative approach, Kolcaba identified the historical usage of concept in nursing. Kolcaba used the findings to strongly support the rationale for her claim of the comfort concept as being central to nursing (Dowd, 2004). The three types of comfort: relief, ease, and transcendence were synthesized from four early nursing theorists, Orlando (1961), Henderson (1966), and Paterson and Zderad (1975) respectively. These three types of comfort are integral to the theory and were tested for validity through factor analysis of the instruments developed with the direction of taxonomic structure (Kolcaba, 1994). Another conceptual framework that influenced the development of Kolcaba’s comfort theory was the work of the psychologist Murray (1938). The work was more abstract and congruent with comfort and contained a manageable number of highly abstract constructs to unify relief, ease, and transcendence (Kolcaba, 2004).

In addition, Kolcaba provided a definition of comfort that is concise and has the immediate state of being strengthened by having the human needs for relief, ease and transcendence met while addressing the physical, psychological, sociocultural, and environmental components (Kolcaba, 1994). This definition emphasizes that nurses may not be able to fulfill all the patients’ needs for comfort; however, they can continue to address them throughout the continuum of care. As a result of the methodological development of the concept, CT is clearly an organized, logical, and coherent theory that is readily applied to different settings namely: practice, education, research, and administration.

Modification of Comfort Theory

Kolcaba’s CT has extended to another area of interest, the universal nature of comfort for further development. Presently, the General Comfort Questionnaire has been translated into Taiwanese and Spanish. CT has been applied in various research settings, cultures and age group (Dowd, 2004). However, through careful review of the literature, the author found gaps in applying CT as a transcultural theory. Therefore, it is the author’s intention to modify and extend CT to Thai women’s health beliefs and behavior in regards to cervical cancer screening.

Kolcaba (1994) stated that the purpose of CT is to postulate relationships among patients’ needs, nursing interventions, comfort, and subsequent outcomes. In addition, the theory of comfort is derived as resulting from these relationships. Kolcaba (2001) identified the concepts of CT as follows: (a) health care needs; (b) nursing intervention; (c) intervening variables; (d) patient comfort; (e) health-seeking behaviors (HSBs) of patients; and (f) institutional integrity. Kolcaba (2001) described CT’s description of traditional nursing practice as humanistic, need-related, and holistic. Each of these components will be explored in more detail and derived to reflect the health beliefs and behaviors of Thai women regarding cervical cancer screening.
Health Care Needs

Parent theory. In the original theory, Kolcaba (1994) identified health care needs that include physical, psychospiritual, social, and environmental needs that arise in stressful health care situations that cannot be met by patients’ traditional support systems. Historically, many strategies for promoting health were developed which include physical comfort. Until recently, physical comfort was secondary to other nursing objectives such as the prevention of complications. According to nursing literature, the tension between strengthening patients for rehabilitation and their comfort is delineated throughout nursing history (Kolcaba, 2006).

According to Kolcaba (2004) physical comfort concerned “bodily sensations and homeostatic mechanism” (p. 258). The bodily sensation may be described by the patients as having the experience of pain, nausea, cold, or numbness, etc. Homeostatic mechanism is manifested when the patient experiences pain or discomfort which may result in his/her blood pressure being elevated, an increased respiration rate, and increased body temperature. It is the nurse’s responsibility to assist the patient to alleviate the discomfort by implementing comfort measures such as administering pain medication, repositioning the patient or applying a warm blanket. Nursing interventions are determined and implemented with the intention of moving negative tension in the positive direction (Koehn, 2000). An increase in comfort is an indication that positive tensions are being restored.

Kolcaba (2004) proposed that psychospiritual comfort needs concerned “the internal awareness of self, including esteem, sexuality, and meaning in one’s life; it also encompassed one’s relationship to higher order or being” (p. 258). Kolcaba (2000) further stated that meeting comfort needs will create a whole person response. Therefore, the concept of holistic comfort encompasses the connection of the mind, body, and spirit.

Sociocultural comfort as described by Kolcaba (2004) pertained to interpersonal relationships among an individual and family members, society, and cultural traditions. The patients’ beliefs, culture, values, traditional ways of life, and religion must be taken into consideration. In this area, Kolcaba (2004) demonstrated that “comfort food” for the soul includes the interventions that entailed old fashioned and basic nursing care. Comfort food intervention aims “transcendence through presencing and memorable connections between nurse and recipient” (p. 734). In this context the recipient may be a patient and family members, an individual patient, and/or a group. Kolcaba’s suggestion for a comfort food list includes music therapy, message, guided imagery environmental adaptations to enhance peace and tranquility, hand-holding, and reminiscence.

The last component of comfort needs is the environmental comfort which includes the external background experience of the human. It encompasses noise, ambience, temperature, natural versus synthetic elements, and temperature (Kolcaba, 2004). Nurses must be mindful of environmental comfort impacting a patient’s health care needs in a stressful situation.

Derived Theory. As a health care provider who works with Thai women in order to provide culturally sensitive care services, she must have a deeper understanding of the holistic comfort needs of this population. In the past decade, an increasing international attention has been focused on women’s sexual and reproductive health as a priority for health care reform. Furthermore, women’s health advocates argue that health care reform involve a careful
consideration of women’s experience in terms of reproductive health, as well as sexual issues. The accessibility and quality of health care services, cultural and gender dimensions of health that may have an impact on women’s sense of vulnerability and perception also need to be considered (Boonmongkon, Nichter, Pylapa, Sanhajariya, & Saitong, 2002).

According to the study among the Thai women population in Australia, Thais have a higher risk incidence of developing cervical cancer. Additionally, relatively high cervical cancer incidence has been documented for Southeast Asian women, compare to the general population. These include women in Singapore and Hong Kong (Jirojwong & Manderson, 2001).

Kolcaba and Wilson (2002) stated that “Comfort is more than the absence of pain and can be enhanced through transcendence” (p. 104). Enhanced comfort involves increased hope and confidence. By communicating with patients about the screening procedure, one can minimize the patient’s feeling of anxiety. The physical comfort needs of Thai women undergoing Pap smear screening include pain or discomfort during the procedure and can be relieved by providing information about the step-by-step procedure of the Pap test and the rationale behind it. Jirojwong and Manderson (2001) found in their study that 45.5% of Thai women’s (N=145) perceived pain associated with the Pap smear procedure. Since the support of physical comfort needs are one type of comfort experience that occurs during Pap smear screening, this type of comfort will be maintained in the derived model.

Psychospiritual comfort needs of Thai women include the need for motivation, insight and being able to “rise above” the discomfort of a Pap smear procedure. These needs are often met by comfort measures aimed at transcendence, such as warming the speculum and special words of encouragement. These special interventions can be called “comfort food” for the soul because they are endearing to the patients and facilitate transcendence (Kolcaba, 2004). Since there is support for this type of measure within context of Thai women undergoing a Pap smear procedure, this type of comfort need will be maintained in the derived model.

Sociocultural comfort needs are the needs for “culturally sensitive reassurance, support, positive body language, and caring” (Kolcaba & Wilson, 2002, p.105). Kolcaba (2004) proposed that these needs can be met through “coaching” that includes intervention designed to minimize anxiety, give reassurance and information, messages of wellness and encouragement, particularly for the patients who are undergoing a Pap smear procedure for the first time. Since there is support of this type of comfort needs occurring in the context of comfort needs of Thai women undergoing a Pap smear screening, this type of comfort will be maintained in the derived theory.

Environmental comfort needs include a quiet, comfortable examination table, maintenance of privacy, warm ambience and temperature of the examination room. Since there are environmental comfort needs as a component of comfort needs of Thai women undergoing a Pap smear procedure, this type of comfort will also be maintained in the derived model.

Nursing Interventions (Comfort Measures)

*Parent Theory.* In the original theory, Kolcaba (2001) stated that nurses design interventions to address patients’ comfort needs. Kolcaba (2001) identified three types of comfort interventions: technical comfort measures; coaching; and “comfort food” for the soul. Kolcaba described technical comfort measures to include the maintenance of homeostasis and
pain management. The purpose of these comfort measures is to assist the patient to maintain or regain optimal physical function, comfort, and to prevent further complications (Dowd, 2006). The coaching method involves nursing interventions aimed to provide information and reassurance, relieve anxiety, provide inspiration, listen, help with realistic discharge planning, community integration or death in a culturally sensitive way. “Comfort food” for the soul intervention aims to facilitate comfort care by fortifying patients for difficult tasks. Comfort food for patients includes nursing interventions such as massage, adaptation of the environment to promote serenity, guided imagery, music therapy, reminiscence, and hand-holding (Dowd, 2006).

**Derived Theory.** In providing care for Thai women undergoing a Pap smear screening, may involve all three methods of nursing interventions, namely, technical comfort measures, coaching, and comfort food for the soul. Holroyd, Twinn, and Shia (2001) conducted a two-phase exploratory descriptive survey utilizing qualitative and quantitative methods of data collection. The researchers’ aim of this study was to explore specific gender and culturally related experiences of Hong Kong Chinese women presenting for Pap tests. The researchers found the women reported both discomfort and pain with Pap smears. The interpersonal skills of the practitioner were identified as important factors influencing Chinese women’s experience of the Pap smear procedure. Moreover, the researchers indicated from the study findings that trusting and feeling secure with the health care provider were regarded as a method of reducing pain.

Boonmongkon et al. (2001) conducted an ethnographic study focusing on women’s sexual and reproductive health in northeastern Thailand. The researchers found that while most of the participants willingly engaged in the screening clinic, they did not fully understand the purpose of a Pap smear and their associated reasons for attending the Pap smear clinic. Thus, this finding did not correspond to the global conception of a Pap smear as a preventive screening procedure for health promotion. The women’s use of the Pap smear clinic was associated with gynecological symptoms and associated concerns that the existing symptoms could turn into cervical cancer.

Jirojwong and Manderson (2001) conducted a cross sectional study of Thai women’s beliefs and behaviors about Pap tests, in Brisbane, Australia. The researchers found that the perceptions of the women were barriers to having Pap tests and include embarrassment, perception of pain and discomfort during procedure, not being sexually active, not perceiving benefits of the tests, feeling well, and lack of choice of the health care provider. Since there is support that nursing interventions are an important concept in the context of comfort care needs of Thai women undergoing Pap smear screening, this type of support will be maintained in the derived model.

**Intervening Variables**

*Parent Theory.* In order to enhance comfort nurses must deliver the appropriate intervention in a caring manner. Often times the appropriate nursing intervention is delivered in a comforting and intentional manner, yet the patient may still not achieve a sufficient enhanced comfort level. The nurse must assess all the intervening variables to find the cause for unmet comfort care. The factors that influence and obstruct comfort care include lack of financial
resources, abusive relationships, and an abusive environment such as homes, upsetting diagnosis, or an impairment of cognition (Dowd, 2006).

**Derived Theory.** In addition, attitudes, beliefs, and perceptions regarding cancer play a significant role in promoting cervical cancer screening (Jioojwong, Maclennan, & Manderson, 2001; Jirojwong & Manderson, 2001). Other factors include the lack of financial support and health insurance, lack of regular primary care services and social support in preventing minority women from undergoing routine screening procedures (Smith, Phillips, & Price, 2001). According to Smith et al. (2001) the socioeconomic disadvantaged group has higher incidences and lower survival rates for different kinds of cancer. This is particularly significant in that many racial and ethnic minority populations are disproportionately characterized by socioeconomic disadvantage.

The United States Congress passed the Breast and Cervical Cancer Act of 1990. As a result of this law, the Center for Disease Control and Prevention’s National Breast and Cervical Early Detection Program (NBCEDP), was created. This Program was designed to increase breast and cervical cancer screening among uninsured low-income women. In addition to the national program, there are community-based strategies that are available and have made significant differences in promoting cervical cancer awareness and earlier detection among minority women (Smith, et al., 2001). It is imperative that health care providers provide the information to minority women regarding the accessibility of resources and screening services. Since there is support that intervening variables are important concept in the context of Thai women health beliefs and behaviors regarding Pap smear screening, they are maintained in the derived model.

**Patient Comfort**

**Parent Theory.** In the original theory, Kolcaba defined comfort as “the state that is experienced by the recipient of comfort measures” (Dowd, 2006, p. 728). In addition, comfort is the immediate and holistic experience of being strengthened through three types of comfort needs met: relief, ease and transcendence; in physical, psychospiritual, social and environmental contexts of experience.

**Derived Theory.** I have delineated the patient comfort concepts with the health care needs component among Thai women. Kolcaba (1994) explained that “States of comfort are often continuous, overlapping and interdependent” (p. 1179). If a Thai woman’s health care needs are met by experiencing these three types of comfort needs (relief, ease and transcendence) in the four contexts of experience (physical, psychospiritual, social and environmental) before, during, and after undergoing the Pap smear screen procedure, then her comfort is being enhanced. As previously stated, pain and discomfort, anxiety, and embarrassment are negative factors influencing cervical cancer screening (Jioojwong, Maclennan, & Manderson, 2001; Jirojwong & Manderson, 2001; Smith et al., 2001). Since there is support that patient comfort is an important concept in the context of Thai women’s health beliefs and behavior about Pap smear screening, it will be maintained in the derived model.

**Heath Seeking Behaviors of Patients (HBs)**

**Parent Theory.** Kolcaba (2001) stated in the original theory that if patients’ “enhanced comfort is achieved, patients are strengthened to engage in health-seeking behaviors” (p.90). The
holistic concept of comfort is appropriate to all practice settings since it would be difficult to think of a nursing setting or practice in which the goal of comfort would not apply. Dowd, Kolcaba, and Steiner (2000) explained that there is a reciprocal relationship between comfort and HBs. Nursing interventions that enhance comfort also support and motivate patients’ efforts to be actively involved in HBs.

Derived Theory. Jirojwong and Manderson (2001) stated that among Thai women participants of the study, young and unmarried women were unlikely to have Pap smears and perceived “feeling well.” This finding is possibly related to cultural beliefs that Thai women are expected to maintain virginity if traditional marriage is desired (Klunklin & Greenwood, 2005). These factors can affect and alter the decision to undergo screening among this group.

Winkler et al. (2007) found in their study among Peruvian women reported benefits of cervical screening such as “peace of mind,” and being in control of their health. The screened women were more likely to exhibit health seeking behaviors, and more likely to seek help from health care facility when ill.

Jirojwong et al. (2001) provided various strategies that could be used to increase regular use of cervical cancer screening by improving communication between Thai women and health care providers and providing information relating to Pap smear procedure, increasing the knowledge of the disease and improving the health care services. While the amount of evidence is scant and there is a conflict related to health seeking behaviors of Thai women regarding the use of cervical cancer screening, the concept will be left in the derived model with the suggestion that further exploration within a cultural context be done among Thai women.

Institutional Integrity

Derived Theory. Within the context of institutional integrity, there is currently no information relating to Thai women health beliefs and behaviors regarding cervical cancer screening. Since most cervical cancer screening is usually provided in a primary care setting such as health care office, doctor’s office, or public health department, the institutional integrity concept will not be retained in the derived model.
Application of Theory to Proposed Research

Derivation of Comfort Theory

The middle range Comfort Theory: A holistic model for Thai women’s health beliefs and behaviors regarding cervical cancer screening could be used in the research proposed to explore health concepts, cultural beliefs, attitudes and practices for health promotion such as cervical cancer screening or self breast examination. This middle range theory could be tested by employing a qualitative approach to gather data in relation to the impact of cultural beliefs, attitudes, and practices for disease prevention and health promotion that are important aspects for motivating and encouraging women with different cultural backgrounds to participate in routine cervical cancer screening. CT will be utilized to assess women with different cultural backgrounds and the physical, spiritual, social, cultural and environmental needs within the context of health promotion.

Contribution to the Discipline

Holistic comfort is a desirable outcome of nursing care in any practice setting. CT provides a framework for practice guidelines. It is important to determine if comfort measures are significant to the patients and their health. CT can predict the benefits of the effective interventions for enhancing comfort. In addition, CT helps to facilitate patients’ engagement in health seeking behaviors. CT assists in strengthening the nursing discipline while bringing it back to its roots of traditional basic nursing care (Kolcaba, 2004). Thus, CT is highly useful theory for nursing.

Analogy of the Comfort Theory Model

Walker and Avant (2005) advised to develop an analogy of the model which helps clarify the theory. Comfort is a “caring embrace,” whether the embrace is physical, mental, social or spiritual, and provides a comfort measure. A caring embrace takes on its own meaning according to a specific need of each individual. A caring embrace provides a sense of relief, ease and transcendence that meets the individuals’ specific need. A caring embrace can surmount obstacles to provide an absence of distress and thus a sense of relief, ease, and transcendence to rise above that distress.

A caring embrace gives each person a mental picture of that type of embrace that provides the greatest comfort. To be ‘embraced’ can take on many forms. For example, a nurse provides what is needed for comfort measures whether physical, psychospiritual, social, and environmental to assist the patient with specific comfort needs arising in health care situations. Thus the nurse is embracing the needs of the patient. A minister or spiritual guidance may pray for the patient, thus embracing the spiritual needs of the patient. Embracing cultural differences through understanding and implementation can provide comfort and relief as it is defined and understood by each culture. We may be embraced by society for variety of reasons such as the victims of hurricane Katrina, who were embraced by society to provide for their needs after the disaster. To be embraced is to be held in our loving mothers’ arms and consoled, providing relief from whatever has assailed us. Thus, embracing encompasses needs and holds the one in need in those caring arms whether physically, psychospiritually, socially or environmentally.
Conclusions and Implications (per Template)

Derivation of Comfort Theory: A theory of holistic comfort for nursing was completed resulting in a new theory called Comfort Theory: A holistic model for Thai women’s health beliefs and behaviors regarding cervical cancer screening (Figure E1). While the underlying structure of the model changed only in a minor way, the concepts underlying the components of the model were adapted to reflect Thai women’s health beliefs and behaviors regarding cervical cancer screening. The holistic and individualized comfort needs for Thai women undergoing a Pap smear procedure are demonstrated by placing Thai women’s needs within the 12-cell grid of Kolcaba’s taxonomic structure of comfort. Each cell indicates an attribute of comfort of Thai women. This approach will assist health care providers to visualize, identify, and implement comfort interventions targeted to meet the needs of Thai women before, during, and after undergoing the screening procedures (Figure B1). Furthermore, this derived model has not been tested and a lack of institutional integrity is identified. I propose this derived model will be tested by using an ethnographic design and a survey method. Kolcaba’s General Comfort Questionnaire (Appendix C) will be employed, modified, and tested in a pilot study of a small sample of Thai women to ensure the validity and the reliability of the instrument. In-depth interviews with a group of Thai women will be conducted to gather information about how Thai women perceived comfort level while undergoing a Pap smear screening and to determine if the model is still applicable within this population.

It is important for health care providers to know the population in which they provide services. Imbedded within the Thai culture are barriers that decrease the utilization of Pap smear screening for women. This service underutilized, decreases potential for early detection of cervical cancer in Thai women. Any intervention that saves lives and increases the quality of life is of vital importance to the nursing discipline at large. It is crucial that health care providers arm themselves with increased knowledge that can provide them with the appropriate tools to implement these interventions. This armor of knowledge correctly applied will increase the effectiveness of health care providers in any setting and any culture. Thus, reaching those that otherwise would not receive much needed health care services and ultimately saving lives.
References


Appendix A

Figure A1. Taxonomic Structure of Comfort

<table>
<thead>
<tr>
<th>Type of comfort:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Relief</strong> – the state of having a specific comfort need met.</td>
</tr>
</tbody>
</table>
Ease – the state of calm or contentment.

Transcendence – the state in which one can rise above problems or pain.

Context in which comfort occurs:

Physical – pertaining to bodily sensations, homeostatic mechanisms, immune function, etc.

Psychospiritual – pertaining to internal awareness of self, including esteem, identity, sexuality, meaning in one’s life, and one’s understood relationship to a higher order or being.

Environmental – pertaining to the external background of human experience (temperature, light, sound, odor, color, furniture, landscape, etc.)

Sociocultural – pertaining to interpersonal, family, and societal relationships (finances, teaching, health care personnel, etc.) Also to family traditions, rituals, and religious practices.

Appendix B

Figure B1. Taxonomic Structure of Comfort Needs as Applied to Thai Women Undergoing a Pap Smear Procedure (Ice, 2007)

<table>
<thead>
<tr>
<th>PHYSICAL</th>
<th>RELIEF</th>
<th>EASE</th>
<th>TRANSCENDENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pain and Discomfort</td>
<td>Comfortable examination table</td>
<td>Trusting and feeling secure with health care providers</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSYCHOSPIRITUAL</td>
<td>Anxiety</td>
<td>Uncertainty about a Pap smear procedure</td>
<td>Need for motivation and insight Special words of encouragement</td>
</tr>
<tr>
<td>ENVIRONMENTAL</td>
<td>Noisy office</td>
<td>Lack of privacy</td>
<td>Need of calm environmental factors such as soothing music, quiet, warm, ambience and temperature of the examination room</td>
</tr>
<tr>
<td></td>
<td>Cold examination room</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SOCIOCULTURAL</strong></td>
<td>Language barriers</td>
<td>Needs for support, need reassurance and information, message of wellness and encouragement</td>
<td></td>
</tr>
<tr>
<td>---------------</td>
<td>------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Absence of traditional and cultural sensitive care</td>
<td>Embarrassment</td>
<td>Providing information step-by-step procedure of Pap test and rationale behind it</td>
<td></td>
</tr>
<tr>
<td>Cultural barriers</td>
<td>Not perceiving benefits of the test</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of financial support and health insurance</td>
<td>Lack of choice of health care providers</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Type of comfort:

- **Relief** – the state of having a specific comfort need met.

- **Ease** – the state of calm or contentment.

- **Transcendence** – the state in which one can rise above problems or pain.

Context in which comfort occurs:

- **Physical** – pertaining to bodily sensations, homeostatic mechanisms, immune function, etc.

- **Psychospiritual** – pertaining to internal awareness of self, including esteem, identity, sexuality, meaning in one’s life, and one’s understood relationship to a higher order or being.

- **Environmental** – pertaining to the external background of human experience (temperature, light, sound, odor, color, furniture, landscape, etc.)
Sociocultural – pertaining to interpersonal, family, and societal relationships (finances, teaching, health care personnel, etc.) Also to family traditions, rituals, and religious practices.
GENERAL COMFORT QUESTIONNAIRE

Thank you VERY MUCH for helping me in my study of the concept COMFORT. Below are statements that may describe your comfort right now. Four numbers are provided for each question; please circle the number you think most closely matches your feeling. Relate these questions to your comfort at the moment you are answering the questions.

Below is an example:

<table>
<thead>
<tr>
<th>Strongly</th>
<th>Strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree</td>
<td>Disagree</td>
</tr>
</tbody>
</table>

I am glad I can fill out this questionnaire about my comfort…… Agree Disagree

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

1. My body is relaxed right now  4 3 2 1
2. I feel useful because I’m working hard  4 3 2 1
3. I have enough privacy  4 3 2 1
4. There are those I can depend on when I need help  4 3 2 1
5. I don’t want to exercise  4 3 2 1
6. My condition gets me down  4 3 2 1
7. I feel confident  4 3 2 1
8. I feel dependent on others  4 3 2 1
9. I feel my life is worthwhile right now  4 3 2 1
10. I am inspired by knowing that I am loved  4 3 2 1
11. These surroundings are pleasant  4 3 2 1
<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.</td>
<td>The sounds keep me from resting</td>
<td>4</td>
</tr>
<tr>
<td>13.</td>
<td>No one understands me</td>
<td>4</td>
</tr>
<tr>
<td>14.</td>
<td>My pain is difficult to endure</td>
<td>4</td>
</tr>
<tr>
<td>15.</td>
<td>I am inspired to do my best</td>
<td>4</td>
</tr>
<tr>
<td>16.</td>
<td>I am unhappy when I am alone</td>
<td>4</td>
</tr>
<tr>
<td>17.</td>
<td>My faith helps me to not be afraid</td>
<td>4</td>
</tr>
<tr>
<td>18.</td>
<td>I do not like it here</td>
<td>4</td>
</tr>
<tr>
<td>19.</td>
<td>I am constipated right now</td>
<td>4</td>
</tr>
<tr>
<td>20.</td>
<td>I do not feel healthy right now</td>
<td>4</td>
</tr>
<tr>
<td>21.</td>
<td>This room makes me feel scared</td>
<td>4</td>
</tr>
<tr>
<td>22.</td>
<td>I am afraid of what is next</td>
<td>4</td>
</tr>
<tr>
<td>23.</td>
<td>I have a favorite person(s) who makes me feel cared for</td>
<td>4</td>
</tr>
<tr>
<td>24.</td>
<td>I have experienced changes which make me feel uneasy</td>
<td>4</td>
</tr>
<tr>
<td>25.</td>
<td>I am hungry</td>
<td>4</td>
</tr>
<tr>
<td>26.</td>
<td>I would like to see my doctor more often</td>
<td>4</td>
</tr>
<tr>
<td>27.</td>
<td>The temperature in this room is fine</td>
<td>4</td>
</tr>
<tr>
<td>28.</td>
<td>I am very tired</td>
<td>4</td>
</tr>
<tr>
<td>29.</td>
<td>I can rise above my pain</td>
<td>4</td>
</tr>
<tr>
<td>30.</td>
<td>The mood around here uplifts me</td>
<td>4</td>
</tr>
<tr>
<td>31.</td>
<td>I am content</td>
<td>4</td>
</tr>
<tr>
<td>32.</td>
<td>This chair (bed) makes me hurt</td>
<td>4</td>
</tr>
<tr>
<td>33.</td>
<td>This view inspires me</td>
<td>4</td>
</tr>
<tr>
<td>34.</td>
<td>My personal belongings are not here</td>
<td>4</td>
</tr>
<tr>
<td>35.</td>
<td>I feel out of place here</td>
<td>4</td>
</tr>
<tr>
<td>36.</td>
<td>I feel good enough to walk</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>37.</td>
<td>My friends remember me with their cards and phone calls</td>
<td>4</td>
</tr>
<tr>
<td>38.</td>
<td>My beliefs give me peace of mind</td>
<td>4</td>
</tr>
<tr>
<td>39.</td>
<td>I need to be better informed about my health</td>
<td>4</td>
</tr>
<tr>
<td>40.</td>
<td>I feel out of control</td>
<td>4</td>
</tr>
<tr>
<td>41.</td>
<td>I feel crummy because I am not dressed</td>
<td>4</td>
</tr>
<tr>
<td>42.</td>
<td>This room smells terrible</td>
<td>4</td>
</tr>
<tr>
<td>43.</td>
<td>I am alone but not lonely</td>
<td>4</td>
</tr>
<tr>
<td>44.</td>
<td>I feel peaceful</td>
<td>4</td>
</tr>
<tr>
<td>45.</td>
<td>I am depressed</td>
<td>4</td>
</tr>
<tr>
<td>46.</td>
<td>I have found meaning in my life</td>
<td>4</td>
</tr>
<tr>
<td>47.</td>
<td>It is easy to get around here</td>
<td>4</td>
</tr>
<tr>
<td>48.</td>
<td>I need to feel good again</td>
<td>4</td>
</tr>
</tbody>
</table>

Appendix E

Figure E1. Comfort Theory: A Holistic Model for Thai Women’s Health Beliefs and Behaviors Regarding Cervical Cancer Screening (Ice, 2007)
Chapter Five

Interpersonal Relationships

*Stephanie Lynch, MSN, PMH-NP*

Peplau (1952) wrote “I believed that theories of interpersonal relations, then a new perspective on human interaction, were especially relevant to the work of nurses”. Peplau knew that this framework, “the interaction phenomena that occur during the nurse-patient relationships have a qualitative impact on outcomes for patients”, and, I believe, on many nurses too (p. v). This theory was originally published in 1952. While the Interpersonal Relations is an important theory, there have been few changes since its conception in 1952. I hope to bring this theory into the twenty-first century.

**Introduction**

Hildegard Peplau was a pioneer for advanced practice nurses in all areas of nursing. Peplau had a vision, and she believed in advanced practice nurses. Peplau knew nurses at the graduate level could offer direct care to psychiatric patients, enabling them to “close the gap between psychiatric theory and nursing practice” (Joel, 2004, ). This is even more evident in today’s health care practice arena. Advanced practice nurses are midlevel providers recognized by insurance companies, hospitals and many in private practice picking up the slack in many underserved areas while working autonomously.

Peplau developed a program that produced clinical specialists who would have expertise in individual psychotherapy, group psychotherapy, and family psychotherapy. Peplau (2002) stated that “Many nurse practitioners wanted to deepen their understanding of interpersonal relations in nursing situations”, enabling them to be more effective and helpful practitioners (p. ix). This theory was the foundation of my master’s degree and is my guide in practice. As a psychiatric nurse practitioner/clinical nurse specialist I would like to expand Peplau’s theory of Interpersonal relations because it is so important to my area of practice.

**Background/Historical Perspective**

I will begin with Peplau’s (2002) definition of nursing: “Nursing is a significant, therapeutic, interpersonal process. It functions co-operatively with other human processes that make health possible for individuals in communities…nursing is an educative instrument, a maturing force, that aims to promote forward movement of personality in the direction of creative, productive, personal, and community living” (p. 16).

I will explain briefly the Interpersonal Relations Theory (IRT). Peplau (2002) defined the phases of the nurse-patient relationship into four overlapping phases: orientation, identification, exploitation, and resolution. Each phase is overlapping, with some phases lasting longer than others. It is very common for an individual to “stay” in a phase for a while. During this time the nurse may also switch her/his role, for example, functioning as resource person, surrogate parent, counselor, and professional expert.
In her book Fawcett (2000) presented 25 research topics that were guided by the theory of Interpersonal relations. The topics of research included: the orientation phase of the nurse-patient relationship; factors that influenced moving from one phase to another; effects on an individualized nursing approach and two control nursing approaches on patients’ systolic blood pressure and remaining vital signs; depressed young women; strategies used by women recovering from depression; nurses’ knowledge of and misconceptions about suicide; and a plethora of nurses’ beliefs. While all these research studies are important I would like to focus on research studies from the year 2000 to the present.

Theoretical frameworks guide nursing practice. Such theories are the source of ideas and direction while guiding the professional development of nurse therapists (McCamant, 2006; Vandemark, 2006). Vandemark (2006) stated “A more thorough application of relevant nursing theory will ensure that nurse psychotherapists are prepared on par with professionals from other related disciplines” (p. 605). Peplau’s training in psychotherapy consisted of 300 hours of analysis, which is still the average in today’s professional training in psychotherapy. At New Mexico State University (NMSU) I personally performed 832 clinical clock hours under the guidance of a practicing clinical nurse specialist, a family nurse practitioner, and two licensed therapists. Of these 832 hours, 140 were in drug and alcohol counseling. My hours included facilitating group therapy, individual therapy, family therapy, participating and collaborating as part of the therapeutic team, and client debriefing with the facility psychiatrist.

As the nurse psychotherapist, it is important that I am aware of my own issues. It is imperative to be effective and therapeutic that I be in touch with my own emotions and “baggage”. Baggage in this context means the psychological, emotional, and physical history of an individual that they bring with them throughout their life. Vandemark (2006) stated that the nurse therapist who performs psychotherapy must have acute self-awareness, and that the nurse needs to be aware of his/her own “internal psychological dynamics, and their impact on the nurse-patient relationship” (p. 607). Peplau (2002) stated that the psychological tasks are found “in the process of learning to live with people as an aspect of formation and development of personality and as an aspect of the tasks demanded of nurses in their relation with patients” (p. 159). Vandemark (2006) stated that these tasks are a set of goals for the mental health care professional, and that each nurse as a person must be able to identify such emotions in “one’s self as a professional who uses self in a therapeutic manner” (p. 609).

In my experience as a student nurse psychotherapist I have seen many other student psychotherapists who have not dealt with their personal issues and emotional baggage. I believe this to be a weakness. If a nurse psychotherapist cannot face his/her own demons, baggage and pain how on earth is he/she to guide and assist another patient in searching, exploring, and overcoming that patient’s own demons, baggage, and pain. While Peplau (2002) stated that nurses should know themselves, there is no standard or promise that they will do so. This is a gap in the interpersonal relations theory.

McCamant (2006) stated that Peplau’s interpersonal relations theory focused on the specific components of the nurse-patient relationship. Peplau (2002) stated that “Only when there is respect and mutual interest between two people can one person inform another” (p. 47). Therefore, if a relationship is to be therapeutic, each person must value the other and then change may occur for the patient. McCamant made an interesting but true point, when Peplau published her theory the average length of stay in the hospital was 2.5 weeks, allowing the nurse-patient
relationship to flourish, to make the connection. Yet today when hospital stays are much shorter, McCamant stated nurses continue to follow Peplau’s phases in the exact order and that the “interpersonal relations theory can provide the theoretical framework for research that seeks to examine the nurse-patient interaction” (p. 336). This is true no matter what and how long the interaction may be.

This connectedness is important in all aspects of the nurse-patient relationship, for example, in regards to the in-patient hospital care, outpatient therapy settings, and also established in computer-mediated communication via electronic means like the internet (Hrabe, 2005; Marchese, 2006; Wheeler, 2005). In outpatient practice it is important and necessary to have a connection between patient and nurse psychotherapist. If this connectedness is missing, there will be no therapeutic foundation from which to build a healing empowering relationship for the patient and the nurse psychotherapist.

Hrabe (2005) stated that connectedness is the “path to therapeutic relationship” and that through connectedness the nurse learns about a patient’s condition, how he/she is responding to the situation, and comes to know the patient as a person; whereas, the “Patient’s connection with the nurse allows him/her to use resources to more fully understand” the details surrounding his/her health problem, identify how the nurse may assist him/her, and gather personal strengths and resources to address the problem (p. 403).

According to Hrabe (2005), during computer-mediated communication one may lose face-to-face interaction with this type of electronic communication; persons may experience a greater sense of isolation and lack of feedback, but it also encourages candor and increased honesty, it enables one to choose when and how much to communicate, while strengthening to the nurse-patient therapeutic relationship.

Wheeler (2005) proposed that not since Peplau’s “seminal book” Interpersonal Relations in Nursing has there been a contemporary nursing framework “to unite disparate psychotherapeutic approaches into one that is user friendly” (p. 1). Wheeler stated that the textbooks used in advanced nursing psychiatric graduate programs are written for and by psychologists, psychiatrists, and other mental health disciplines, hence requiring a need for a nursing framework and textbooks specific for advanced practice nurses who practice psychotherapy. I would consider this a gap in the model.

According to Wheeler (2005), many times nurse psychotherapists are quick to write a prescription say for anxiety instead of understanding the psychodynamic issues of the patient. Wheeler stated that in today’s managed care environment it is hard to develop a therapeutic relationship, and that this environment “does not foster a nurturing context” for the patient and the nurse psychotherapist who may want to connect in a meaningful way (p. 2). This is definitely a weakness in today’s psychotherapy practice arena.

Peplau’s interpersonal relations theory has been used to guide nursing practice. Examples of this theory include:

- To educate patients after bladder surgery;
- Incorporated into the care of patients with end stage kidney disease;
- Utilized in a small study of prenatal clients and public health nurses;
• Explained how the contemporary significance of the interpersonal model is used today in New Zealand nurses;
• Peplau’s theory and its use in psychiatric nursing;
• Utilized in a descriptive qualitative study of the nurse-client relationship using an interpersonal focus and Leininger’s method of qualitative analysis;
• A synthesis of qualitative home visiting research describing home visiting practice of public health nurses to maternal-child clients (Marchese, 2006; Graham, 2006; McNaughton, 2005; O’Brien, 2001; Church, 2000; Forchuk et al. 2000; McNaughton, 2000).

Several authors stated that it does not matter the length of the nurse-patient interaction, what it is important is the therapeutic relationship and the patient’s perceptions on that patient’s needs during that interaction (Ryan & Brooks, 2000; McCamant, 2006; McNaughton, 2005; O’Brien, 2001). Unfortunately the restrictions and limited access for/of the patient have resulted in less quality time for that relationship to grow and develop. This leads to problems for the patient and for the nurse to identify and help resolve the patient problems (Stockmann, 2005).

Peplau made some important and bold statements in 1952 about nurses and nursing when nursing was considered an art, not a science or profession. I believe those words have profoundly changed my life and have enabled me to be passionate about nursing. I would like to conclude this section with Peplau’s (2002) words:

Nursing is a process…”it’s serial and goal-directed nature demands certain steps, actions, operations, or performances that occur between the individual who does the nursing and the person who is nursed. Nursing is an interpersonal process and often a therapeutic one, it consists of actions that require participation between two or more people…Nursing is a human relationship between an individual who is sick, or in need of health services, nurses are educated to recognize and to respond to the need for help” (pp.5, 6).

I propose that many nurses have forgotten what nursing is truly about, and the fundamental importance of the interpersonal and therapeutic relationship for all parties involved.

**My Own Ideas**

When I learned about the wonderful Dr Peplau 3 years ago, I wished I could have met her. I purchased Peplau’s book when I was completing the master’s degree in nursing and the psychiatric mental health nurse practitioner/clinical nurse specialist program (PMH-NP/CNS). The focus of the PMH-NP program was Peplau’s Interpersonal Relations Theory. The book and the professors stressed to us the importance of the nurse-patient connection; after all, without the connection there would be communication, no healing, and no advancement for the patient.

*Male and Female Nurses*

First of all I would modify and update Peplau’s IRT by redefining the term *nurse* to include both female and male persons. When Peplau published her Interpersonal Relations Theory her focus was on women in the profession because women were the majority of nurses in the 1940s and 1950s. I found it interesting when reading Peplau’s (2002) book *Interpersonal Relations in Nursing* that Peplau addressed the nurses as female and the patients as male.
As I developed this paper I wondered if male nurses view nursing in the same light as female nurses. I personally believe nursing is a lot like mothering, in that it is a nurturing profession. I think this is why women have dominated this line of work. I want to perform qualitative research involving male nurses and their perspective on what nursing means to them. While I appreciate the increased interest by men to enter the field of nursing, I do not want nursing to lose its femininity. I truly believe this is why it has been such a beautiful journey for me. I am empowered as a woman; I touch many lives with gentle, caring, feminine nursing ways.

Countertransference and Transference

The interpersonal relations theory must delve further into the phenomenon of Countertransference and transference. Countertransference is defined as “a leader’s emotional responses to members that are a result of the leader’s own needs or unresolved issues with significant others” (p. 196) and transference as “the displacement of affect from one person or another; the projection of inappropriate emotions onto the leader or group members” (Gladding, 2003, p. 195). It is necessary to be aware of these emotions as a competent and responsible nurse psychotherapist.

This phenomenon happens more than we think, since after all, nurse psychotherapists are people, too. For example, a client may remind me of someone from my past that I may have disliked or had a negative relationship, and this may develop into countertransference. These negative emotions need to be addressed if the therapeutic relationship is to be established, and then I would remove myself as the nurse psychotherapist for that client.

Yalom (1995) explained that the psychotherapist plays a role in every aspect of therapy. If a psychotherapist cannot recognize “blind spots”, “personal distortions”, “countertransference responses”, or his/her own feelings and fantasies in the therapeutic work then this will limit the effectiveness of the psychotherapist (p. 526). A positive therapeutic relationship will not occur.

The Nurse Psychotherapist Knowing Oneself

Yalom (2003) stated that the most “valuable instrument” a therapist has is “the therapist’s own self” (p. 40). In my program of study, as student nurse psychotherapists we had to watch several videos of different clients in group therapy, individual therapy or marriage therapy. One day while our class was viewing the video on group therapy I was so emotionally drawn into the lives of these people that I had to remove myself from the lecture hall because I began crying. After the film I apologized to the professors, and they told me that I was showing emotion, which was a good thing.

According to Vandemark (2006), many other professions for example psychology, psychiatry, occupational therapy and music therapy who also practice psychotherapy require their students to attend either individual or group therapy. Yalom (1995) strongly encourages his psychotherapist student trainees to become “bona fide” members of group therapy because being, feeling, and living, as a member is an invaluable experience. The clinician will be able to better understand the group therapy process.

The problem so often is many nurse psychotherapists or PMH-nurse practitioners have never attended group or individual therapy. I am fortunate to have attended since the age of 14
years old individual and group psychotherapy. It truly is an invaluable experience to know how it feels to be on the opposite end of the office sitting on the couch. I believe this experience has made me a better practitioner. I would expand the interpersonal relations theory by recommending that nurse psychotherapists participate as members in group or individual therapy. I would create an instrument directed towards the nurse psychotherapist that would reflect on personal emotions and beliefs, inquire about countertransference, and present case studies to ponder and work through as the therapist.

**Becoming the Patient**

Many of us have been patients in today’s health care system, but do we remember how it felt? Utilizing the interpersonal relations theory I would encourage nurses to debrief amongst themselves regarding what experiences emerged in their roles that day. I believe this is an important part of the nurse-client relationship, to empathize, or to walk in the other person’s shoes. Yalom (2003) explained “Therapy is enhanced if the psychotherapist enters accurately into the patient’s world” (p. 18). Yalom called this looking out the other person’s window. This enabled his students to learn empathy. It is also important to understand accurate empathy because the client does not view the therapy session the same way as the nurse psychotherapist. In this context, empathy refers to “capacity to identify with a person or object” (Oxford Pocket Dictionary, 2002).

**Rewording the Interpersonal Relations Theory**

I would do a lot of updating of the words used by Dr Peplau. First of all, I would expand the theory to include advanced practice nurses. Many of us practice autonomously and independent of physicians. In fact here in New Mexico, we do not need collaborating physicians to practice or write prescriptions. This is true for family, psychiatric mental health, geriatric, and pediatric nurse practitioners, certified registered nurse anesthetists, and certified nurse midwives.

According to Tourville and Ingalls (2003), Peplau described the patient as one who seeks the services of a nurse to help solve any health problems. I would change this wording to a mutually respectful relationship. My goal would be that the relationship between advanced practice nurse and patient to an understanding partnership.

**The Twenty-First Century**

The interpersonal relations theory was specifically developed for psychiatric nurses by a psychiatric nurse. Because this theory focuses on the relationship between nurse and patient, it may be used for nurse psychotherapist and client. This theory may be used with other forms of psychotherapy that involve establishing a therapeutic relationship, goal and task attainment. This theory may be used across all disciplines, thereby broadening its reach. I especially want this model to reach across all areas of nursing practice, enriching the interpersonal relationship between nurse and client in all settings.

Hrabe (2005) believes that Peplau’s work with the interpersonal relations theory is an “ideal model” in today’s computer-mediated world. I would like to bring this theory to the forefront of the computer age. I have consulted with other PMH-NP’s, and they also believe that counseling will be performed via computer. Increasing numbers of households have computers, and people lead busy lives. Therefore it is probably inevitable that counseling will be performed
via the internet in the homes that have computers. The interpersonal relations theory will need to focus on the nurse-client therapeutic relationship via computer.

Home visits are important in nursing today. I would like to incorporate the home health/community nurse in the updated interpersonal relations theory. Home health nurses are an important feature of the nursing profession, especially here in New Mexico, and home visits are an integral part of patient care. The nurse-client relationship in home visits is the most important part of the patient health care. Without this mutual respectful relationship no sharing can happen, no trust may be established, and health status is inevitably impacted.

**Rewriting Peplau’s Book**

I will amend Dr Peplau’s book with the love and respect she deserves. I would not only change the wording to incorporate male/female nurses and advanced practice nurses, but I would also reorganize her chapters. Peplau (2002) stated in chapter 12 that the “interlocking operations” of the nursing process is the “utmost importance to the outcome of illness for patients” (p. 263). Chapter 12 included the important topics of observation, communication, and recording. As a PMH-NP I believe these topics are the most important in the therapeutic relationship. Therefore, I would present a new “Table of Contents” moving this chapter to the beginning of the book.

**Conclusions and Implications**

As a nurse psychotherapist and psychiatric mental health nurse practitioner I embraced Peplau’s theory of interpersonal relations. I believe this theory enables me several things: first my client and I are on equal ground; my client and I are able to build a mutually trusting relationship; as the nurse psychotherapist it deepens my understanding of interpersonal relationships; and I understand the importance of connection through human caring.

As an educator I teach my students by utilizing the interpersonal relations theory. I teach students to respect their patients, to understand that each and every one of those patients comes from a different place in terms of history, experience, and culture. I instruct the students to realize each person has a history; an invisible set of baggage, some joyful, some painful, but all deserving of respect.

On a macro level I support the interpersonal relations theory in nursing as part of all nursing curriculum. I propose that all future nurses need to learn and understand the splendor and importance of the nurse-patient relationship while learning other nursing skills. As nurses, many of us are giving to others, but I also suggest that on the micro level, we receive something from the interpersonal relationship, since there are many magnificent gifts and lessons that may be learned from our patients.

The interpersonal relations theory of nursing may be used in future research. As mentioned above I would like to understand the male nurse perspective of nursing, how men view the therapeutics and art of nursing. Do they view it as nurturing? How do they feel when they are practicing nursing? How do they view the relationship they have with their patients? Is the nurse-patient interaction an equal playing field? In addition I would like to apply the interpersonal relations theory to a study of women suffering from postpartum depression.
I have embraced nursing from the beginning of my career. I cherish this choice I have made in my life. I would like to do qualitative research because I believe the lived experience of nurse and client goes hand in hand with the interpersonal relations theory. I also trust there is future research with interpersonal relationships, nurse psychotherapy and computer-mediated communication. The nurse-patient relationship is about the connection between two human beings that individually and together share an important and meaningful relationship.
References


Chapter Six

Experiencing Transitions

Karen Lottis, MSN, APRN, BC

“Then the time came when the risk it took to remain tight in a bud was more painful than the risk it took to blossom.”

Anais Nin

Chronic disease and disability are fundamental processes of dramatic transitions in an individual’s life. Meleis, Sawyer, Im, Messias & Schumacher (2000) developed an emerging middle-range theory, based on a collection of previous studies utilizing transitional frameworks, in Experiencing Transitions. Elements of emergence, the use of narrative in nursing therapeutics, change and values-change are explored in an attempt to deepen the applicability to nursing practice for populations suffering from chronic disease and disability. This construct also provides awareness of multicultural and ecological nuances which may affect transitional phases.

A Deeper Exploration of Experiencing Transitions

Introduction

For those who receive a diagnosis of chronic disease or are newly impacted with a life-changing disability, important shifts are demanded. These demands can span across the physical, emotional, spiritual and ecological levels and thus be very complex in nature. In Experiencing Transitions (ET), Meleis, Sawyer, Im, Messias & Schumacher (2000) provide a model for nurses to increase awareness, identify types of transitions and facilitate the process. For those unable to complete healthy transitions, there is a high risk of increasing health ramifications and decreasing quality of life.

The theory of ET has been composed through analyses of different concepts and studies which used transitions as a framework. These studies included feminist approaches to becoming an African-American mother, Korean women who neglected/ignored the menopausal transition, parents of children diagnosed with congenital heart defects, transnational migration and multidimensional transitions in Brazilian women, and family caregivers (Meleis, et al., 2000). Through the analyses of these studies it became apparent that different kinds of transitions occurred in a variety of patterns.

Three distinct aspects of transitions included type, pattern and properties (see Appendix A). A multitude of transitions occur throughout the lifespan, and may or may not be primarily associated with health. Transitional patterns may appear singly or in multiplicity, and are not necessarily interrelated. Meleis, et al.(2000) described five conceptual properties associated with transitions, which included awareness, engagement, change and difference, transition time span, and critical points and events.
Each transitional experience held specific conditions through which the environment and personal belief systems either inhibited or facilitated the process. Key patterns of response were identified which included “feeling connected, interacting, location and being situated, and developing confidence and coping” (Meleis, et al., 2000, p. 24). Outcome indicators were assigned, and included “mastery and fluid integrative identities” (p. 26). Nursing interventions were described as entering at any point within the transitional process, towards completion of outcome indicators.

Philosophical frameworks or connection to grand theories were not made by Meleis, et al. (2000). Through linkage of specific concept analyses and mid-range theories to grand theories, nursing professionals will understand not only the ‘how’ of it, but the ‘why’ of it as well, thus embracing new models of practice. While nursing theorists have proliferated over the past few decades, there continues to be a significant disconnect between practice and scholarship. Perhaps through creation of clear pathways across the domains, bridges will be built which allow integration of all that nursing scholarship has provided.

The experience of transitions by all humans, no matter what the circumstance or cause, is a given in this lifetime. Understanding of the basic components, particularly when confronting a slow or impeded progression through transition, is fundamental to nursing. As the population base increases in complexity of chronic disease and disability, innovative strategies must be uncovered to augment the current biomedical focus. Nursing provides a unique perspective and opportunity to confront these issues. Grimes (2000) reminds readers that “sickness is the biological reality; illness is the social reality” (p. 342). With one foot in the world of evidence-based empirics and the other in the world of human sciences, and with ears and hearts tuned to the needs of those nurses serve, there is a possibility for a new style of healthcare.

Historical Perspective and Context for Theory Development

Literature Review.

Transitional theory has been prominent in the human science fields for many years. Perhaps best known is the work of Van Gennep (1960), who formalized work on rites of passage, and felt that this was further subdivided into three categories, that of “rites of separation, transition rites, and rites of incorporation” (p. 11). From this perspective it can be seen that chronic disease and disabilities represent a specific sort of rite of passage, and that each of the components play an integral part in successful progression at a holistic level of being (Appendix B). Grimes (2000) carries this one step further when he states that the primary purpose of a rite of passage is that “we attend to such events fully, which is to say, spiritually, psychologically, and socially” (p. 5).

The Meleis, et al. (2000) theory of ET has been utilized in a variety of applications in nursing. Davies (2005) studied the transitional experiences of relatives who had family members placed in a nursing home from an ET framework. She stated the theory did hold potential in assisting family members during transitional periods, but that “the model failed to represent adequately the interactive and dynamic nature of relationships” (p. 658). It was felt that reciprocity in relationships was not fully developed or represented within the theory.
Porter & Ganong (2005) studied the transitional experiences of elderly women attempting to maintain their independence through the reliance on family or caregivers, and how loss of aid affected them. While aging and encroaching loss of independence is an obvious transition, the authors struggled with ET in how to identify a precipitating event, or clarify involvement when entry came well after the initial transitional phase. The authors also discussed the fact that identification of transition type as detailed by Meleis, et al. (2000) may not be of primary importance – rather it was the ensuing change and growth into a new identity or circumstance with which the individual was most concerned.

Wilkins & Woodgate (2006) studied the transitions siblings of children with cancer undergo. They concede the importance that ET placed on the contextual significance, as well as the trajectory which this placed individuals on in their process. One significant point that Wilkins & Woodgate highlight, which Meleis, et al. (2000) spend little time with, were the consequences of unhealthy transitions.

Kralik (2002) explored the theory of ET as developed by Meleis, et al. (2000) in her doctoral research in the experiences of midlife women living with chronic disease. This qualitative study confirmed the importance of recognizing the individual’s personal and societal context and support, as well as the fluidity of the timeframe in which change was experienced. Further questions arose in this study concerning those who were lost to study, and whether this was secondary to lack of positive progression through transitional phases.

**Discussion of Key Components**

Meleis, et al. (2000) were clear to acknowledge ET as an ‘emerging’ midrange theory. Positive aspects of this theory include the temporality and multiplicity of transitions, as well as the complicated personal and societal web that impacts these periods of transition. The authors identified several areas in which work continues, particularly around that of awareness. Further research is required to determine whether lack of awareness prohibits transitions, changes the quality of the experience or the outcome, or whether awareness must be present in all stakeholders in order to recognize effective transitions. Transitional types, even those not associated with health, may indeed become complicated, with somatization the result. Thus healthcare must be able to identify these transitional components and the interplay.

Level of engagement in the transition is considered integral, and is defined as the “degree to which a person demonstrates involvement in the processes inherent in the transition” (Meleis, et al., 2000, p. 19). Obviously the level of awareness that a person holds will influence the depth of engagement in the transition. Nonetheless, there is also a point that was not brought up in this theory, namely the patient who is fully aware and non-engaged. Meleis, et al. state that the “level of awareness influences the level of engagement” (p. 19), but full awareness may not be simultaneous with engagement, nor is awareness synonymous with acceptance. Unfortunately this might describe numerous individuals, particularly within the realm of chronic disease. In the practice setting, there could also be competing values or agendas between a patient and the nurse.

Within the theory, no specific links were made to influencing theorists or to philosophical underpinnings. Nonetheless, review of the literature implies that one must take a closer look at change, change-readiness, and value changes as these are considered to play a large role in
transition theories. The theory of ET has change and differences incorporated into the model, and Meleis, et al. (2000) acknowledge distinctions between transitions that are the “result of change and result in change” (p. 19). However, transition is by no means a result of every change, despite frequently being used synonymously with transition in the literature.

Another point that admittedly remains under discussion is how to identify transitional incidents, and is identification necessary by the nurse, patient and/or both? Concerns not discussed in the Meleis, et al. (2000) article include the challenge of facilitation into forward movement when transition conditions are inhibited, as well as the issue of awareness versus self-denial. For instance, many diabetics are thoroughly aware of their diagnosis, but refuse to accept treatment necessary to complete a transition into mastery of the disease or improved quality of life.

One of the key components to transitions is the time span, which Meleis, et al. (2000) characterize as “flow and movement over time” (p. 20). These authors discuss the fact that attempts to place boundaries around transitional completion are counter-intuitive at best. Dependent upon the nature of the transition, there indeed may not be any end-point, but rather waves of high change and chaos which Kralik terms as “extraordinariness” (2002, p. 149), alternating with periods of ordinariness or calm. Certainly this aspect of temporality fits well with Newman’s (1999) model of Health as Expanding Consciousness (HEC).

In all studies, transition involved critical turning points. Some of these were associated with diagnoses, at other times with severity of experience, which left individuals vulnerable and uncertain. The importance of early identification of these heightened periods of risk, and provision of appropriate measures is key to the success of this theory.

Deepening the Theory of Experiencing Transitions

Further development of primary concepts.

Change as used in ET is a property of the transitional experience, but is also the catalyst that propels individuals forward through transitions, or lodges them firmly in a physical-emotional quagmire, dependent upon the ability to embrace change agents. Many are the changes that occur in life that do not result in transition per se, and are not significant enough to warrant attention. The important piece is to grasp the import of major changes and recognize that these may well be the impetus for transformation if recognized and agreed to.

Several concepts are important components of successful transitions. These involve an individual’s readiness to change as integral to successful navigation of a chronic illness. Has the individual the physical or psycho-spiritual capacity to change? Is there incongruity of values within personal, family, societal or indeed provider frameworks? There is a plethora of work around change theory and while much of it is specifically focused, the structure is readily useable in any change environment, and will not be further detailed in this paper (Finnell & Osborne, 2006; Mpofu & Bishop, 2006; Murphy, 2006; Singer, 2007).

Key to change theory, however, is that without the initial buy-in from, or change-readiness on the part of the patient, the transitional process may feel out of control. In other words, physical and perhaps psychological changes occur with or without an individual’s permission or even awareness, but to capitalize on these changes for transition into new levels of
being or function – this is what the change theories speak to. It is this level of awareness that Meleis, et al. (2000) continue to explore. One might consider that the knowledge or awareness of body-mind-spirit becomes integrated around a specific set of changes, and this then would constitute change-readiness. It is at this place in time that an individual grapples with what these changes truly consist of in meaningful ways, and how these occurrences affect one’s values.

Fostering engagement with individuals is critical to initiation of healthy transition. An individual must come to the point in time when she says “this is no longer working for me,” and is then willing to explore what that means and how to energize and effect a change which will lead to transition. Nursing must be capable of stimulating thinking in that direction, as well as be prepared with alternatives when an individual reaches a stage of change-readiness.

Within chronic disease and disability, change does not simply mean the decision to begin a particular medical therapy, but requires deep shifts within a particular value system. Mpofu & Bishop (2006) offer an excellent discussion of value-laden changes and how the complexity of this in times of transition is frequently overlooked by the provider. There is a danger at this point of miscommunication between the provider and patient. Differing values, differing agendas, previous culture-laden themes of mistrust for paternalistic styles of medicine or cultures, all are potentials for a breakdown in relationship. Engagement is dependent upon the nurse setting aside personal values, judgments or labels and truly listening to the spoken words as well as the silence of patients. In the lyrics of Ben Harper (2003), “…silence is the loudest parting word you never say …” (Amen, Omen).

In the face of chronic disease, the survival of the triad which constitutes each person – physical, psychological, and spiritual – is placed at risk. It is up to the nurse to negotiate priorities, to mutually envision or create with an individual an end-target. Emergence is one of these goals – to improve the quality of life through transmutation of the inherent potentialities combined with the energy (or chaos) of the environment.

This exposure to some type of chaos demands a high-order reorganization of lower order function. Emergence is the resultant complex system the whole of which cannot be explained by any of its parts. The essence of emergence allows one to become effective in the face of adversity. This is the process of forming new or stronger identity, with modifications in outdated value systems that no longer hold the same meaning in the face of chronic disease. This is the desired result of a transition – mastery of the illness and/or recreation of self-identity for survival.

Examination of the concept of a successful transition takes on mythic proportions, and in fact frequently demands mythic qualities be enacted for transformation. To look at one’s own place in story as a mirror which reflects personal culture and values, and recognize whether the path is leading towards a desired result is a difficult task, for provider and patient alike. Nurses must understand that within the space and time of the shared visit, each is cocreating within the story of the other – these can be powerful tools (or weapons).

Good & Good (2000) remind readers that a “prominent form of critique of medical care has been based on physicians’ failure to recognize the narrative dimensions of the illness experience” (p. 51). Yet in taking these stories to the next level and placing the individual at the start of her own personal journey, such as Campbell (1972, 2004) depicts through the archetype
of the *Heroes Journey*, there is an implication for hope and transcendence. The underlying themes of any narrative will hold any or all elements of restitution, chaos and quest (Frank, 1993), and an astute nurse will assist an individual in reflection of where each is in this process.

Medical anthropologists continue to debate the subjective nature of the recounted story (Mattingly, 1998). However for the purposes of nursing and healthcare, the subjectivity is mute. It is not the accuracy of the narrative, but rather the meaning and organizational structure which is derived from the recounting. In the setting of illness, meaning-making is essential for transitions in health. It is through the story that nurses gather a picture of the internal workings of perceived reality – the reality that places each within family, community or larger cultural myth. Healthcare narratives provide the vehicle for transportation across difficult situations in order to emerge with a new version of identity, or what Newman (1999) describes as *evolving consciousness*. Mattingly (2000) describes this as “emergent narrative” (p. 205). It is the power of the *emergent narrative* that can be priceless within nursing and the work of healing for individuals. To place an individual within her journey is the impetus that shifts a simple recounting of the past, into a mythic quest for the future – and allows for a dynamic, unfolding process.

Ecology is an aspect of *ET* that received little attention by Meleis, et al. (2000), however, holds the greatest importance in terms of how an individual transitions. *The New Dictionary of Cultural Literacy, Houghton Mifflin* (2002) defines ecology as “the study of living things, their environment, and the relation between the two”. Approach from this perspective demands close inspection of the socioeconomic, family and community support, as well as degree of responsibility, educational level, and access that each individual has to positive health supports. For many cultural groups, ties and relationship to the land are also vital aspects of self-identity. For a population of nurses who predominate from the European American societies, these are issues that are frequently invisible and go unrecognized. Do individuals have access to water and electricity, refrigeration, communication, or safe places to exercise? Is the nature of the illness preventing regular access to that which an individual sources from? If any of these are missing, extra time is required on behalf of the provider to explore alternatives or find services that may provide some of these essential needs.

*Nursing Therapeutics*

While Meleis, et al. (2000) were clear in the description of nursing therapeutics as functioning at any level of transition, little was offered in what these interactions might mean. The diagram and explanation were somewhat linear in nature, and did not effectively communicate the repetitive nature of encounters that nurses are frequently involved with in order to facilitate a healthy transition.

One cannot discuss nursing therapeutics effectively without referring to nursing’s *Ways of Knowing* (Carper, 2004; Chinn & Kramer, 2004) which include empirics, ethics, aesthetics and personal knowledge. This author strongly agrees with White (1995) in defining sociopolitical knowing as blatantly absent in nursing. This knowledge provides a window into the balance of power and historical foundation from which each individual arises – issues of trust and ability to build a sound relationship are intimately tied to this pattern. The work of Munhall (2004) adds *unknowing* as the sixth way of knowing (See Appendix C). In the present healthcare
environment, nursing tasks rely heavily on empirics and the biomedical model. Nonetheless, integration of each of the other ways of knowing is essential to the profession of nursing.

Continual reevaluation of ethics in the face of ever-changing cultural populations and increasing technological ability leave ethics most challenging to sort through at a personal level—and exceptionally sensitive while working outside of one’s cultural comfort zone. Nursing must question whether utilization of aesthetics and personal knowledge are not the ways of knowing that get pushed to the side, as time allows. Particularly within the realm of chronic disease and disability, while empirics are indispensable in terms of medical treatments, once these are established, the nurse will continually need to come back to involve the other ways of knowing. Munhall (2004) has provided an eloquent state of being—that of unknowing. In this state nurses sit with patients in presence and curiosity. Perhaps unknowing could be considered the removal of the blinders for a wider, deeper perspective. Nonetheless, these ways of knowing are intensely personal and creative, and individuals must determine from within those categories operant truths with which each will practice.

Central to change and engagement is the idea of relationship building and cocreation, not only with the individual, but potentially with members of the extended family or community as appropriate. Despite the Western value of independence, major transitions do not happen in a vacuum, but rather with significant interplay within an individual’s social construct. Kirmayer (2000) warns within “the social level we have the conflicting interests of doctor and patient, who take up each other’s metaphors for different ends. This play of cross-purposes tears apart the fragile world of shared experience” (p. 169). Essential to relationship-building is the creation of trust between provider and individual. Respect for the individuals’ personal health goal, despite the fact that these and the nurses’ goals may be competing in nature is elemental.

In all but a few instances, there will sometimes be forward movement, then back again, and sometimes, there will be no movement at all. The role of the nurse is to repeatedly come back to question, to check in with each individual, to push, prod or perhaps simply listen to where each is on the journey, according to previous negotiations on the nurses’ role with the patient. As the adapted diagram of Transitions reveals (see Appendix D), evaluation of the individual is circular and repetitive in nature regarding the stages of change and where this places her within the transitional process. At one visit there may be significant headway made towards applied change, and what Meleis, et al. (2000) term as patterns of response and outcome indicators. The next visit may well have the individual back at the contemplation level of change. No matter how much each nurse might wish to see an individual at the stage of positive mastery, it is the individual’s journey to complete, her new identity to integrate, and nursing can only facilitate.

Narrative provides the backdrop for reorganization of central themes in an individual’s life (Dreier, 2000). As Mattingly (2000) recounts so eloquently the encounter between provider and patient “acquires phenomenological weight because it creates a present which is threefold, which embodies connections to past and, especially, to future” (p. 206). These connections to the past bring one to reconsider restitution. Cultural contexts allow alternative explanations for illness—which may not be empirically based. For many, chaos cannot be resolved, nor can quest be initiated without first seeking restitution (Somé, 1993), which means that the specific medical treatment for the disease or disability may just have been one small aspect of healing (despite a provider’s believe that it was primary). This also indicates the underlying tension around change-
readiness, as there may be hidden agendas that must first be accomplished. While in many European American communities restitution is a much more invisible element, this may still be a need which resides at the core of one’s being. Nurses must be comfortable and nonjudgmental in compassionate discussion around matters of the heart.

Multicultural awareness and needs of individuals in maintaining illness stories are challenging nuances, but hold great potential for an increased understanding of incongruity between healthcare provider and patient. Frank (1995) claims “bodily symptoms are the infolding of cultural traumas into the body. As these bodies continue to live and to create history, these symptoms outfold into the social space of that history” (p. 28). This frequently can have unexpected results in terms of working with multicultural populations and/or people of oppression.

Medical anthropologists recount striking examples of secondary gain which are achieved by maintenance of the illness persona (Garro, 2000; Hunt, 2000). Hunt (2000) reminds us that refusal to master a transition may “reflect the practical outcome of people creatively constructing a revised identity when confronted with the permanent disruptions presented by living with chronic disease” (p. 90). These examples may be as simple as obtaining attention and assistance that has otherwise been unavailable from family members during wellness. At a more profound level, for those who work to support large extended families, illness may present the opportunity to say “someone else must now take the responsibility. I can no longer carry on in this way.” In this light, while an individual might not gain mastery over a disease process, they may indeed shift into the other outcome indicator that Meleis, et al. (2000) spoke of – that of “fluid integrative identities” (p. 26). Nonetheless, it is up to nursing to identify these phenomena, and where possible to seek constructive alternatives which meet the global needs of the individual.

Grimes (2000) states that we “undergo passages, but we enact rites” (p.5). While including rites within the same framework as nursing therapeutics may seem outrageous to some, in reality nurses enact rites on a daily basis. One of the greatest and perhaps most unrecognized enactment of a rite that nurses perform regularly is that of touch: the touch of a hand on the shoulder while listening to heart sounds; the circle of hands and caress of the elderly diabetic woman’s lower leg as feet are inspected for wounds; or the simple holding/squeezing of a hand in greeting. It is the time apart from time during these encounters which make the rite of touch by a nurse memorable – that allows each individual to feel that a provider cared for, and saw her as unique.

There are a multitude of methods for enacting clinical rites which hold meaning, and set encounters as distinct – creating as Watson (2005) so beautifully describes, the sacred spaces that are essential to healing work. These demand creativity on the part of nursing to develop meaningful rites which develop trust between individuals rather than threaten or diminish in any way. Rites are the celebratory moments when pounds are lost, or blood sugar is controlled – when an individual has mastered if only for a week or a day something that had felt insurmountable in the past. Rites also mark those solemn occasions when diagnoses are given, along with hope and the potential to overcome in psycho-spiritual means that which might not be surmountable on the physical level. Nurses excel at these crossroads with patients, and with development of the skill, intuit the appropriate rite to carry an individual on the journey. In this manner, nurses will continue to facilitate healthy transitional states.
Philosophical and Theoretical Integration.

Transitions are phenomenological in nature. The successful transition demands a personal awareness on the part of the nurse, and awareness of how she perceives others. As Merleau-Ponty (1945) states “If the other people who empirically exist are to be, for me, other people, I must have a means of recognizing them, and the structures of the For Another must, therefore, already be the dimensions of the For Oneself” (p. 520).

Armed with self-awareness, nurses can then utilize The Theory of Human Becoming (THB) by Rosemarie Parse in patient interactions. The three concepts which are key to this theory – meaning, rhythmicity and transcendence – are each core to the transitional process. Meaning in this context is a multidimensional cocreation through the “languaging of valuing and imaging” (Cody, n.d.). It could be added that assisting an individual to find her place within personal narrative will allow a new level of meaning-making to arise, and thus support the journey through a transitional process.

The ebb and flow has been well-described in this paper, and attunement by the nurse to the rhythmicity within these interactions is critical. It must be emphasized that each hold inherently different rhythms, and it is a syncing with the patient’s rhythm no matter how dissonant it may feel to the nurse, that is paramount here. To make oneself available to those rhythmic moments of opportunity as they present is to facilitate transition – and to reveal the artistry of nursing.

Finally, transcendence is the ability to move forward on a unique and individual path no matter the uncertainty and changeable nature of life (Cody, n.d.). This transcendence creates the space and vision for transition to occur. Healthy transitions allow for emergence.

The study of the emergent identity reveals evolution – an evolution of consciousness. Newman (1999) reminds us in HEC that “health is the expansion of consciousness … regardless of what form or direction it may take” (p. xxiii). Newman’s HEC also reflects the same ebb and flow present in that of Parse’s THB. Both of these scholars speak to the fact that pattern does emerge from chaos. Transitions are about an individual finding her way through chaos, and each of these theorists offer insights which impact style of care.

Conclusions and Implications

In reviewing the middle-range theory Meleis, et al. (2000) have provided in ET, one can appreciate the dynamic role transitions play in the life of every individual. It is felt that further evaluation of change and change-readiness and the interaction of these in transitional theory deepen the usefulness of this framework. Including and adapting work by medical anthropologists provides nursing a wider lens with which to inspect the progress through, and perhaps the impediments to healthy transitions. Links with transitional theory to Van Gennep’s (1960) rites of passages remind nurses that these moments of high drama for an individual, may seem very ordinary in the eyes of the provider.

Mattingly (2000) reinforces that “The very possibility of healing may depend upon the capacity and desire of the actors to transform the merely ordinary into an extraordinary moment” (p. 206). For narrative therapy, these extraordinary moments allow an individual to restructure personal meaning. Nurses must be aware of the themes of restitution, chaos and quest within
these stories, assist in moving a patient out of the past and indeed recognize that “the future plays an especially important part in organizing meaning of any event” (Mattingly, 2000, p. 195). In the fluidity or spiraling nature of nursing therapeutics, it must be recognized that individuals are acting within multiple contextual environments of which the illness itself may play a small role (Dreier, 2000).

Throughout the theme of transition, there has been an implication of something which previously had not been labeled or recognized being termed as ‘emergent’. In this context, there is an awareness or discovery of new behaviors that can be developed, the foundation of which already exist, and yet in retrospect, are more complex than those on which they were built. These behaviors are developed particularly towards survival and are transformative in nature, if even at a subtle level, allowing an individual to thrive in potentially adverse environments.

It is not the role of a nurse to ensure a positive transition. It is the role of the nurse to be present – to embark on the journey with each patient. It is the role of the nurse to facilitate where possible, to prompt or to let go, but always to build a relationship that honors the one cared for. To return to the lyrics of Ben Harper (2003), nurses are those who are “searching for an answer when the question is unseen….,” (Amen Omen).

*Experiencing Transitions* as developed by Meleis, et al. (2000) provides insight into a fundamental process. By focus on the application to chronic disease and disability, the circular and repetitive nature of nursing therapeutics are amplified, and indeed are primary in this theory. Evaluation of the goals that each participant has at the outset, as well as repeatedly reviewing with individual and family members, will prompt increased movement and understanding. Building trusting relationships is paramount to transitions, and is a large part of what nursing contributes to healthcare. While the application of predominantly biomedical evidence-based medicine is in use, the facilitation of transitions will be impeded. Development of practice based on a balance of the six ways of knowing, the use of narrative, and creation of meaningful rites will promote healthy transitions. Qualitative evidence will provide a window into these lived experiences, providing clues with which nursing will strengthen interventional practice. The future use and involvement with transitional phases in nursing is exceptionally exciting if the wisdom of the collective is brought forth into cohesive discovery and integration.
References


Appendix A


Appendix C

Chapter Seven

Chronic Care Model and the Use of Promotoras

Trinette Radasa, MSN, APRN-BC, CNS

“Caring is the essence of nursing”

Jean Watson

Figure 1. Chronic Care Model

The Chronic Care Model

Community
Resources and Policies
Self-Management Support

Health Systems
Organization of Health Care
Delivery System Design
Decision Support
Clinical Information Systems

Informed, Activated Patient
Productive Interactions
Prepared, Proactive Practice Team

Improved Outcomes

(UCIC, 2007)
Background/Historical Perspective, Context for theory/model, Review of Literature

Background/Historical Perspective

Wagner (1998) states that he, along with other staff at the MacColl Institute for Healthcare Innovation developed the CCM drawing on available literature about promising strategies for chronic illness management, and organizing the literature in a new more accessible way. The model was further refined during a nine-month planning project supported by The Robert Wood Johnson Foundation (RWJF), and revised based on input from a 40-member advisory committee including experts from medicine, nursing, health services research, patient education, quality improvement, performance evaluation, and accreditation as related to the care of chronic illnesses (Wagner, Davis, Schaefer, Von Korff, & Austin, 1999). Further funding provided by RWJF allowed the MacColl Institute to test the CCM in various health care settings and patient populations that included congestive heart failure patients, diabetes management, cooperative health care clinics (Wagner, et al., 1999). Thus the national program was titled “Improving Chronic Illness Care” (ICIC, 2007).

Essential Elements of the CCM

The essential elements of the CCM include a health care system that encourages high-quality chronic disease care. The essential elements (Table 1) include 1) the community, 2) the health system, 3) self-management support, 4) delivery system design, 5) decision support, and 6) clinical information systems.

Community-Resources and Policies

The objective for the community element is to mobilize community resources to meet patient needs. According to the ICIC (2007) by looking outside of itself, the health care system can enhance care for its patients and avoid duplicating effort. Community programs can support or expand a health system’s care for chronically ill patients, but systems often don’t make the most of such resources (ICIC, 2007). A health system might form a partnership with a local senior center that provides exercise classes as an option for elderly patients (ICIC, 2007). There is a vast amount of learning materials available from state health departments and other agencies that is readily available for patient education and self-help strategies.

Self Management Support

The goal of this element of the CCM is to empower and prepare patients to manage their health and health care. ICIC (2007) suggests effective self-management support means more than telling patients what to do. Patient’s need to be aware that they have a responsibility for there own health and they need to take advantage of the programs that are available to them and acquire support and strategies that will help them to live with there chronic disease. Not only attending classes will help with self-management support. It is also important to incorporate a collaborative approach where providers work with patients to develop a plan of care that includes defining problems, setting priorities, establishing goals, creating treatment plans and solving problems (ICIC, 2007).
Health System—Organization of Health Care

The objective of the health system element is to create a culture, organization and mechanisms that promote safe, high quality care. ICIC (2007) states that a system seeking to improve chronic illness care must be motivated and prepared for change throughout the organization. Senior leadership must identify care improvement as important work, and translate it into clear improvement goals and policies that are addressed through application of effective improvement strategies, including use of incentives, that encourage comprehensive system change (ICIC, 2007). Within the health system to be effective, it is important for the organizations to develop a plan for preventing errors, and if errors occur they should be investigated and changes made to prevent reoccurrence. Breakdowns in communication and care coordination can be prevented through agreements that facilitate communication and data-sharing as patients navigate across settings and providers (ICIC, 2007).

Delivery Design System

The goal of delivery system design is to assure the delivery of effective, efficient clinical care and self-management support. According to the ICIC (2007), improving the health of the people with chronic illness requires transforming a system that is essentially reactive-responding mainly when a person is sick-to one that is proactive and focused on keeping a person as healthy as possible. The complete health care team should play a particular role in the care of the patient, and the care is clearly delineated with scheduled contacts. And it requires making follow-up a part of standard procedure, so patients aren’t left on their own once they leave the doctor’s office (Wagner et al., 1996). More complex patients may need more intensive management (care or case management) for a period of time to optimize clinic care and self-management (ICIC, 2007). Health literacy and cultural sensitivity are two important emerging concepts in health care, therefore providers are increasingly being called upon to respond effectively to the diverse cultural and linguistic need of the patients (ICIC, 2007).

Decision Support

The goal of the decision support is to promote clinical care that is consistent with scientific evidence and patient preferences. ICIC (2007) states treatment decisions need to be based on explicit, proven guidelines supported by clinical research. Specific course of action should also be discussed with patients, so they can understand the rationale for the care they are receiving. Those who make treatment decisions need ongoing training to stay up-to-date on the latest evidence, using new models of provider education that improve upon traditional continuing medical education (ICIC, 2007). To change practice, guidelines must be integrated through timely reminders, feedback, standing orders and other methods that increase their visibility at the time that clinical decisions are made (ICIC, 2007). Involvement of health care team members that specialize in the more complex disease processes add an additional piece that is an important educational means.

Clinical Information Systems

The goal of clinical information systems is to organize patient and population data to facilitate efficient and effective care. ICIC (2007) states effective chronic illness care is virtually impossible without information systems that assure ready access to key data on individual
patients as well as populations of patients (Wagner, et al., 1999). If there is a comprehensive clinical information system it can enhance the care of individual patients by providing timely reminders for needed services, with the summarized data helping to track and plan care (ICIC, 2007). At the practice population level, an information system can identify groups of patients needing additional care as well as facilitate performance monitoring and quality improvement efforts (ICIC, 2007).

All of the critical elements lead to an informed, activated patient and prepared, proactive practice teams, and are evidence-based change concepts under each element. These in combination lead to functional and clinical outcomes. According to the ICIC (2007) the model can be applied to a variety of chronic illnesses, health care settings and target populations.

More specific concepts were added to each of the six elements of the CCM by the ICIC and experts in the last few years to reflect advances in the field of chronic care both from the research literature and from the scores of health care systems that implemented the model in the improvement efforts (ICIC, 2007). These concepts include patient safety (Health System), cultural competency (Delivery System Design), care coordination (Health Systems and Clinical Information Systems, community policies (Community Resources and Policies) and case management (Delivery System Design). The ICIC (2007) cites no specific examples of the research literature or whether it was peer reviewed, and does not specify the types of health care systems that implemented the model. The above mentioned could contribute to weakness of the CCM.

According to the ICIC (2007), the expanded model of care needed to be capable of meeting the information and psychosocial needs of patients, providing modern, evidence-based care, and coordinating care across settings (e.g., hospitals, outpatient clinics, assisted living facilities, and rehabilitation facilities). The above mentioned is a strength of the CCM for the reason that the focus of health care has been in the past to provide care to the acutely ill with various illnesses. Additionally, primary care practice was largely designed to provide ready access and care to patients with an emphasis on triage and patient flow, short appointments, diagnosis and treatment of symptoms and signs, reliance on laboratory investigations and prescriptions, brief, didactic patient education, and patient-initiated follow-up (Wagner, 1998). A shift of focus from primary care to an increased focus on chronic illness may improve clinical outcomes in both individuals and populations alike.

**Literature Review**

Review of the literature yields several research studies using the CCM. In addition, literature was also found that described and specified application for practice, applying the principles of the CCM and a survey of leading chronic disease management programs.

**Strengths and Weaknesses**

Nutting, Dickinson, Dickinson, Nelson, King, Crabtree, and Glasgow (2007) examined the association between clinician-reported use of elements of the CCM and diabetic patients’ hemoglobin A1c and lipid levels and self-reported receipt of care. Nutting, et al. (2007) concluded that clinicians in small independent primary practices are able to incorporate elements of the CCM into their practice style, often without major structural change in the practice, and this
incorporation is associated with higher levels of recommended processes and better intermediate outcomes of diabetes care.

Stroebel, Gloor, Freytag, Riegert-Johnson, Smith, Huschka, Naessens, and Kottke (2005) conducted a pilot project to determine the feasibility and effectiveness of an adaptation of the CCM and found that the CCM was successfully used as a template for the delivery of chronic disease care to an uninsured population. Key components of the CCM that included community, information system, and delivery system design were utilized in this study and contributed to the success of the project.

Pearson, Wu, Schaefer, Bonomi, Shortell, Mendel, Marsteller, Louis, Rosen, and Keeler (2005) qualitatively analyzed the implementation activities of intervention organizations as part of a larger effectiveness evaluation of yearlong quality improvement collaboratives that included congestive heart failure, diabetes, depression, and asthma. Key study variables included measures of implementation intensity (quality and depth of implementation activities) as well as fidelity to the CCM (Pearson, et al., 2005). Pearson, et al. concluded that most organizations were able to make substantial changes to their systems of chronic care. However, the findings also suggest that it is difficult to improve all elements of the CCM at a substantial level of intensity in one year (Pearson, et al.). Furthermore, with collaborative help and encouragement, the organizations made multiple, diverse changes to more closely align their systems with all six major CCM elements (Pearson, et al.).

Another study conducted by Chin, Cook, Drum, Jin, Guillon, Humikowski, Koppert, Harrison, Lippold, and Schaeffer (2004) found that when using the CCM in community health centers, with a health disparities collaborative, diabetes care was improved in one year. Furthermore, many health centers felt that they needed more resources to free staff time for the project (Chin, et al., 2004). This could indicate another weakness of the CCM because of the need and lack of availability of staff to implement the model.

Throughout the review of the literature, I was able to identify strengths and weakness of the CCM. Only certain elements of the CCM are being implemented, and it is unclear as to which elements are commonly utilized. Further investigation would help to identify the most common elements. In addition, a notable problem is the lack of staff and resources mentioned to assist in utilizing the CCM and lack of specified timeline to initiate the CCM into a healthcare setting. According to Gorski (2005), obstacles to adopting the CCM include reimbursement issues, need for visionary leaders, cost of clinical information systems, and clinicians’ lack of time. Strengths identified were the association of the CCM with higher-quality care for diabetes, defined as patient self-management support, group cluster visits, examination of laboratory values, and success when used as a template for the delivery of chronic disease care to an uninsured population (Chin, et. al, 2004; Stroebel, et al., 2004).

Major Presentation of Own Ideas and Modification of CCM

Middle range theory is defined as less abstract than grand theories, more accessible to researchers and clinicians, however, they are at a higher level of abstraction than empirical findings, and contain prepositions that reflect generalizations that go beyond specific clinical case studies (Meleis, 2005). Modifying and extending the CCM will aid nurses in developing interventions, bridging communication gaps, and assisting in developing safety programs.
Implementing promotoras into the health system will assist with staffing issues and help nurses with communication and education linkage, creating a bridge between nurses and patients.

**Community-Resources and Policies**

ICIC (2007) does not define policies in the above, so it is unknown what is exactly intended. I would recommend omitting policies and implement the concept of community liaison. Nurses and health care providers are continually challenged with communication barriers and trust issues within underserved populations, specifically the Hispanic communities along the U.S-Mexico border (Tillet, 2005). Nurses can act as educators and advocates for promotoras, in that they could be a resource for questions that may arise and assist with continuing education. In addition, the nurse can act as a resource for promotoras, by having access various national patient organizations, for example, American Diabetes Association.

**Patient Safety**

It is important to add the concept of patient safety to the community element of the CCM. Socioeconomic factors such as poverty, unemployment, as well as younger parental age and single marital status contribute to increased injury incidence at home. Promotoras are lay health workers than live within the community that they work in. Promotoras have the ability to identify these factors by making home visits regularly and reporting back to nurses their findings. Nurses can then access community resources to implement interventions to rectify safety issues in the home environment. Figure 2 depicts an extension/modification of the Community element of the CCM.

Figure 2.

**Radasa’s Adaptation Health System-Organization of Health Care**
Nurse-Managed Delivery Design System

I recommend changing the element delivery design system to nurse-managed delivery design system and would also add case management and cultural competency as additional concepts. Nurses and promotoras can work together to determine the treatment plan for the patient. Partnerships that engage community members as well as community advocates and service providers in designing culture-centered interventions and programs increase their cultural relevance (Anderson, Calvillo, & Fongwa, 2007). According to Anderson, et al. (2007) nurses as well as patients and community members (promotoras) are stakeholders in the processes that lead to desired patient outcomes (p. 53). The goal of delivery system design is to assure the delivery of effective, efficient clinical care and self-management support. Care planning is a core case management task, requiring the specification of what service will be delivered by whom, with what frequency, and at what cost (Austin, McClelland, & Gursansky, 2006). According to Austin, et al. (2006) services can be delivered by formal caregivers as well as informal caregivers (promotoras).

Clinical Information Systems

The goal of clinical information systems is to organize patient and population data to facilitate efficient and effective care. I would add the concept coordination of care to this element. It is important to have a patient population that is readily accessible in a database; it is equally important to coordinate this care with not only nurses and promotoras, but other providers as well. For example, in well managed healthcare systems, most patients with newly diagnosed diabetes mellitus can be managed on an out patient rather than in patient basis (Gleeson, Foris, Cypress, Rodriguez, Friedman, & Kent, 1999). With the help of the promotoras making phone calls and visits out in the community, patient follow-up on treatment plans can be coordinated between nurses and physicians. Effective chronic illness care is virtually impossible without information systems that assure ready access to key data on individual patients as well as populations of patients (Wagner, et al., 1999).

Patient Safety

I would also add the concept of patient safety under the health systems element in the CCM. Effective organizations try to prevent errors and care problems by reporting and studying mistakes and making appropriate changes to their systems (ICIC, 2007). In order to promote patient safety, it is important to identify errors that are made in the health system. For example, a breakdown in communication would lead to inadequate data-sharing about a patient between providers. Figure 3 depicts an extension/ modification of the Radasa Adaptation Health System element of the CCM.
Conclusion and Implications for Nursing

The CCM’s desired future is clearly delineated in that the functional and clinical outcomes are to assist with chronic disease management. The CCM has the potential to influence nursing actions. For example, Fiandt (2007), states that nurse practitioners and other advanced practice nurses are particularly well qualified for chronic disease management due to their ability to address the multifactorial nature of chronic problems.

The CCM is an organizing framework for improving chronic illness and an excellent tool for improving care at both the individual and population level (Fiandt, 2007). As nurses, we know that clinical outcomes are an important aspect of nursing practice, and there is a need to shift from acute care to managing chronic illnesses. Many deficiencies exist in the care of the chronically ill, such as established guidelines that are not followed, lack of adherence to long-term therapies, unskilled health care workers that do not have the skills in developing interventions, lack of care coordination, lack of follow up, and inadequate education among patients.

Use of the CCM research has shown that elements in the model are effective in managing chronic diseases. The purpose of the CCM is based on the assumption that improvement in care
requires an approach that takes into account the patient, provider, and system level interventions, and can be viewed as a midrange theory. Use of the extended/modified version of the CCM in future research with the Mexican American population and promotoras would help to achieve success in both the patient population and the patient care teams with outcomes.

Moreover, nurses require the ability to implement much needed research and interventions to help them to understand the benefits of using promotoras as a means of health education and improving health related behaviors within the community. Therefore, as nurses we must strive to attain the knowledge regarding various ways of communicating with the Mexican American culture. By conducting research with the Mexican American population and skilled promotoras we can achieve this knowledge goal and improve the health status of an underserved population.
References


Chapter Eight
Self Transcendence in Chronic Illness

Lourdes Ticas, MSN, APRN,BC

“To see health as a pattern of the whole, we need to see disease not as a separate entity that invades our bodies but as a manifestation of the evolving pattern of person-environment interaction.”

Margaret Newman, 1994

The Theory of Self Transcendence was modified to fit experiences of self transcendence in individuals who are chronically ill. Newman’s Theory of Health as Expanding Consciousness informed the new theory. The concepts of inner strength, transcendent nature, personal transformation and identity reconstruction were added to the original set of concepts. The Theory of Self Transcendence is a middle range theory that serves to guide practice among adult populations who experience life events that increase awareness of mortality and vulnerability. Utilizing this theory in the clinical setting provides opportunities to enhance self transcendence and well-being in adult populations.

Introduction, Overall Purpose, Rationale and Description

In today’s society, there is a focus upon the preservation of health. A polarization between health and illness exists (Newman, 1994). The conceptualization of health as being in a continuum dichotomizes health and illness. Health is viewed as the positive state and disease as a negative state (Newman, 1994). This, however, is the old paradigm of health. Illness and disease have lost their power to demoralize (Newman, 1994). Life events such as chronic illness and aging that heighten our sense of mortality and vulnerability need not be viewed solely as negative entities, but as opportunities for personal reflection on inner strengths, growth and renewal. The Theory of Self Transcendence provides us with this new perspective on health. It supports the idea that one can find meaning in suffering (Newman, 1994).

The purpose of this paper was to develop a modified version of the Theory of Self Transcendence in order to fit personal life experiences of individuals with chronic diseases. These personal life stories show the possibility of self transcendence (Neill, 2002). Coward (1991) studied self transcendence in women with advanced breast cancer and found a strong correlation between self transcendence and emotional well-being. Neill (2002) identified transcendence of self boundaries in women living with rheumatoid arthritis in their life journey to find new ways of living. Mellors, Riley, and Erlen (1997) found high levels of self transcendence among individuals with Human Immunodeficiency Virus (HIV). In addition, this paper will also present new concepts identified in the literature and are relevant to experiences with chronic disease. A new model for the theory of self transcendence will be shown incorporating both new and old concepts.
Description on the Theory of Self Transcendence

The Theory of Self Transcendence was developed to enhance the understanding of well-being in older adults as they approach the end of life (Reed, 2003). The theory centers on two key assumptions. The first assumption was that human beings are integral with the environment (Reed, 2003). Secondly, that self transcendence is an innate human characteristic. Key assumptions and relationships among the concepts were identified through previous studies of mental well being among adults, as well a rich collection of psychosocial philosophical and nursing theories (Reed, 1991b). Reed’s theory of self transcendence is based on two major sources of knowledge: life span theories on adult social-cognitive and transpersonal development and Rogers’ theory on conceptual systems (Reed, 1991b). The life span perspective on aging presents that older adults have innate characteristics that serve as valuable resources when faced with difficult life situations, particularly end of life issues. These social-cognitive and transpersonal theories provided the basis that self transcendence is a developmental pattern in later phases of life (Reed, 1991b). Martha Rogers’ science of unitary, irreducible human beings serves as a major foundation for the Theory of Self Transcendence. The theory is based on Rogers’ view of the universe as open systems, pandimensionality and energy fields. Rogers viewed the universe as an open system where energy fields are infinite, open, and integral with each other (Rogers, 1986). It is through this openness that individuals can define their own reality and maintain a connectedness between themselves and the environment (Reed, 1991b).

Three key concepts were identified in Reed’s Theory of Self Transcendence (see Appendix B). These were self transcendence, well-being and vulnerability (Reed, 2003). Self transcendence was defined as:

the capacity to expand self boundaries interpersonally (toward greater awareness of one’s philosophy, values and dreams), interpersonally (to relate to others and one’s environment, temporally (to integrate one’s past and future in a way that has meaning for the present) and transpersonally (to connect with dimensions beyond the typical discernible world. (Reed, 2003, p. 147).

Well-being was described as “a sense of feeling whole and healthy.”(Reed, 2003, p. 148). Reed (2003) stated that self transcendence is associated with one’s well-being. In general, individual’s perception of well-being varies. Examples of indicators of well-being include life satisfaction, positive self concept, hopefulness, and meaning of life (Reed, 2003).

Vulnerability refers to an awareness of one’s mortality. Life events include chronic illness, disability, aging, parenting, childbirth, bereavement, career-related and other life crises (Reed, 2003). Vulnerability was found to be correlated with higher levels of self transcendence. These life experiences trigger self transcendence which in turn increases well-being (Reed, 2003).
Background/Historical Perspective, Context for Theory/ Model Development.

Theoretical and Philosophical Background – Health as expanding consciousness

Reed (2003) based her theory of self transcendence primarily on Rogerian nursing philosophy. The basic idea is that people are viewed as open systems continuously interacting with the environment (Rogers, 1986). A change in one triggers a parallel change in the other. This view remains relevant to self transcendence among individuals with chronic disease.

Most studies on chronic disease life experiences were informed by Margaret Newman’s Theory of Health as Expanding Consciousness (HEC) (Rosa, 2006; Wade, 1998; Neill, 2005); therefore, this theory will serve as the theoretical foundation for this paper. The theory of HEC centers on patterns. Each individual has his or her own pattern. Each one must seek out the meaning of that pattern. These patterns of consciousness provide the person with identity (Newman, 1994). Understanding own patterns enables one then to go to an absolute state of consciousness. (Newman, 1994). In essence, “the person is consciousness” (Newman, 1994, p. 33).

Health is possible in both disease and non disease states (Newman, 1994). A person cannot lose or gain health; therefore, becoming ill does not reduce a person’s health. Health is then viewed as the continuous process of expanding one’s levels of consciousness as part of the interaction with the environment (Newman, 1994).

New Model, New Concepts

Self transcendence is a life journey (Wade, 1998). The journey to self transcendence involves experiencing difficult life changing events such as chronic illness, tapping into inner resources of strength, learning from past experiences, and most importantly, continued progress toward personal growth and maturity. It is a high point of developmental maturity when a person can expand beyond personal boundaries. It is one’s inner strength and transcendent nature (Watson, 1999) that makes self transcendence and personal transformations possible.

Self transcendence, personal transformations and identity reconstruction were among the key concepts identified in qualitative studies examining life experiences of individuals with chronic disease. There is a connection between personal transformations and self transcendence. Neill (2002) states that both these concepts are essential for expansion of consciousness. Personal transformation differs slightly from self transcendence in that it reflects a lifelong process of expanding consciousness. With personal transformation, one sees a progressive advancement toward higher levels of consciousness. It is an endless journey (Wade, 1998). Self transcendence occurs at the point of developmental maturity (Reed, 1991b). Within the context of this paper, it is viewed as an outcome of successful transformations and identity reconstruction.

Major Presentation of Own Ideas

Utilizing the Chinn and Kramer (2004) guide to theory development, a modified version of the theory of self transcendence was developed to accommodate experiences of self transcendence and personal transformations in individuals with chronic disease. The concepts of
inner strength, personal transformation and identity reconstruction will be added. In addition, relationships between the concepts and key assumptions will be discussed. Finally, a new version of the model of self transcendence will represent all the concepts and how each one relates to one another.

**Inner Strength and Our Transcendent Nature**

People possess inner resources of strength that enable them to overcome difficult life experiences (Davis, 2004; Moloney, 1995; Rose, 1990; Rutherford & Parker, 2003; Dingley, Bush, & Roux, 1999; Dingley & Roux, 2003). Rose (1990) studied inner strength in nine women. She identified that part of having inner strength means “having capacity” (Rose, 1990, p. 66). This theme refers to the idea that individuals are capable of self healing, of problem solving, and of having the energy to continue through life despite difficulties and downfalls. Dingley, Bush & Roux (1999) found that women recovering from coronary artery disease (CAD) described their experiences with inner strength as “living with a new normal” (Dingley et al, 1999, p. 47). This renewed life centered around the women’s engagement in new activities, new relationships, developing a new understanding, a new sense of purpose, and a renewed faith in God (Dingley et al, 1999). A study showed that men with prostate cancer found their strength through spirituality (Walton & Sullivan, 2004).

Watson (1999) stated that humans have a transcendent nature. They are able to transcend nature and yet be a part of it (Watson, 1999). A person is regarded as a soul with its own body, therefore, is not bounded by time and space. Instead, a person is capable of transcending nature, through his or her mind, by expanding to levels of higher consciousness. Transcending is accomplished through one’s imagination and emotions. According to Watson (1999), individuals have the capacity to exist with their past, present and future all at the same time. Their souls are held in the highest regard since they may continually exist throughout time. This human spirit represents a higher level of humankind (Watson, 1999).

**Self transcendence**

When a person is diagnosed with a chronic disease, he or she goes through a set of similar experiences that older adults go through at the end of life. Several studies show that self transcendence has been identified in individuals with chronic disease (Neill, 2005; Reed, 1991a; Reed, 1991b; Reed 2003). Reed (2003) defined self transcendence as the capacity to expand self-boundaries intrapersonally, interpersonally, temporally, and transpersonally (Reed, 2003). Self transcendence represents a higher level of personal change in response to a life changing event.

**Identity Reconstruction**

Individuals with chronic disease go through a reconstruction of their self identity (Kralik, Koch, Price & Howard, 2003). Whitehead (2006) studied identity reconstruction among individuals with chronic fatigue syndrome or myalgic encephalomyelitis and found that reconstruction of a new identity following the onset of diagnosis was possible. It was found that although the participants did not fully recover from their illness, they were able to gain a positive identity through reconstruction. Identity reconstruction remains key to achieving personal growth and maturity and represents a crucial step toward self transcendence.

**Personal Transformation**
Personal transformation was defined as “a dynamic uniquely individualized process of expanding consciousness whereby an individual becomes critically aware of old and new views and chooses to integrate these views into a new self-definition.” (Wade, 1998, p. 716). Personal transformation is closely connected with self transcendence (Neill, 2005). With each transformation, the individual advances to higher levels of consciousness (Wade, 1998). It is a multidimensional concept (Wade, 1998). It is circular in nature and continuously expanding (Wade, 1998). Appendix A illustrates a conceptual map of personal transformation.

Transformation in chronic illness refers to a forming over or restructuring. The new self willingly accepts a new future that rejects the old self (Wade, 1998). It was defined as “a dynamic, uniquely individualized process of expanding consciousness.” (Wade, 1998, p. 716)

Personal transformations were studied in individuals with chronic illness. Neill (2002) studied life patterns in three women with rheumatoid arthritis (RA). Personal transformation for these women were evident through the theme “new ways of living” (Neill, 2002, p.44). Enjoying the simple pleasures of life and being positive were key to transformations. Enjoying simple pleasures for these women included being open to accepting help from others, balancing work with exercise and yoga, and setting aside quiet time for self. Other examples given were traveling, enjoying time with pets and gardening. Having a positive outlook for these women represented a lifetime effort. Being positive was described as taking things slow, doing fewer things, and finding new ways to occupy time.

**Well being**

Well-being was described as a subjective view of what it means to feel whole and healthy (Reed, 2003). Well-being is a correlate and an outcome of self transcendence (Reed, 2003). Achieving well-being becomes an important goal in the event of chronic illness (Neill, 2002; Whitehead, 2006).

**Vulnerability among the Chronically Ill**

Vulnerability is another key concept in the theory of self transcendence. Reed (2003) described vulnerability as an awareness of one’s own mortality, and inadequacy. Certain life events may enhance one’s vulnerability (Frankl, 1984). Examples of these life event were chronic illness, disability, aging, parenting, child birth, bereavement, career-related and other life crises (Reed, 2003). An identity loss with relation to work and social life has been identified in individuals diagnosed with fibromyalgia (FM) (Asbring, 2000).

**Definition and Summation of New Concepts – Inner Strength, Personal Transformation and Identity Reconstruction.**

The three new concepts added to Theory of Self Transcendence were defined to fit the revised model. The concept of inner strength is defined as an innate characteristic which a person discovers when he or she is dealing with a difficult and stressful life experience. It is this life experience that unravels one’s personal strength and causes a person to maintain their will to live and find new meaning in their changed lives.

**Personal Transformation** is a lifelong process of change. It is process of developmental maturity and growth as one deals with difficult experiences such as aging, chronic illness and
end of life issues. It is a time when a person experiences personal growth as he or she goes through life’s highs and lows. Personal Transformation is described appropriately as an endless journey (Wade, 1998).

Finally, identity reconstruction is a redefining of oneself. A person who experiences a difficult phase or event in their lives such as having a chronic illness or aging is capable of redefining their identity. This redefining includes reflection on what health means for them or what quality of life is. In summary, when a person discovers their inner strength, successfully undergoes personal transformations and identity reconstruction then they can find meaning in their new lives. Having a chronic illness or going through aging is irrelevant to their perception of what a good, healthy and meaningful life is.

Relationships

The three relationships in the original Theory of Self Transcendence apply to individuals with chronic disease. First, increases in one’s vulnerability increases levels of self transcendence (Reed, 1991a; Reed 1991b; Reed, 2003). Second, there is a positive relationship between self transcendence and well-being (Reed 1991b; Reed, 2003). Finally, there is a wide variety of factors that may affect the relationship between well-being and self transcendence. Sources of inner strength may affect one’s wellbeing. Studies found that inner strength is manifested through identifiable patterns or themes of healing, balance, nurturance and connectedness with self, others and future (Dingley et al, 1999).

Assumptions

This modified version of the theory of self transcendence contains three key assumptions. First, inner strength and transcendence are both innate characteristics in a person. Second, individuals are one with the environment, therefore, no separation between person and environment exists (Rogers, 1986). The third assumption is that health refers to one’s journey through expanding levels of consciousness when dealing with a chronic illness. Health can be possible in the presence of illness (Newman, 1994).
New Model of Self Transcendence for Individuals Who are Chronically Ill

The new model shows each of the concepts and how they relate to each other (see Fig.1). Chronic illness causes a feeling of vulnerability in a person. Dealing with the stressful effects of chronic disease and continued feelings of vulnerability triggers a set of responses. These responses are varied. Through a person’s inner strengths and self transcendent nature, identity reconstruction occurs. This is the first step toward a lifelong process of expanding consciousness or personal transformation. Personal transformation involves a journey of highs and lows as represented by the spiral. The process of transformations shapes and sets the stage for self transcendence. When a person reaches a higher level of developmental maturity, then self transcendence may occur. Self transcendence along with contextual factors affects a person’s well being. It is assumed that self transcendence is correlated to well-being.

Conclusions and Implications for the Nursing Discipline

Nursing Research

The Theory of Self Transcendence has been used to examine life experiences of adults living with chronic disease. These studies lend support to the idea that people find health in the presence of illness. Future studies are needed to explore self transcendence in other debilitating and stressful conditions. Domestic violence, multiple sclerosis and amyotrophic lateral sclerosis
(ALS) are areas where self transcendence has not been studied. In addition, there have been no studies of self transcendence in children with a terminal illness.

*Nursing Practice*

Findings from studies of self transcendence provide nurses with opportunities to enhance self transcendence in patients faced with a chronic or terminal diagnosis. Meditation, prayer, visualization, life review and journaling are interventions nurses can utilize to enhance self transcendence. The use of support groups and face to face contact are examples of interpersonal strategies to facilitate self transcendence (Reed, 2003).

In the wake of a new health paradigm, the Theory of Self Transcendence offers a positive outlook on experiences with chronic illnesses. Self transcendence provides opportunities to gain meaning in the presence of illness, despair and suffering. It provides a place of solace when cure or treatment is out of reach. Individuals possess innate characteristics of inner strength and transcendence that demands expression when faced with a stressful or difficult life event.
Appendix B

References


Chapter Nine

Innovations in Theory Development for the Nursing Discipline

Laura Marsh, MSN, RN

For decades, nursing scholars have researched ways to understand and develop the body of nursing knowledge. This development and understanding has resulted in the creation of theories and models to express nursing knowledge and guide nursing practice.

Benner’s Model and the ECHO Model will be examined, modified and applied to the author’s phenomena of interest which is telehealth technology and the role of the practicing nurse.

Innovations in Theory Development for the Nursing Discipline

Introduction and Purpose

Patricia Benner introduced her nursing model “From Novice to Expert: Excellence and Power in Clinical Nursing Practice” over two decades ago. This model was adapted from the Dreyfus model of skill acquisition which was developed by examining the different performance levels of chess players and pilots (Dreyfus & Dreyfus, 1986). The Dreyfus brothers identified five levels of skill acquisition from novice to expert.

Benner utilized the Dreyfus model and applied it to nursing “in order to ascertain and understand the differences in clinical performance and situational appraisal of beginning and expert nurses” (Benner, 1984, 2001, p. 14). Benner (1984, 2001) indicated that by documenting the clinical performance of specific sets of skills by expert nurses, a crucial, initial step has been taken in the development of clinical knowledge.

The ECHO (Extension for Community Healthcare Outcomes) Model was created by Dr. Sanjeev Arora to provide a means to bring specialized care to rural and underserved communities. The treatment of Hepatitis C (HCV) was utilized to pilot the model in New Mexico. The ECHO Model has created partnerships between the University of New Mexico Academic Medical Center, the New Mexico Department of Health, the New Mexico Department of Corrections, the Primary Care Association, Indian Health Services, and rural community clinics. These partners participate in the ECHO model utilizing disease management protocols, best practice standards, and comanagement with specialists. Telehealth technology leverages connectivity between rural providers and urban medical specialists to comanage patients with chronic, complex diseases. This is accomplished through educational sessions of case-based learning and “learning loops” (Arora, Geppert, Kalishman, Pullara, Bjeletich, et al., 2007).

The author will modify the Benner model by integrating the use of the ECHO Model and telehealth technology to provide “real time” dialogue of the clinical performance of specific sets of skills by the expert nurses and/or case based learning versus the documentation of narratives. The
ECHO Model and telehealth technology can leverage the Benner Model with the use of interactive video and audio technology especially for nurses in rural communities.

**Historical Background and Review of Literature**

*Benner’s Model.* Benner’s (1984, 2001) model utilized the same skill levels that are described in the Dreyfus Model. These levels are a) novice, b) advanced beginner, c) competent, d) proficient, and e) expert. In each skill level, Benner (1984, 2001) identified meanings that arise in “common issues” that nurses encounter during the care they deliver to their patients. Benner (1984, 2001) also noted that as nurses pass through each of the skill levels, they exhibited changes in the aspect of skilled performance. Nurses were able to rely less on abstract principles and integrate concrete principles that were experienced based. Other transitions in skill levels included being able to compile relevant parts of the complete whole instead of integrating “bits and pieces” and moving from an observer role into a performer role.

Benner’s (1984, 2001) qualitative study consisted of nurse interviews that asked nurses to describe their patient care episodes and put this description into a narrative form. These notes and transcripts were compiled and studied with 31 competencies emerging from the analysis. These competencies resulted in the identification of seven domains of nursing practice. These domains included a) the helping role, b) the teaching-coaching function, c) the diagnostic and patient-monitoring function, d) effective management of rapidly changing situations, e) administering and monitoring therapeutic interventions and regimens, f) monitoring and ensuring the quality of health care practices, and g) organizational and work-role competencies. The greatest advantage of this model is in the descriptions of actual nursing practice. “The context of this performance is maintained, and thus the description is synthetic, or holistic, rather than elemental and procedural” (p. 45). Benner used an interpretive approach to unveil this clinical knowledge by describing the context of the situation and limiting the number of interpretations so the best interpretation could be identified.

The Benner Model (1984, 2001) has been used to create competence scales and by nurse leaders to create and promote autonomous practice environments for nurses (Fennig, Bender, Colby, & Werner, 2005; Meretoja, Isoaho, & Leino-Kilpi, 2004; Hardt, 2001). The creation of these tools assisted in identifying existing levels of performance excellence and areas that require development. Altman (2006) used the Benner Model to assist nursing preceptors in identifying performance characteristics and learning needs at each student level.

The ECHO Model (Arora, et al., 2007) was designed to improve patient care “by developing and supporting the competence of primary care providers in underserved areas to manage complex diseases” (p.154). The characteristics that make the disease amenable to treatment by rural providers through the use of the “knowledge networks are: a) the disease is complex, b) the disease is common and chronic, c) the treatment for the disease is evolving, d) the disease is associated with a high societal impact, e) with no treatment, outcomes are serious, and f) with treatment, outcomes will improve.

The ECHO Model utilizes “learning loops” with cased-based learning in which rural providers learn in three ways: a) the comanagement between the urban medical specialists and the rural provider, b) the rural providers’ peers on the network who are also presenting cases on the network, and c) through education presentations. “These learning loops create a deep domain
knowledge about the area in question – here HCV- enabling them to provide the highest quality treatment for their patients” (Arora, et al., 2007, p. 156).

Telehealth Technology. The Oxford English Dictionary and the Oxford American College Dictionary were consulted for a definition of telehealth. Neither dictionary defined telehealth, however, there was a definition for the prefix “tel” and a definition for the word “health”. The prefix “tel” has origins from the Greek “téle” meaning “afar; far off”. “The combination of this prefix with scientific or technical terms, connected with appliances or methods for operating over a long distance” (Oxford English Dictionary Online, 1989). Health was defined as “soundness of body; that condition in which its functions are duly and efficiently discharged”(Oxford English Dictionary Online, 1989). The Oxford American College Dictionary (2002) had the same definition for the prefix “tele”. Health was defined as “the state of being free from illness or injury” (p.618).

The origins of telecommunications, as it is used in telehealth, started with the telephone. Nurses first used the telephone in the late 1800’s and continue to use the telephone today to deliver a variety of nursing services nationwide (Greenberg, 2000).

‘Telehealth” is a new term for what was previously known as “telemedicine”. The ability to “telecommunicate” over long distances began in the late 1950’s at the University of Nebraska. This technology was utilized to provide primary and specialty care that slowly developed during the 1960’s through the 1980’s and rapidly progressed within the past decade. NASA (National Aeronautics and Space Administration) was first to develop the use of telemetry to monitor physiological signals and determine the state of health in astronauts in space. This specialized equipment monitored body temperature, heart rate, blood pressure, and other physiologic indicators using this wireless, “telecommunication” system ((Folen, James, Earles, & Andrasik, 2001).

According to Pinciroli (2001), telehealth is a component of many “teleservices”. Health professionals want to deliver their services and provide care to their patients over great distances. When providers achieve this level of care, they provide “teleservices” with the use of information and communication technology methods and devices.

Telehealth is an integrated system that provides healthcare activities over a distance. It is a technique of delivering health care, directly to the patient or in a consultation/ educational format with the provider, at a distance rather than in person. Telehealth implies an ability to communicate health care delivery without the barriers of time and distance. The removal of these barriers facilitates an increase in access to healthcare and an increase in capacity. This decreases costs while maintaining quality health care (Marineau, 2005).

Strengths and Weaknesses

Benner Model. The strength of this model is in its ability to capture the experiential learning of the practicing nurse. Learning and knowledge are identified in five levels of skill acquisition, from the beginner to the expert (Dreyfus & Dreyfus, 1986; Benner, 1984, 2001). “Narratives of experiential learning link the learner, context, relationships, and timing. Experience-based narratives tap into common human predicaments and vulnerabilities that may show up differently in other cultural and organizational settings” (Benner, 1984, 2001, p. v). Collecting and reading
the narratives allows the reader to acquire new clinical knowledge from other clinicians in various levels of clinical development. These narratives provide a venue for sharing realities of nursing practice and an opportunity to apply this shared knowledge to change and improve practice.

The weakness of the model has been identified by Benner. The narratives provide diverse, innovative, first hand clinical information about nursing practice and for the development of nursing practice but “they have not, however, had the advantage of talking to one another so that they could compare their experiences” (Benner, 1984, 2001, p. 221). The ability to share clinical experiences through dialogue could enhance the strengths of this model.

The ECHO Model. The strength of the ECHO model is that there are over fifteen rural primary care providers currently comanaging and treating patients with HCV throughout the state of New Mexico and in the Department of Corrections. Through the use of this model, access to this specialized treatment has increased. Currently, there are over 290 patients on pegylated interferon and ribavirin treatment and over 1200 patients receiving medical management for their chronic HCV. Also, in a qualitative provider satisfaction survey conducted in September 2006, of the twenty nine rural providers participating in the model, ninety-six reported improved knowledge with respect to treating patients with HCV. Ninety-two percent of the providers expressed gained competence in treating patients with HCV. This survey questionnaire was developed by the University of New Mexico’s Program of Evaluation and Research (PEAR).

The most significant weakness of the ECHO Model is the barriers in rural provider time and scarce resources. Many of these communities are struggling with a lack of providers and assuming the challenge of treating patients with a specialized disease is extremely difficult.

Telehealth Technology. The greatest strength of telehealth technology is in the ability to communicate health care delivery, education, or consultation without the barriers of time and distance. The removal of these barriers facilitates an increase in access to health care knowledge and an increase in capacity. The use of telehealth technology for health care delivery to patients is increasing in an attempt to decrease costs while maintaining quality care. In 1999, there were over 200 telehealth programs in the United States. The predictions are that these programs will increase 40% annually over the next 10 years and that these programs will represent 15% of health care expenditures by the year 2010 (Marineau, 2005).

A weakness with utilizing telehealth involves the technology component. The technological component in Telehealth is the key factor that determines the success of this distance service. Real time telehealth involves synchronous interaction between parties, while store and forward (S&F) telehealth is asynchronous and allows the interaction to take place during a time of convenience for both parties. It is important to recognize that there are costs associated with providing adequate computer systems. This includes hardware, network infrastructure to link sites, technical staff, and computer software for the success of the clinical interaction (Hughes, 2003, Harnett, 2006).

Context for Model Development

Medical research continues to provide us with increasing amounts of information. This information impacts clinical settings in transforming existing standards of practice to improve the delivery of patient care. In these clinical settings, translating new knowledge can be challenging.
Traditional medical management and treatments rapidly become obsolete and in this era of patient driven outcomes, clinicians are challenged to implement the newest and most effective therapies (Cuzzell, 2002). Figure 1 illustrates how medical knowledge rapidly and steadily increases over time. Attempting to keep up with these knowledge changes is difficult because our learning capacity is not increasing as rapidly. The challenge and goal is to minimize this gap by integrating the Benner Model and the ECHO Model with the use of telehealth technology to provide practicing nurses with the opportunity to share knowledge through dialogue without the barriers of time and distance.

**Nursing Knowledge Network**

The Nursing Knowledge Network (see figure 3) will combine Benner’s Model and the ECHO Model with the use of telehealth technology and focus on three main objectives; the translation, integration and application of nursing knowledge through case-based practice sharing. The goal of the objectives will be to synthesize “knowing that” into “knowing how” (Dreyfus & Dreyfus, 1986) during the “case based practice sharing” dialogue between “Urban Nurse Specialists” and “Community Nurse Experts”. This will be defined further by examining the Nursing Knowledge Network, the objectives of translation of best practice standards (theory based), integration of shared knowledge, application of this knowledge to nursing practice, and the “Knowledge Sharing Loop”.

**Translation.**

As stated above, translating best practice standards and theory is crucial in the delivery of quality patient care. Translation has been defined as “a rendering, a conversion, and a change” (The Oxford American Dictionary, 2002). Translation of best practice standards and theory encompasses our knowledge by understanding the changing dynamics and determinants of health care. According to Dreyfus & Dreyfus (1986) translation is “knowing that”. Dreyfus & Dreyfus (1986) use the analogy of riding a bicycle to describe the differences between “knowing that” and “knowing how”. An individual “knows that” it is possible to ride a bicycle because he/she has witnessed bicycle riding. The “know how” comes from the actual experience of riding a bicycle. Again, the objective of translation is “knowing that”.

**Integration.**

Knowledge integration is acquired through instruction and experience. The skill acquisition process shows that an individual passes through five stages of “qualitatively different perceptions of his task and/or mode of decision-making as his skill improves” (Dreyfus & Dreyfus, 1986, p. 19). Benner (1984, 2001) identified skill acquisition in the experiential clinical learning of nurses with the use of the “experienced-based narratives” (p.v). These narratives provided the “documented” knowing and a means to share this knowledge with other nurses. The objective of integration is in the transitional phase between “knowing that” and “knowing how”.

**Application.**

Chinn & Kramer (2004) state “the fundamental reason for developing knowledge in nursing is for the purpose of creating expert nursing practice” (p.14). Nursing literature is full of discussion surrounding nursing knowledge and application to practice. Researchers and theorists continue to try and capture the development of nursing knowledge through the caring interactions between
nurse and patient. Application to nursing practice is “bringing together ‘knowing’ and ‘doing’” (p.15). It is in this area of practice application that the levels of skill acquisition will be seen from novice to expert. The objective of application is through implementing “knowing how” into nursing practice.

Case-Based Practice Sharing.

This is the primary method of knowledge sharing on the Nursing Knowledge Network between “Urban Nurse Specialists” and “Community Nurse Specialists”. This is not a new approach to learning and knowledge sharing. It is also known as “case-based learning”, “problem-based learning”, or “work-based learning”. The focus is on integrating knowledge and experience and is perceived as a continuous process grounded in experience (Sangster, Maclaran, & Marshall, 2000). Problem-based learning encourages individuals to a) construct an extensive and flexible knowledge base, b) develop effective problem-solving skills, c) develop self-directed life long learning skills, d) become more effective collaborators, and e) become intrinsically motivated to learn (Massaro, Harrison, & Soares, 2006). Case-based practice sharing will facilitate this process of learning, develop nursing knowledge, and improve nursing practice.

Nursing Knowledge Network “Knowledge Sharing Loop”

Operationally, the Nursing Knowledge Network encompasses technological and knowledge sharing components. The technology component is seen in Figure 2. This illustrates the infrastructure to connect urban and community nurse specialists in a session of knowledge sharing. These nurses can join the session by audio (telephone) or interactive video connectivity. Once the participants are connected, the “Knowledge Sharing Loop” is initiated, as seen in Figure 3. The “Urban Nurse Specialists” or the “Community Nurse Specialists” can facilitate the session. Prior to the session a topic of interest is identified to be discussed during the session. This can be a patient situation, integrating a new therapy or technology to improve patient care, or any topic that impacts the nurse patient relationship. The knowledge sharing loop provides an environment where nurses can translate best practice standards, integrate shared knowledge, and apply the knowledge to practice. The knowledge sharing “loop” is created when the nurses a) dialogue and learn from their own encounter with the experience, b) share the experience with other nurses on the network, and c) learn from the shared experiences of other nurses.

The qualitative survey tool created by PEAR could be redesigned to assess the efficacy of the “Nursing Knowledge Network”. The objectives of translation, integration and application could be determined by utilizing this survey tool. The levels of skill acquisition identified by Dreyfus & Dreyfus, (1986) and Benner (1984, 2001) could also be examined.

The original survey was focused on physician/providers and how the ECHO model impacted their practice. Arora et al., (2007) hypothesized that participation in the ECHO model would increase the level of physician/provider competence in treating specialized diseases like HCV. Also, the physician/provider would experience less isolation by creating an environment of work and learning. The major benefit that was expressed by the physician/providers was their increased confidence and integration of new knowledge to improve their practices. The survey results from the September 2006 provider questionnaire are provided in Figure 4.
Conclusion and Implications

The integration of these models, one focused on nursing and the other focused on medical providers, has the potential to give nursing the opportunity to share and build knowledge. The use of telehealth technology facilitates overcoming the barriers of distance and time. Implementing the “Nursing Knowledge Network” is an avenue where nurses can contribute their own personal knowledge and receive knowledge from their peers through dialogue that is leveraged by technology. Integrating these models with telehealth technology offers tremendous opportunity for research and ultimately building the nursing body of knowledge.
References


Appendix A

Figure 1. The gap between medical knowledge and learning capacity. (Arora, et al., 2007)
Appendix B

Figure 2. This illustrates the technology infrastructure. (Pak, W., & Marsh, L., 2007).
Figure 3. Nursing Knowledge Network, “Knowledge Sharing Loop”. (Marsh, L., 2007).
Appendix D

Project ECHO Annual Meeting Survey

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<td>Ability to identify patients who should be screened for Hepatitis C</td>
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<tr>
<td>Ability to identify suitable candidates for treatment for HCV</td>
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<td>Ability to assess severity of liver disease in patients with HCV</td>
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<td>Ability to educate clinic staff about HCV patients</td>
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September 23, 2006

Project ECHO Annual Meeting Survey

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<th>Skills and knowledge after participating in Project ECHO</th>
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<td>Ability to assess and manage psychiatric co-morbidities in patients with HCV</td>
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<td>Serve as local consultant within my clinic and in my area for HCV questions and issues</td>
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September 23, 2006

Figure 4. Project ECHO Annual Meeting Survey Results (Arora, et al., 2007)
Chapter Ten

A Theoretical Approach to Interprofessional Collaboration

*Cynthia Nuttal, MPA, MSN, RN*

Collaboration among physicians and nurses has been espoused as a means of improving patient outcomes and increasing job satisfaction of health care professionals. It has been proposed as being central to effective patient care delivery models and is being demanded by accrediting agencies. Despite these acclamations and mandates, for many, collaboration between nurses and physicians remains an elusive goal. The purpose of this paper is to extend Vygotsky’s Sociocultural Theory of Learning to enhance current research focusing on collaboration among nurses and physicians.

Theories are considered starting points in relation to knowledge development. What is important is what is done with theories and how they are utilized. A rigorous theoretical approach to conceptualizing the basic components of interprofessional collaboration has not been developed. Although there are no empirical data to illuminate why theory has not been used more extensively when studying collaboration, it appears that the level of reporting of the theories used and the design of collaborative intervention measures are poor. This paper proposes a modification of Vygotsky’s Sociocultural Theory of Learning through integration of key elements found in D’Amour’s Model of Interprofessional Collaboration and Situated Learning Theory. The aim of this integration is to develop a comprehensive theoretical approach to conceptualize the important factors of interprofessional collaboration and their inter-relations.

This proposed theory integration of sociocultural learning and situated cognition could be appropriately applied in both academic and work environments. The educational system would be the ideal starting point of interprofessional collaborative practice because it represents the principal lever for promoting collaborative values among future health care professionals. However, in the workplace, organizations could implement structures and standards conducive to collaborative practice as well. Implementation of this proposed expanded sociocultural learning theory holds promise that a nurse-physician collaborative practice model may be developed with all the subsequent benefits realized by nurses, physicians and, foremost, our patients.

Introduction

A theory is an organized, heuristic, coherent, and systematic articulation of a set of statements related to significant questions that are communicated in a meaningful whole for the purpose of providing a generalizable form of understanding. It describes observations, summarizes current evidence, proposes explanations, and yields testable hypotheses. It represents aspects of reality that are discovered or invented for describing, explaining, predicting and controlling a phenomenon (Meleis, 2007).
A theory presents a systematic way of understanding events or situations. It is a set of concepts, definitions, and propositions that explain or predict these events or situations by illustrating the relationships between variables. Theories must be applicable to a broad variety of situations. They can be abstract, without a specified content or topic area. Some theories can have shapes and boundaries, but nothing inside. They become useful when filled with practical topics, goals and problems. Theory gives planners tools for moving beyond tuition to design and to evaluation. Theory development initiates a road map for studying problems, developing appropriate interventions, and evaluating their successes (Fawcett, 2000).

Multiple nursing theories were adapted from the social and behavioral sciences, as nursing overlaps with various disciplines such as psychology, sociology, medicine and anthropology. No single theory dominates nursing practice, nor should there be, as the problems, behaviors, populations, cultures, and contexts of nursing care are broad and varied. Adequately addressing a nursing issue may require more than one theory, and no one theory is suitable for all cases. Because different theoretical frameworks are appropriate and practical for different situations, selecting a theory that “fits” should be a careful, deliberate process.

Effective nursing practice depends on using theories and strategies that are appropriate to a situation. When a specific theory does not address a specific topic or content area, theorists need to refine, modify or adapt existing theories. Social Learning Theory is an example of a theory that a subset of subsequent theories, such as Bandura’s Social Cognitive Theory and Vygotsky’s Sociocultural Theory were derived from (Thomas, 1990).

Purpose

Cognitive psychology is a family of learning theories that emphasizes the role of the learner in the construction of knowledge. Specifically, the sociocultural theory emphasizes the important role of social interaction in the construction of knowledge. Within sociocultural theory, the concepts of zone of proximal development (ZPD), scaffolding, and self-efficacy are particularly relevant to collaborative practice.

Self-efficacy theory provides valuable insights regarding student learning in the social environment. Bandura's social cognitive theory postulates that perceived self-efficacy affects an individual in all aspects of life, including educational experiences (1986). Beliefs about one's competence to successfully perform a task can affect motivation, interest, and achievement. The higher the perceived efficacy, the higher the goal aspirations people adopt and the firmer their commitment to achieving those goals. Educational activities should foster self-efficacy through the use of social interaction. By doing so, the learning environment is structured to de-emphasize competition and highlight self-comparison of progress to build a sense of self-efficacy and promote academic achievement.

The purpose of this paper is to extend Vygotsky’s Sociocultural Theory of Learning, beyond social cognitive theory, to enhance current research focusing on collaboration among physicians and nurses. Collaboration among physicians and nurses has been espoused as a means of improving patient outcomes and increasing job satisfaction of health care professionals. It has been proposed as being central to effective patient care delivery models and is being demanded by accrediting agencies. Despite these acclamations and mandates, for many, collaboration between nurses and physicians remains an elusive goal.
Collaboration is challenging to health care professionals for a variety of reasons. It requires a sharing of information and expertise among disciplines that have typically worked independently. The traditionally hierarchical, and hence competitive relationship, which typifies nurse-physician interactions, does not exist in a collaborative environment. Because collaboration is a process between people, ultimately individuals themselves determine whether or not collaboration occurs. The formation of a theoretical framework that enhances collaboration and the development of interdependent nurse/physician relations which results in mutual recognition of the body of knowledge and skills of each discipline is clearly needed.

General Description

The concept of collaboration between health care professionals has been the focus of much attention in the last few years due to its impact on how care is delivered and what outcomes are achieved. Collaboration between health care professionals has been linked with positive health outcomes and higher job satisfaction (Ryan, 1999). However, current research indicates that nurses generally feel that physicians do not respect them for their unique knowledge and skills, which has a negative affect on their relationship (Jansky, 2004). This is a cause for concern, as studies have demonstrated that communication and collaboration between nurses and physicians can have a profound effect on workplace environment and patient care (Baggs, Schmitt, Mushlin, Eldredge, Oakes & Hutson, 1997).

Nurse-physician collaboration is more than simply working together in proximity to one another; it requires recognizing a common purpose and the mutual responsibilities and duties required to deliver effective, safe, high-quality, and efficient care. It is essential that the positive aspects of the nurse-physician relationship be nurtured and the negative features more effectively managed. Optimal nurse-physician collaboration is associated with higher levels of satisfaction for physicians (Corser, 1998; Miccolo & Spanier, 1993) and for nurses (Jansky, 2004). It has also been linked to lower turnover levels for nurses (Jansky, 2004) and a quality practice environment (Matthews & Lanshear, 2003). These outcomes provide the impetus for further research into nurse-physician collaboration.

Although hospitals have little control over patient characteristics such as the severity or complexity of a patient’s condition, they may have significant influence on other aspects of the overall health care system. These aspects include nurse characteristics, system characteristics and behaviors, and environmental complexity factors, which are amenable to policy and management interventions (O’Brien-Pallas & Baumann, 2004). Accordingly, interventions targeted at certain areas of patient-care delivery, for example nurse-physician relationships, may be extremely useful in improving nurses’ workplace environment, satisfaction, and concomitantly the recruitment and retention of nurses (Rosenstein, 2002). The body of literature on nurse-physician relationships is sizable; however, while the studies may comment on, editorialize, or encourage the use of collaborations, very few studies have been carried out which seek to improve collaboration within healthcare organizations through intervention focused research (Boyle & Kochinda, 2004).

The current nursing shortage has focused public attention on the importance of nursing care (Estabrooks, Midodzi, Cummings, Ricker, & Giovannetti, 2005) and the unfavorable conditions under which most nurses work: poor financial rewards, low professional autonomy, and limited participation in decision making processes (O’Brien-Pallas & Baumann, 2004).
Jansky (2004) states that the current nursing shortage is directly affected by nurse-physician relationships. When those relationships are positive, nurses are more likely to feel satisfied within their workplace and to remain in their current positions. This job satisfaction maintains nurses’ equilibrium and prevents burnout. This is particularly important as the growing concern about the worldwide shortage of nurses will necessitate more attention to recruitment and retention issues (Laschinger, Shamian, & Thomson, 2001).

Boyle and Kochinda (2004) define collaboration as nurses and physicians working together cooperatively to achieve shared problem solving, conflict resolution, decision making, communication and coordination. Collaboration has also been described as a process which allows the interaction of colleagues within a flat hierarchy, with individuals being able to make decisions both independently and as part of a team (Taylor-Seehafer, 1998), and an interaction that includes consideration for all comments involved in the interaction and active integration of the perspective and skills of various participants (Coeling & Cukr, 2000).

Regardless of which description is used, the central element of collaboration seems to be communication. As derived from the literature, the other factors which contribute to collaboration seem to be mutual trust, respect, and shared decision making responsibilities. Interestingly, good nurse-physician relationships have been repeatedly identified as a fundamental characteristic of magnet hospitals (Hinshaw, 2002), and the link between magnet hospitals and positive nurse-physician collaboration has been strongly established.

Theory Selection and Conceptual Model

The work of the Russian psychologist Lev Vygotsky provided the foundation for the application of sociocultural learning theory. This important theorist underscored the dynamic interdependence between the social and individual processes in learning. Vygotsky's work emphasized three major themes. First, he contended that cognitive development, including higher-order learning, is rooted in social interactions and mediated by abstract symbols, which he referred to as tools. Second, Vygotsky asserted that these tools are not created in isolation, but rather are products of the sociocultural evolution of an actively involved individual. Third, Vygotsky viewed learning as a developmental or genetic process (Woolfolk, 1998). This general genetic law of cultural development emphasized the importance of concentrating on the process by which higher functioning is established.

Vygotsky’s Sociocultural Theory of Learning emphasizes that human intelligence originates in our society or culture, and individual cognitive gain occurs through interpersonal (interaction with social environment), rather than through intrapersonal (internalization). This theory suggests that social interaction leads to continuous step-by-step changes in children’s thought and behavior that can vary greatly from culture to culture (Woolfolk, 1998). Basically, Vygotsky’s theory suggests that development depends on interaction with people and the tools that the culture provides to help form their own view of the world.

There are three ways a cultural tool can be passed from one individual to another. The first one is imitative learning, where one person tries to imitate or copy another. The second way is by instructed learning, which involves remembering the instructions of the teacher and then using these instructions to self-regulate. The final way that cultural tools are passed to others is
through collaborative learning, which involves a group of peers who strive to understand each other and work together to learn a specific skill (Woolfolk, 1998).

Vygotsky’s theory combines the social environment and cognition. Children will acquire the ways of thinking and behaving that make up a culture by interacting with a more knowledgeable person. Vygotsky believed that social interaction will lead to ongoing changes in a child’s thought and behavior. These thoughts and behaviors will vary between cultures.

There are four basic principles underlying Vygotsky’s Sociocultural Theory:

1. Children construct their knowledge
2. Development can not be separated from its social context
3. Learning can lead development
4. Language plays a central role in mental development

A key element in this sociocultural theory is the zone of proximal development (ZPD). Vygotsky believed that any pedagogy creates learning processes that lead to development, and this sequence results in zones of proximal development (ZPD). It is the concept that a child accomplishes a task that he/she cannot do alone, with the help from a more skilled person. Vygotsky also described ZPD as the difference between the actual development as determined through problem solving and the level of potential development level as determined through problem solving under adult guidance or collaboration with more knowledgeable peers. The result of this process is that children become more socialized in the dominant culture, and it induces cognitive development.

In order for ZPD to be successful it is essential that two individuals begin a task with different understanding and eventually arrive at a shared understanding. This is a critical process that has application in collaborative learning. Environmental interaction has the potential to foster sharing of different perspective and increased understanding of different positions. While Vygotsky’s primary focus was on developmental learning, starting in childhood, a modification of Vygotsky’s theory could integrate D’Amour’s model of interprofessional collaboration, which is suitable for an adult focus.

An organizational sociology interprofessional collaboration model was developed by D’Amour, which has been tested with data from several case studies, in order to understand interprofessional and interorganizational collaboration (D’Amour, Ferrada-Videla, San Martin Rodriguez & Beaulieu, 2005). D’Amour’s model conceptualizes the process of collaboration according to four dimensions:

1) Finalization (shared goals/vision) refers to the existence of common goals and their appropriation by the team, the recognition of divergent motives and multiple allegiances, and the diversity of definitions and expectations regarding collaboration.
2) Interiorization (sense of belonging) refers to the awareness by professionals of their interdependency and of the importance of managing interdependency, and it translates into a sense of belonging, mutual knowledge of values and of disciplinary frameworks and trusting relationships.
3) Formalization (structuring of clinical care) which is analyzed in terms of rules meant to regulate action by strengthening structures.
4) Governance, which deals with central leadership, local leadership, expertise and connectivity.

The inclusion of this model would serve to strengthen collaboration with the goal of improving patient care, enhancing job satisfaction, boosting productivity, and helping to contain costs (Pavlovich-Danis, 1998).

The development of understanding, respect, and trust among healthcare professionals, seems to be an essential process in ensuring effective collaboration, as well as an appreciation of each individual’s strengths and limitations. Successful collaboration fosters quality, satisfaction and enhanced productivity for those who provide and those who receive healthcare (Korabek, Rosenau, Slauenwhite, & Ross, 2004). A successful collaborative team has been characterized as a multidisciplinary team in which the healthcare professionals treat a patient independently, but share information, pool their knowledge, and jointly evaluate or develop an appropriate plan of care (Warren, Houston, & Luquire, 1998).

Vygotsky’s theory is complementary to the work of Bandura (1986) on social learning and could readily be aligned with situated learning theory. Situated learning theory could also be easily integrated into the concept of interprofessional collaboration. Situated learning theory’s goal is to create learning communities that are more closely related to the collaborative practice of the real world. When people work collaboratively in an authentic activity, they bring their own framework and perspectives to the activity. They see a problem from different perspectives and are able to negotiate and generate meanings and solution through shared understanding. This model of learning emphasizes meaning making through active participation in socially, culturally, historically, and politically situated contexts. A crucial element of active participation is dialog in shared experiences, through which situated collaborative activities, such as modeling, discourse and decision making, are necessary to support the negotiation and creation of meaning and understanding.

Situated cognition is a sub-component of situated learning theory, which is very applicable to interprofessional collaboration. The premise in situated cognition is that it is not possible to separate cognitive tasks from social tasks, because all cognitive tasks have a social component. Thinking is both physically and socially situated, so that problem tasks can be significantly shaped and changed by the tools that are made available and the social interactions that take place during problem solving (Pea, 1994).

Situated cognition, a new paradigm of learning, emphasizes apprenticeship, coaching, collaboration, multiple practice, articulation of learning skills, stories and technology. “Community of practice,” a concept emerging from situated cognition, emphasizes sharing and doing, construct meaning in a social unit (Roschelle, 1995). Situated learning occurs when students work on authentic tasks that take place in real-world settings. A merging and subsequent application of this theory into collaborative sociocultural learning would be very applicable in a health care setting seeking to strengthen and optimize nurse-physician relationships.

Conclusions and Implications

The literature presents the educational system as one of the main determinants of interdisciplinary collaborative practice, because it represents the principal lever for promoting
collaborative values among future health care professionals. Traditionally, students in health-related fields have been socialized with a strong professional identification that fell within the boundaries of their respective professionals (Ivey, Brown, Teste & Silverman, 1987; Reese & Sontag, 2001). Such socialization results in a very limited knowledge of other professionals in the team. Members of each profession know very little of the practices, expertise, responsibilities, skills, values and theoretical perspectives of professionals in other disciplines. This is considered to be one of the main obstacles to collaborative practice in health care teams (Albert, Goldman, Kilroy, & Pike, 1992; Bradford, 1989; Fagin, 1992; Mariano, 1989; Reese & Sontag, 2001).

Some of the empirical studies also underscored how being familiar with, understanding and valuing the roles played by other professionals facilitate the development of interdisciplinary collaboration (Baggs & Schmitt, 1997; Silen-Lipponen, Turunen & Tossavainen, 2002). Indeed, a study by Liedtka and Whitten (1998) of twelve interdisciplinary teams working in hospitals demonstrated how various values, work styles, and personality of different professional groups hinder the development of collaborative relationships.

According to Glen (1999), there is a need for an educational system that helps students to recognize the values and responsibilities of their respective profession while instructing them in professional plurality. To that effect, several authors stress the need for interprofessional educational programs (Fagin, 1992; Johnson, 1992; Lindeke & Block, 1998; MacIntosh & McCormack, 2001; Mariano, 1989). Such an educational program should help students value professional pluralism and promote awareness, sharing and the integration of their knowledge and practices. Research related to traditional and clinical components of medical/nursing education reflects the basic tenets of Vygotsky's work. Mentoring, nurturing, modeling, student participation, and a humanistic orientation, all of which occur in a social environment, were found to be important factors in student development and learning.

The proposed theory integration of sociocultural learning and situated cognition could be appropriately applied in both academic and work environments. The educational system would be the ideal starting point of interprofessional collaborative practice because it represents the principal lever for promoting collaborative values among future health care professionals. There is need for an educational system that helps students to recognize the values and responsibilities of their respective profession, while instructing them in professional plurality. To that effect interprofessional education programs would be ideal settings to apply this expanded theory.

In the social environment, students learn personal skills related to professional development, such as communication. It is critical that the role of the acculturation process, commonly experienced through clinical experiences and internships in the development of interpersonal and communication skills in health care students, be emphasized. This critical process of acculturation facilitates professional growth as students prepare to enter the workforce. The social environments in which these interactions occur build the scaffolding upon which the student frames new knowledge. Clinical experiences and internships, among other connection-making strategies, foster the development of technical and interpersonal skills.

Exposing students to an actual work environment as part of the learning process is a necessary and fundamental component in knowledge construction. Being submerged in the culture of the profession enhances professional competency and facilitates self-efficacy beliefs...
for success in one's chosen profession. In this environment, students become active learners capable of solving complex problems and constructing meaning that is grounded in real-world experience. Educators can foster student motivation by providing structure in the clinical setting, autonomous support through learning activities, and active involvement with other students and teachers.

In the workplace, organizations could implement structures and standards conducive to collaborative practice. The influence of organizational factors and organizational culture on the development of interprofessional collaboration are key elements that influence the success or failure of any collaborative implementation. However, no external organizational factors will be successful if the providers themselves are not committed to a collaborative process.

Designing theoretically-informed interprofessional collaborative implementation interventions should be the goal of both academics and industry. Interventions to optimize nurse-physician collaboration reported in the literature include training workshops in collaboration and communication skills, joint interdisciplinary staff meetings, case scenarios, coordination of care, and patient centered care efforts. Interventions directed towards establishing professional practice environments are also linked to nurse-physician collaboration. Attributes of a professional practice environment include evidence-based practice, clinical competency, and systems and processes that facilitate practice and professional development.

Matthews and Lankshear (2003) identified sixteen essential elements of a professional practice environment that could be grounded in the proposed theoretical framework. These include formal communication lines that promote the involvement of all stakeholders in decision-making, structures and roles that reflect the interprofessional nature of the staff, collaborative practice principles and strong nurse-physician linkages.

The authors share strategies reported as having been successful in strengthening these elements. These include implementation of the principles of shared governance and continuous improvement, and the identification and articulation of expectations, systems, and processes that support consultation and collaboration. Ultimately theoretically based interventions that enhance nurse-physician relationships promote a quality work environment, one which positively influences nurses’ job satisfaction, promotes retention of the nursing workforce and recruitment of new graduates and decreases health care costs.

Theories are considered as starting points in relation to knowledge development. What is important is what is done with theories and how they are utilized. Since the study of collaboration among health care providers is still not very well defined, the efforts of the nurse researcher/theorist studying collaboration would be both timely and welcomed. A theoretical approach offers the advantages of a generalisable framework within which to represent the dimensions that nurse-physician collaborative studies address. In doing so, this theoretical approach informs the development and delivery of collaborative interventions, guides their evaluation, and allows exploration of causal mechanisms. Implementation of this proposed expanded socialcultural learning theory holds promise that a nurse-physician collaborative practice model may be developed with all the subsequent benefits realized by nurses, physicians and, foremost, our patients.
References


Chapter Eleven

Integrating Motivational Interviewing and Tidal Model Theory

*Sandra McClelland, MSN, RN*

This paper describes the integration of two established approaches to motivating therapeutic change, Motivational Interviewing (MI) and the Tidal Model Theory (TMT). The integration of the theoretical focus of the TMT and the key principles and clinical strategies of MI will strengthen the approach of each to nursing clinical practice (Villarruel, Bishop, Simpson, Jemmott, & Fawcett, 2001). MI has a strong similarity to the tenets of TMT. MI like the TMT is a directive, client-centered approach eliciting behavior change by helping clients to explore and resolve ambivalence (Barker & Buchanan-Barker, 2005; Miller & Rollnick, 2002). A comparison of MI and TMT is given with an integration of the two approaches.

**Introduction**

TMT is a recent mental health, middle range theory that emphasizes the need for nurses to collaborate closely with individuals they care for by developing a therapeutic user-empowering relationship (Barker & Buchanan-Barker, 2005). TMT builds upon nursing’s core concepts of caring. It has six guiding principles (curiosity, resourcefulness, respect, crisis as an opportunity, setting small goals, and simplest forms of intervention) concerning the function of nursing therapeutic relationship with client (Barker & Buchanan-Barker, 2005). It promotes recognition of individual strength and attributes, and people’s ability to bring about change in their lives with appropriate support from caregivers (Barker & Buchanan-Barker, 2005). This theory’s use of metaphor and client empowerment closely reflects the assumptions and philosophical tenets of MI that a comparison seems appropriate.

MI, like TMT, is a directive, client-centered approach eliciting behavior change by helping clients to explore and resolve ambivalence (Barker & Buchanan-Barker, 2005; Miller & Rollnick, 2002). Miller & Rollnick (2002) stated that MI did not evolve from a theory, but instead a style or method that he subsequently tried to ground to behavioral science findings, constructs, and metaphors. Insights in how to help clients be proactive in their treatment was developed from clinical practice.

This paper will attempt to link Motivational Interviewing techniques to the Tidal Model Middle Range Nursing Theory in the hopes of offering a theoretical basis to MI, and also to strengthen the TMT’s approach to clinical practice (Villarruel et al., 2001). Perhaps a comparison of MI and TMT could theoretically integrate the two approaches for a practical, counseling style that can be used by nurses.

**Background**

*Motivational Interviewing*

MI is a popular contemporary approach to enhancing clients’ treatment motivation. It was first described by Miller (1983), and was a result of experiences in treating alcoholism.
Since then, health professionals have begun to apply this approach to encourage change in chronic disease behaviors such as diet, physical activity and medical adherence (Hettema, Steele, & Miller, 2005). Several reviews of MI interventions have been reported, with most studies showing a positive effect, but the mechanism of action is not well understood (Hettema et al., 2005). Strategies for how to help clients be proactive in their treatment were developed from clinical practice, rather than based on a theory (Miller & Rollnick, 2002). Although a systematic theory evaluation on MI was not formally completed, at first glance it has the attributes of a middle range nursing theory (Fawcett, 2005). It provides a research based, holistic and person-centered approach to nursing practice. The concepts are simple, logical, clear, and the assumptions are consistent. MI has been used internationally, suggesting that it is cross culturally relevant. MI has been taught successfully to nurses, doctors, dietitians, counselors etc. There is a wide range of research that supports its use in diverse clinical practices and different nursing and medical specialties.

Miller (2002) tried to link MI to behavioral science findings, constructs, and metaphors. MI provides practical principles that can promote treatment motivation. These principles include expressing empathy, developing discrepancy, rolling with resistance, and supporting self-efficacy (Miller & Rollnick, 2002). They have been shown to be effective in a number of domains such as addiction treatment, diet, exercise, hypertension, diabetes, and bulimia; although there is less confirmation in the domains of smoking cessation and HIV risk (Emmons & Rollnick, 2001; Gance-Cleveland, 2007; Knight, McGowan, Dickens, & Bundy, 2006).

In a meta-analysis of randomized controlled trials using motivational interviewing (MI) as an intervention, MI was found to produce better results than the traditional advice-giving in the treatment of behavioral problems and diseases (Emmons & Rollnick, 2001). MI had a significant and clinically relevant effect in three out of four studies. Sixty-four per cent of the studies showed a positive effect with just one brief encounter of 15 minutes. Studies with more than one MI encounter, however, helped ensure long term effectiveness.

In a review of MI in health settings, the authors found that MI had substantial benefits for health behavior change, in particular with patients who are ambivalent or not ready for change (Britt, Hudson, & Blampied, 2004). They found that it is unclear which patients benefit most from MI and which motivational intervention is best for which patient. Britt, et al. (2004) suggest developing MI interventions that are usable in health consultations, which are teachable, and specific to enable evaluation.

It is important to view MI as an interpersonal style and not as a set of manipulative techniques that are applied to people. MI is a balance of directive and client-centered principles that are guided by a philosophy and understanding of what triggers change (Zimmerman, Olson, & Bosworth, 2000). Important elements of the philosophy that are vital to the spirit of MI are: a) motivation to change has to come from the client; b) the client articulates and resolves his/her ambivalence, not the counselor; c) ambivalence is not resolved by direct persuasion; d) the style of the counseling session is quiet and non-confrontational; e) resistance and denial are not client traits, but a cue to the counselors’ need to modify motivational strategies; f) the therapeutic relationship is a partnership between the client and the counselor with respect given to the client’s autonomy and freedom of choice regarding his own behavior (Miller & Rollnick, 2002). Some specific therapist behaviors that are characteristic of MI style are: a) understanding the client’s point of view using reflective listening; b) expressing affirmations; c) recognizing the clients’ motivational statements, desire and intention to change; d) giving the client the freedom of choice and self direction (Miller & Rollnick, 2002).
The Tidal Model Theory

The TMT (Barker & Buchanan-Barker, 2005) was developed in the mid 1990’s over a four to five year period with its aim of refocusing nursing practice toward the human needs of people needing mental health care. It was originally developed and pilot tested in the United Kingdom as an alternative model for mental health nursing practice (Barker, 2001; Barker, Jackson, & Stevenson, 1999). This model is a philosophical approach to the treatment in mental health with its focus on helping people recover. The first step in people’s recovery is the telling of their personal story of distress, then helping them reclaim control over their lives (Barker & Buchanan-Barker, 2005). TMT is an interdisciplinary model of care that assumes within every person there is the need for empowerment and that there is a possibility for resolution and recovery (Barker, 2001; Barker & Buchanan-Barker, 2005). The core philosophical elements of this theory are (a) that recovery is possible, (b) change is inevitable, (c) the person has all the resources needed for recovery, (d) the person is the teacher and the helper is the pupil, (e) we need to be curious to learn what needs to be done to help them now (Barker, 2001; Barker & Buchanan-Barker, 2005).

TMT draws from chaos theory in emphasizing the fluid nature of human experience, characterized by incessant change and unpredictability (Barker, 1996). Metaphors are used in theory writings to convey meaning and suggest paths for action, and to enhance concept and theory development (Smith, 1992). TMT uses metaphors to convey meanings. Water is the core metaphor of the TMT (Barker, 2001; Barker & Buchanan-Barker, 2005). The following Metaphor is the basis of TMT (Barker & Buchanan-Barker, 2005):

Life is a journey undertaken on an ocean of experience. All human
development, including the experience of illness and health, involves discoveries
made on the journey across that ocean of experience. At critical points in the life
journey the person experiences storms or even piracy (crisis). At other times the
ship may begin to take in water and the person may face the prospect of drowning
or shipwreck (breakdown). The person may need to be guided to a safe haven to
undertake repairs or to recover from the trauma (rehabilitation). Once the ship of
the life journey is made intact or the person has regained the necessary sea-legs
the ship may set sail again, aiming to put the person back on the life course
(recovery) (p.10).

This theory acknowledges the great depth of the person and huge scale of the person’s
ocean of experience. Understanding how people become emotionally, physically, spiritually
“shipwrecked” will aide in learning how to 'care with' the person, helping them begin again their
journey on the ocean of experience (Barker & Buchanan-Barker, 2005).

TMT is based on principles concerning the nature and function of the therapeutic
relationship. These principles aim to identify first what needs to be done, as identified by the
client, and all the care that follows will focus on ways of involving the client and others when
appropriate. By focusing on what is absolutely necessary the care plan becomes simpler and
more elegant. The focus is on the client’s need and not the setting where the care is given.

There are three dimensions in the TMT that are representative of personhood and they are
distinct and related to caring: world, self, and others (Barker & Buchanan-Barker, 2005; Fletcher
& Stevenson, 2001). In the world dimension, understanding the person’s experience of distress,
ilness or trauma is the main focus. The person is in need of validation by others. Documentation
of significant events and what s/he perceives as needing to be done in response to the events
should be in the person’s words without interpretation. In the self dimension a person’s
emotional and physical security is of most concern involving identification of what kind of support is necessary to ensure safety to avoid risk of harm to self or others. The other dimension includes the services a person would need for everyday living including medical, psychological or social interventions.

Within each of these dimensions the nurse explores the person’s experience through his/her understanding and narrative without judgment or interpretation, but engaging in the person fully to determine what interventions might meet the person’s needs (Barker & Buchanan-Barker, 2005). Documentation is done verbatim in the person’s words without translating into professional language. The TMT assumes that people are their narratives or stories; it is not concerned with the cause of the present problems, but aims to use the experience of the person’s journey and its meaning to plan the next step that needs to be taken (Barker & Buchanan-Barker, 2005). The nurse and the person together write the narrative of the experience in the first-person which includes what the person believes she/he needs in the form of nursing.

Integration of MI and TMT

Common Origins

Both MI and TMT developed from dissatisfaction with existing frameworks that de-emphasize the phenomenology of the individual. Miller and Rollnick (2002) were dissatisfied with the prescriptive nature of many treatment approaches such as confrontational therapies. They argue that fear-inducing or pressuring communications can immobilize the individual, making the possibility for change remote. TMT was developed as a practical model to guide psychiatric and mental health nursing. Barker (2001) describes this theory as a reconceptualization of mental heath problems and needs as human, rather than psychological, social or physical. TMT has several theoretical credits, but Barker credits Peplau’s interpersonal paradigm for his collaborative exploration of the client’s story (Tomey & Alligood, 2006).

Limitations of MI and TMT

MI has been criticized as not being theoretically based, but numerous research based articles have been published on this intervention (Emmons & Rollnick, 2001; Gance-Cleveland, 2007; Hettema et al., 2005; Knight et al., 2006). TMT reports that research is being done, but few articles have been published and those are by the theory developer, with few by other nurse scientists (Barker, 2001; Barker, 2003; Fletcher & Stevenson, 2001; Stevenson, Jackson, & Barker, 2003). MI and TMT at first glance seem superficial and somewhat simplistic in its tenets and philosophy. These limitations support the integration of TMT and MI by offering a theoretical basis to MI, and strength to TMT’s approach to clinical practice (Villarruel et al., 2001).

Shared Assumptions of MI and TMT

MI encourages clinicians to create a situation where clients engage in self-exploration and contemplation of change, making the client responsible for the treatment decision (Miller & Rollnick, 2002). This is true for TMT in that the patient is regarded as the expert in his/her problem and in finding his/her solution (Stevenson et al., 2003). TMT and MI are not a prescriptive activity in which the therapist or counselor directs and guides the change process, but they assist in drawing out motivation from people by supporting their inner resources. TMT and MI are not focused on teaching new coping skills, reshaping cognitions, or excavating the past, but they focus on the here and now (Barker & Buchanan-Barker, 2005; Miller & Rollnick,
Diagnostic labeling is avoided by MI and TMT as it often carries a stigma that can harm self-esteem, and competence.

**Theory Integration**

An integrated session of MI and TMT would be described as being quiet, non-confrontational, and being “with” the client (Miller & Rollnick, 2002). Some common counseling techniques that are useful are reflective listening, asking open ended questions, affirmations, and summarizing. Emphasis is on the client’s story of documented in own words. The counselor is learning from the client, who is the expert of their situation. The team of client/counselor works together in a collaborative, friendly relationship, to find what is needed now as the first step towards recovery and change. This person-centered approach focuses on answering these questions: a) Why is this client having difficulty now, and what needs to be done; b) What life was like before the situation occurred; c) Why is the client in difficulty now; d) How does the client understand or explain the current situation; e) How confident is the client the she/he will be able to change the behavior successfully; f) Explore the client’s previous experiences with change; g) What is the least restrictive intervention that the client could do to bring about a therapeutic change (Barker & Buchanan-Barker, 2005; Miller & Rollnick, 2002).

Integrating the philosophical elements of MI and TMT results in the following:
- Support self-efficacy.
- A client’s motivation to change makes recovery possible.
- The client is the expert and has all the resources needed for recovery so confrontation or persuasion is not needed to elicit change.
- The therapeutic relationship is between the client (teacher), and the counselor (pupil).
- The counselor listens with curiosity, without judgment, and without interruption.
- Respect the client’s autonomy and freedom of choice for his/her behavior change and/or treatment decision.
- Do not label the client with a diagnosis that can carry a stigma.
- Clients are responsible for their progress.

These assumptions, principles, philosophies, and style appear as one and the same but perhaps through a different perspective such as Nurse/doctor. One can actually confuse what is being read, MI or TMT? The similarity is so strong that since MI was first published in 1983 and TMT in the early 1995, it is surprising that Miller is not referenced in any TMT publications.

The integration of TMT and MI would be an approach to a counseling style that could benefit in patients who are non-adherent to their chronic disease treatment. Of particular research interest to this author is improving non-adherence in the hemodialysis client. WHO (2004) found that in developed countries adherence to long-term therapies is approximately 50%. The costs of poor adherence to medication have been estimated to be greater than $100 billion yearly and hospital readmissions from non-adherence occur from 5 to 40% of the time (Dunbar-Jacob & Mortimer-Stephens, 2001; Cveingros, Cristensen, & Lawton, 2004). With these percentages it is clear that some type of intervention is necessary. MI and TMT offer an innovative theory based, approach to helping clients in our everyday practice.

**Conclusion and Implications**

The two methods or approaches to counseling provide nurses with a good, practical intervention that is theory based. TMT can benefit with additional practical techniques or style,
and MI can benefit with a nursing theory as a foundation. The lack of TMT published research studies to review indicates the need for published research in this theory. MI provides research in many areas of mental health and chronic disease. One could argue that they are so alike that neither needs integration. It is this authors opinion that integrating these two methods, by incorporating the style and spirit of MI, while providing the theoretical foundation of TMT, allows for expanding the use of TMT in other practice settings. Further research will be needed to examine and measure the techniques of the therapeutic sessions in relation to client satisfaction, relapse, increased or decreased adherence to treatment.
References


