Innovations in Theory Development for the Nursing Discipline

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FOREWORD

As in a previous version of this class, I asked the students to either adapt or extend an existing midrange theory, advancing not only their conceptual insight, but also their specific ideas for where/how to apply the revised theory to their research interests. I maintain that scholarly creation or achievement in nursing should serve to improve practice or health outcomes, demonstrate a viable connection between the theoretical/conceptual and the operational/practical dimensions of nursing, and stimulate critique regarding the merits of the chosen theory or model. I would add that in the current health care and organizational climate, it is more important than ever to provide compelling evidence for the value of nursing ideas, creativity, innovations, and knowledge. I believe that the following examples of theoretical growth and transformation are very promising, as they address the domains included here, enriched by the visions of the writers. We invite all consumers of theoretical thinking in nursing to participate in the analysis, development, and transformation of models fundamental to our discipline and to the health of people in all care settings.

Sincerely,

Jennifer B. Averill, PhD, RN, Instructor
Introduction

This second volume of theory development demonstrates further exploration and expansion of some of the theories used in nursing practice. Interdisciplinary theories were researched and utilized in the various theory expansions and development. Through our exploration of the theories incorporated in nursing practice and scholarship, we have expanded ways to extend or modify those theories to enhance our individual research interests.

Melanie Mayo is a Nurse Practitioner who works in a geriatric environment and has expanded her practice into the realm of palliative care. She has expanded Reed’s middle range theory of self-transcendence, combining it with Roger’s science of unitary beings.

Hanna Krieger explored and extended Orlando’s nursing process theory and its applications to her interest in clinically inflicted pain.

Kristen Kuehlmann introduced a new theory, Promoting Health Actions, which is synthesized from Ajzen’s theory of planned behavior. This new theory provides a tool to assist clients in performing healthy lifestyle behaviors, develop interventions for individuals to make health life-style changes, and design strategies for use in community-wide health programs.

Stephen Hernandez works at the Veterans Administration Hospital in Shreveport, Louisiana. He is interested in the stigma experienced by veterans who experience mental health disorders. Stephen chose to adapt and extend the modified labeling theory approach to mental health while incorporating the theory of unpleasant symptoms.

Carol Bett teaches nursing at the Northwest Nazarene College in Idaho and plans to complete her research in research on developing healthy communities. She modified Persily’s and Hildebrandt’s community empowerment model by adding elements from Lewin’s change model and incorporating principles from the Anderson, Guthrie and Schirle nursing model of community organization for change.
Susan Steel works at the Veterans Administration Hospital in Albuquerque, New Mexico. Her research interest is women veterans in the Veterans Administration health care system. She has described the application of Harding’s feminist standpoint theory as it will apply to her area of research.

Mark Siemon has experience in public health, primarily Native American, and is currently a Robert Wood Johnson scholar. He is interested in health promotion change among children because health promotion activities adopted by children and adolescents may continue into adulthood, thereby decreasing rates of chronic disease in both children and adults. The Health Promotion Model (HPM) developed by Pender was chosen as a model for his planned research in childhood health promotion programs.

It is evident that our unique contributions and styles are displayed in this volume. It is also evident that we are a caring group of scholars whose goal is to improve the outcomes for those clients with whom we engage. It is our hope that by using creative and innovative methods of research, we may impact the health of our communities.
**CHAPTER ONE**

**PROMOTING HEALTHY ACTIONS: A MIDDLE RANGE THEORY**

Kristin L. Kuhlmann

Planned behavioral change requires conscious attention in identifying health risk, assessment of whether change toward reducing health risk is desirable and achievable, and consideration of possible actions to reduce or ameliorate the risk. A change in lifestyle can greatly reduce the risk for contracting some chronic diseases, particularly those with psychosocial behavioral components. A new middle range nursing theory, *Promoting Healthy Actions (PHA)*, is introduced for use in both nursing practice and research. The theory, PHA, proposes a synthesis of concepts from Ajzen’s *Theory of Planned Behavior* and the process of nursing praxis. PHA provides nursing with a pragmatic, yet powerful tool that can be used to assist clients in performing healthy lifestyle behaviors, in developing interventions for the individual client to make healthy lifestyle changes, and to design strategies to help in community-wide health programs. Additionally, concepts within the PHA theory are easily operationalized for use in nursing research.

Reacting to an impending stimulus, adaptive or protective, is very different from planning change in order to reduce health risk or complications. Planning and promoting behavioral change requires conscious attention in identifying a health risk, assessment of whether change toward reducing the risk is desirable and achievable, and consideration of possible actions to reduce or ameliorate the risk.

A change in lifestyle (healthy dietary choices, regular physical activity, and maintaining a healthy weight) can greatly reduce the risk for contracting some chronic diseases, particularly those with a psychosocial behavioral component. For example, obesity has been implicated in the early onset of Type 2 diabetes, cardiovascular disease, hyperlipidemia, hypertension, and some types of cancer. Attaining and maintaining healthy lifestyle changes can greatly reduce the complications of chronic disease over time (Aufseeser, Jekielek, & Brown, 2006; Zeller, Reiter-Purtill, Modi, Gutzwiller, Vannatta, & Davies, 2007).

Middle range theories are often employed to deal with specific phenomena that are present in several specialties, or fields, of nursing and while not present in all situations, the phenomena are commonly recognized as recurrent concerns or themes within the nursing realm. Middle-range theories are less abstract than grand theories, with a limited number of propositions and concepts. Middle range theory concepts are also easier to translate for use in nursing research and practice (Chinn & Kramer, 2008; Meleis, 2007).
Nursing scientists often choose to borrow, share, or adapt theories from other disciplines, rather than using existing nursing theory. While many nurse leaders contend that reliance on theories from other disciplines dilutes and diffuses nursing knowledge development, a recent review of research literature demonstrates that nursing researchers are still using borrowed theories more frequently than using nursing theory (Villarruel, Bishop, Simpson, Jemmott, and Fawcett, 2001). Reasons offered for this phenomenon include a lack of clarity in nursing theories, difficulty in defining and operationalizing concepts for use in research or practice, a lack of acknowledgement and adoption of nursing theory by other disciplines, and a lack of precedent in using nursing concepts and theory in multidisciplinary research. In addition, many nursing leaders received their doctorate degrees in another discipline- such as sociology, anthropology, psychology, or education - and have assimilated these borrowed theories into their on-going research and practice.

Therefore, careful analysis must be established to determine if there will truly be advancement in nursing knowledge, practice, and research through the use of these borrowed theories. It is important that theories used in nursing practice and research be substantive, containing structures and concepts that reflect the nursing paradigm, theories, and underlying tenets of nursing practice. Theory derivation from other disciplines can prove useful in cases where relationships among concepts are identified and there is not a structural model available within established nursing theory, or when a theory in another field contains innovative or insightful concepts that will add to the body of nursing knowledge in a significant manner.

As part of the derivation process, the theory must be altered or modified to fit within the field of nursing with a specific purpose in mind. Walker and Avant (2005) propose a 5-step process for development of substantive nursing theory derivation:

1. Perform a comprehensive literature review on the phenomenon and evaluate existing nursing theory for adequacy.

2. Explore theory development in related fields, searching for strong relationships in knowledge and concept definitions that are congruent with nursing.

3. Focus on a parent theory, or parts of a borrowed theory, that best explains or predicts the phenomenon of interest.

4. Select relevant concepts and eliminate parts of the theory that are not useful.

5. Refine or redefine the concepts, assumptions, or structures from the parent theory to develop a meaningful nursing theory, utilizing the processes of creativity and reflection.

*Theory of Planned Behavior*
As the first part of the process, Ajzen’s *Theory of Planned Behavior (TPB)* will be examined to determine how derivation of this middle range theory may be used to create a unique nursing theory. The Theory of Planned Behavior (TPB) contains eight concepts with demonstrated relationships that provide both innovative and measurable conceptual correlations that can be readily utilized in health promotion behaviors. The TPB, rooted within a social psychology context, has been used extensively in behavioral and health sciences research and has demonstrated success in identifying those factors related to intention of behavioral change, and can be correlated with the actual performance of healthy behaviors.

The theory has been developed over 30 years and has followed a logical progression. In 1975, Fishbein and Ajzen authored a book that introduced the Theory of Reasoned Actions, and with further research analysis, authored another book five years later (Fishbein & Ajzen, 1975; Ajzen & Fishbein, 1980). After more predictive analysis, Ajzen added the major concept of *perceived behavioral control* as a concept with major importance in predicting intention and behavior. The theory was then renamed as the Theory of Planned Behavior (Ajzen, 1991).

The TPB is very pragmatic and can be easily operationalized for both nursing research and practice. The concepts are easy to understand and can be quickly integrated into a questionnaire or survey (Francis, et al., 2004). The scope of the TPB is narrow enough to be easily used in nursing practice, yet has sufficient conceptual development to be used in research as well. Multiple studies have demonstrated that the concept of perceived behavioral control (*PBC*) provides additional support of intention, or to the performance of the behavior (Ajzen, 2006). Based on a substantial meta-analysis of the TPB, the results within the majority of studies have had moderate to large effect in predicting both intention and overt behavior (Armitage & Conner, 2001). The studies represented a large range of topics relating to social, psychological, and health-related behaviors.

The TPB assumes that reasoned processes underlie attitudes and actions, which can be influenced by both past and present personal and social influences, as well as accurate information about the effects of change (*background factors*). Figure 1 illustrates how the TPB allows exploration of differences among *beliefs, subjective norms* (social influence), and *perception of behavioral control (PBC)* in the prediction of stated behavioral *intentions* and actual behavior. Additionally, if past behavior patterns are set as part of the background factors, or when the subject is able to perform the behavior with little difficulty (no impediment or barrier), PBC is able to influence behavior directly (Ajzen, Albarracin, & Hornik, 2007).

Phrased as an algebraic equation (Ajzen, et. al, 2007), the weights ascribed to attitude (), subjective norm (), and perceived behavioral control () determine the amount of behavioral intention (BI):  \[ + = BI. \]
Ajzen (2005) summarizes the assumptions of the TPB in the following way:

1. People generally act in a sensible and reasonable manner.

2. After consideration of all available information, the implications of a planned action is weighed by the individual (benefits vs. barriers).

3. Planned intentions and actions are a function of three basic determinants: personal attributes, social influence, and issues of control.

4. The expression of intention to perform an action is the most powerful determinant of whether the action will be completed.

Literature Review of Research Studies using the TPB

The Theory of Reasoned Actions (TRA) and the resultant, modified TPB have been used in numerous research studies over the past 35 years. A library search of the PsycINFO (psychology and psychosocial discipline) database yielded over 2500 research citations for the TRA and TPB, and a CINAHL (Cumulative Index to Nursing and Allied Health) search resulted in over 1000 research citations. Two reasons offered for the popular and wide-spread use of the TPB include clarity of concept definitions and the ability to explain strong relationships in predicting behavioral intention and follow-through of behavior.
In a meta-analysis, Sheeran (2002) reported an overall correlation between intention and behavior of 0.53, while another meta-analysis (Armitage & Conner, 2001) demonstrated that the TPB predicted 39% of variance in the intention and 27% of variance in behavior overall. The concept, PBC, independent of other variables, accounted for significant amounts of variance in both intention and behavior. In another study (Fife-Schaw, Sheeran, & Norman, 2007), the concepts of attitude, subjective norm, and PBC accounted for 30-50% of variance in intention, with the concepts of intention and PBC accounting for 20-30% of behavioral change. Another important finding of this study was that the predictors worked synergistically, rather than simply in an additive manner. This finding suggests that the most effective interventions target several of the applicable concepts within the TPB.

In a nursing study using the TPB to predict intention to exercise in 92 obese adults, the TPB explained 66% of the variance in physical activity intention, with PBC and attitude standing out as independent and significant predictors of intention to perform healthy behavior. Past behavior related to physical activity explained an additional 7% of the variance (Boudreau & Godin, 2007).

While people do not always perform the behavior they intend to perform because of a change in attitude, social support, or other factors causing an impediment in voluntary control of the situation, the TPB states that the level of behavioral intention will predict planned behavior performance to a large degree (Ajzen, et al., 2007). In an attempt to determine consistency in a desired behavior, Ajzen (2002) also considered the residual effects of past behavior on behavioral intention and behavioral performance, and argues that if intention and PBC stay constant, behavior will continue. If, however, there is a change within the background factors or major concepts (attitudes, beliefs, subjective norm, intention, or PBC), behavior consistency also changes. Similar findings have been noted in predicting on-going behavior - if a predictive measure changes, the behavior may wax or wane accordingly (Ajzen, Brown, & Carvajal, 2004; Ajzen, et al., 2007). It is important, therefore, to monitor and assist clients to continue healthy actions over time.

Nursing Research using the TPB

Numerous nursing studies have used the TPB as their theoretical base. These have included studies measuring nurse attitudes and beliefs, nursing practice behaviors, and for use in the development of patient/client interventions. The TPB has also been used in cross-cultural nursing studies.

Examples of studies exploring nurse attitude and nursing care intentions have included: obstetric nurse care intentions with HIV-positive women (Tyer-Viola, 2007); nurse intentions to follow clinical guidelines in offering a smoking cessation intervention to patients with heart disease (Puffer & Rashidian, 2004); nursing attitudes and beliefs regarding pain management (Young, Horton, & Davidhizer, 2006); integration of tobacco cessation content into an advanced
practice nursing curriculum (Heath & Crowell, 2007); and intention to use physical restraints on elderly patients (Werner & Mendelsson, 2001). All of these studies showed significant correlations among attitudes, beliefs, and intentions to perform specific nursing behaviors.

Studies relating specifically to nursing behaviors have included: adherence to hand hygiene recommendations (O'Boyle, Henly, & Larson, 2001); adherence to pediatric fever management guidelines (Edwards, et. al, 2007); implementation of a community tobacco use prevention and cessation program (Tingen, et. al, 2006); and measuring the effects of nursing interventions on lipid levels in a community-based program (Jairath, Culpepper, Long, & Murtagh, 2002). In these studies, the inclusion of knowledge-based content, and exploration and interventions targeting attitudes, beliefs, and social norming processes increased both behavioral intention and actual behavior.

Poss (2001) also found that the TRA/TPB is well suited for cross-cultural studies because the subjective norm concept - the influence of friends, family, and society on behavior- adds cultural congruence and relevance. This is due, in part, to Ajzen’s and Fishbein’s (1980) recommendation that the research instrument be based on an exploratory study of the participants’ behavioral and normative beliefs. Other cross-cultural nursing studies using the TPB include: the intention of married Jordanian women to use oral contraceptives (Kridli & Newton, 2005); Taiwanese nurses’ intentions to report child abuse to authorities (Feng & Yow-Wu, 2005); and exploration of background factors affecting the intentions of critical care nurses to provide culturally-congruent care to Arab Muslims (Marrone, 2008).

Creating a Derived Nursing Theory using the TPB

While the TPB can be used to describe and predict health-related behavior, the global concepts of person, environment, health, and nursing are not specifically addressed within this theory. This is the major area where the TPB requires an infusion of substantive nursing development before it can be effectively used as a shared, rather than borrowed, theory.

Using the TPB, nurses can assist in designing interventions for clients which are focused on the development of positive perception of behavioral control, and assist in the removal of barriers which inhibit behavioral performance. However, the theory lacks depth for those situations requiring nursing knowledge to guide nursing practice or research. For example, if perceived behavioral control is severely impaired, the theory provides no direction for nursing intervention or remedy.

Ajzen (2005) states, however, that clarification of attitudes, subjective norms, and the perception of control in performance of an action will result in an increase in behavioral intention. First, addressing incongruent attitudes and perceived social constraints and lack of control will motivate people to make the desired change. Exploration of beliefs held by the individual or group provides the nurse investigator with insight into the attitudes, subjective
norms, and perception of behavioral control. Once beliefs are examined, interventions to improve or change beliefs in order to effect desired changes in health action can be developed.

Promoting Healthy Actions and Praxis

Chinn and Kramer (2008) encourage integrating theory and knowledge in nursing through a process of *emancipatory knowing*, which includes the integration of social and political context in the provision of nursing care. The actual process of emancipatory knowing is *praxis*. Through on-going critical reflection and discussion, nurses are able to derive knowledge, make sound judgements, and take justifiable actions to improve health status for their clients/patients. Critical praxis occurs when nurses “recognize conditions that unjustly limit abilities and experiences, reflect on the situation with growing realization that things could be different, and take action to change the circumstances” (Chinn & Kramer, 2008, p.5).

An exciting development has been the integration of the process of praxis into a nursing curriculum. The Linfield-Good Samaritan School of Nursing in Portland, Oregon has developed the undergraduate nursing curriculum based on a praxis model. Within this practice model, praxis is defined as “thoughtful action- the kind of action that brings elements of intention, mindfulness and critical thinking into nursing practice” (Linfield-Good Samaritan School of Nursing, 2003, p. 1). The Linfield-Good Samaritan Model of Nursing Practice (2003) contains three major categories: engaging and connecting, searching and analyzing and reflecting and responding.

While, by definition, praxis is individualized based on the nurse, the client, and the context, this praxis model can be used as a guide to engage in the nursing process. For example, while *engaging and connecting*, the nurse and client enter the relationship with their own background factors, including past experiences, cultural and social influences, and attitudes and assumptions about self and others. The relationship forged between the nurse and client in this first step will directly influence the nursing process and healthy action outcomes. The nurse must take care not to interject personal assumptions and values into the interaction.

During the *searching and analyzing* process, the nurse gathers data on the client (individual, group, community, organization, or societal area under study). Based on the context of nursing research or practice, the nurse will employ thinking processes and analysis- in collaboration with the client- to determine client beliefs and attitudes about behavior; social norms or beliefs, social support and available resources to perform behavior; and the client’s perceived level of behavioral control. Nursing praxis may be communicated through a series of informal interactions in the provision of nursing care, or may extend to a formalized, quantitative research process with carefully developed assessment tools and statistical analysis.

The final area of praxis, *reflecting and responding*, is an assessment of what healthy actions are indicated, what barriers or sources of support are present, how much control does the
client have over the planned behavior, and how strong is the intention to perform the behavior. An analysis of the ability to perform the planned behavior and necessary revisions in the control, intention, and implementation of healthy action will be assessed at this juncture.

From: University Press, p. 135. Copyright 2005 by Icek Ajzen, and Model of Nursing Practice, 2003, Portland, OR: Linfield-Good Samaritan School of Nursing

**Figure 2.** Synthesis of Ajzen’s TPB and the Linfield-Good Samaritan nursing praxis model.

**Implementation Intentions**

Once a positive behavioral intention is developed through the praxis process, obstacles or impediments can be explored and removed, and specific steps toward a goal can be identified to maximize the effectiveness of the intention to perform a healthy action. The initiation of goal-directed actions can be constructed through the development of *implementation intentions*, a process developed for effective goal achievement by Gollwitzer and Brandstatter (1997).

For example, if the client and nurse have identified the need to advance a healthy change process to reduce obesity risk, implementation intentions will include breaking down each goal into a series of small, measurable steps. The steps of change consist of a list of planned actions within a specific context and timeframe. An implementation intention is clearly stated: “To achieve X (the goal), I must perform Y 1, 2, 3 (steps of change)”. For example, the behavioral intention statement: “I will lose 20 pounds in 6 months” (X) can be broken down into multiple steps, such as: “This week, I will walk on the high school track field for 30 minutes daily from 5:30 to 6:00 pm” (Y1) and “This week, I will incorporate two fresh fruit servings (with breakfast and dinner) and three vegetable servings (with lunch and dinner) into my meal plan daily” (Y2). This explicitly stated plan of action, a series of “snapshots” that can be easily visualized, measured, and revised, will result in an increase in intention and successful performance of healthy actions.

**Conclusions and Implications**

Middle-range theories can be used to guide nursing practice, research and theory development. The PHA provides nursing with a pragmatic, yet powerful tool that can be used to assist clients in performing healthy lifestyle behaviors. The PHA can be used to assist the individual client to make healthy lifestyle changes, and can also be used to design strategies for community-wide health programs. The impetus to make a change (attitude), the influence of the community and significant others (subjective norm), and identification of barriers and difficulties that may undermine perceived behavioral control (PBC) can assist in increasing behavioral intention and performing positive health related change.

Using PHA, nurses can assist in designing interventions for clients which are focused on the development of a positive perception of behavioral control, and assist in the removal of barriers which inhibit behavioral performance. Once a positive behavioral intention is developed through the praxis process, specific steps toward a goal can be identified through the nurse/client
relationship to perform a health action. The initiation of goal-directed actions can be constructed through the development of implementation intentions.

PHA can be used in cross-cultural nursing care and research as well. It has been successfully used to develop nursing curriculums and community education programs. Additionally, research instruments can be developed using well-documented resources like the questionnaire construction manual by Francis, et al. (2004). In any nursing situation where planned behavioral change will improve health status, the PHA can be used as a tool to promote healthy change.

References


Chapter Two

Diffusion of Health Promotion: The Additive Effects of Combining Pender’s Health Promotion Model and the Diffusion of Innovations Model to Expand Adoption of Health Promotion Practices

Mark Siemon, RN, MPH, MSN

The Health Promotion Model (HPM) developed by Pender focuses on assisting individual behavior change through a process of examining an individual’s interaction with her/his environment and how these interactions influence distinct health behaviors (Pender, 2006). The Diffusion of Innovation Model (Diffusion) describes how new ideas or innovations are adopted by individuals and societies (Rogers, 2003). By extending Pender’s HPM to include concepts of Diffusion, the focus of the HPM will be expanded, and rates of adoption of health promotion activities by individuals will be increased as projected by the adoption S-curve. This paper describes the expanded HPM, the Health Promotion Diffusion Model (HPM+D), and how it can improve adoption of health promotion activities. This paper focuses on health behavior change among children. Health promotion activities adopted by children and adolescents may continue into adulthood, thereby decreasing rates of chronic disease in both children and adults.

Introduction

Pender first published her complete Health Promotion Model (HPM) in 1982 in her book Health Promotion in Nursing Practice. Pender developed the HPM to provide nurses with a model to increase health promotion activities, as opposed to more traditional disease prevention models (Pender, 1982). Health-promotion behaviors are influenced by the interaction of individuals and their environments. Individuals consciously engage in health promotion activities to prevent future disease and disability (Pender, 2006).

Diffusion of innovations models originated in the early twentieth century in European schools of anthropology (Center for Interactive Advertising, 1998). The Diffusion of Innovation Model (Diffusion) developed by Rogers (2003) demonstrates how the communication of an idea or practice is adopted through a social system over time. Diffusion has been used by a wide range of public health researchers to examine the adoption of health promotion programs by individuals, organizations, and communities (Lia-Hoagberg, Schaffer, & Strohschein, 1999; Pearcey & Draper, 1996; Olade, 2003). The purpose of this paper is to provide a brief description of the HPM and Diffusion, and to describe the combination of the two models into an expanded HPM, the Health Promotion Diffusion Model (HPM+D), with the hope of increasing the effectiveness of HPM in promoting healthy behaviors.
Health Promotion Model

Pender (2006) developed the HPM in response to what she saw as the increasing medical and disease orientation of the U.S. health care system and nursing’s changing role in health care. She proposed that health promotion should be a focus of nursing practice and education because it has been one of the primary goals of nursing throughout history (Pender, Barkauskas, Hayman, Rice, and Anderson, 1992).

The HPM is based on Social Cognitive Theory (SCT) and Expectancy Value Theory (McCullagh, 2009). The HPM was developed as a framework to help nurses understand the multiple factors that influence health behavior in individuals, and to provide a guide to assist nurses with health promotion strategies on an individual level (Pender, 2006). The concepts of the HPM are divided into three areas: 1. Individual characteristics and experiences, 2. Behavior-specific cognition and affect, and 3. Behavioral outcome. The concepts of individual characteristics, behavior-specific cognition and affect, and behavioral outcome are outlined in a linear fashion in the model, but individuals do not necessarily adopt health promotion practices in a linear fashion. The movement of individuals through the model is more of a cyclical or back and forth process, rather than moving smoothly from one stage to the next (Pender, 2006).

The relationship in HPM between individuals and their environment is proposed as a bi-directional relationship whereby individuals are impacted by their environment and they also impact the environment. This interaction between individuals and their environment is also used in the Diffusion Model to promote change or adoption of new ideas by individuals and societies (Rogers, 2003).

Diffusion of Innovation

The Diffusion of Innovations Model describes how new ideas or products are accepted by populations (Rogers, 2003). Rogers describes the diffusion process as social change initiated by the communications about new ideas. Roger’s early work was in the adoption of novel agricultural practices in the middle of the twentieth century. During that time new seed varieties were being developed and new agricultural practices were being promoted as part of the green revolution. Rogers was intrigued by the fact that some mid-western farmers adopted these new agricultural techniques quickly, early adopters, while others took longer to adopt, late adopters, and some farmers never adopted these new practices, laggards (Rogers, 2003).

Since the early work with agricultural technology, the Diffusion of Innovations Model has been used to describe the adoption of new technology and new ideas in many disciplines including: business, public health, and behavioral sciences (Rogers & Scott, 1997). The application of the model has been shown to improve the adoption of HIV prevention programs and evidenced-based nursing practice, as well as to explain why some innovations in healthcare have not been adopted (Lia-Hoagberg, Schaffer, & Strohschein, 1999; Pearcey & Draper, 1996; Rogers, 2003).
The diffusion of new ideas causes social change, which leads to changes in social structure and how social systems function (Rogers, 2003). There are five key elements of innovations: (1) Relative advantage (2) Compatibility (3) Complexity (4) Trialability (5) Observability (Rogers, 2003). Relative advantage relates to how the innovation is perceived and whether or not it is perceived as an improvement over current technology. Compatibility describes how closely the new technology or idea relates to the values and experiences of individuals. Complexity refers to how difficult the new technology or idea is to understand and use. Trialability refers to whether the new idea of technology can be tried out by potential adopters. Observability refers to whether the innovation can be seen by others.

The type of communication channel that is used to introduce the innovation is also important. Homophily is the degree to which two individuals are similar culturally, linguistically, and socially. The greater the similarities between individuals, the more effective the communication and the more likely innovations will be adopted (Rogers, 2003). The variables for the Diffusion Model are shown in Figure 1.

**Figure 1.** Variables in Determining the Adoption Rate of Innovations (Rogers, 2003, p. 222)

The rate at which innovations are adopted by a society has been shown to follow an S-shaped adoption curve (Rogers, 2003). When a critical mass of individuals in a society has adopted an innovation the rate of adoption increases quickly. The Diffusion Model has
demonstrated that once 10 to 25 percent of the population adopts the innovation, the rate of adoption accelerates as more and more people adopt the new innovation as shown in Figure 2 (Rogers, 2003). The goal of combining HPM and Diffusion (HPM+D) is to increase the number of early adopters of health promotion activities and thereby decreasing the time necessary to reach a critical mass of individuals who have adopted health promotion activities.

Health Promotion Diffusion Model 30/30 for own innovations/extension of previous model

The HPM+D would increase the likelihood that individuals will adopt health promotion behaviors through the additive effect of HPM and Diffusion. The HPM+D uses concepts from HPM to influence individual behavior change, and then maximize the effect of these individual behavior changes by working to influence other members of the community or social group to adopt similar health promotion practices.

Figure 2. Rate of Adoption S-Shaped Curve (Rogers, 2003, p. 11).

The key to increasing the number of early adopters through HPM+D relies on the interaction of HPM concepts of interpersonal influences and concepts of Diffusion including: relative advantage, compatibility, complexity, trialability, and observability, to increase HPM’s influence on other individuals. Nurses who assist individuals adopt health promoting behaviors need to also consider how these individual behavior changes can be used to increase the
effectiveness of HPM with other individuals within the same social and peer groups. The proposed relationships between the HPM and Diffusion in the DHPM are shown in Figure 3.

**Figure 3. Proposed Diffusion of Health Promotion Model**

HPM and Diffusion borrow concepts as from Social Cognitive Theory (SCT) in helping to explain behavior change in individuals. One of the principle concepts of both SCT and HPM is self-efficacy, the belief that individuals have in their ability to perform an action or activity (Bandura, 2000). An individual’s perception of self-efficacy is influenced by observation of others participating in the activity and social persuasion (Bandura, 2000), both of which are principle concepts of Diffusion. Rogers (2003) writes “The central idea of SCT is that one individual learns from another by means of observational modeling” (p. 343). Individuals who can observe health promotion behaviors (observability) that others who are similar to themselves (homophily) are engaged in are more likely to be persuaded into trying (trialability) the health promotion activity. The additive effect of HPM+D on individual self-efficacy and the adoption of healthy behaviors are shown in Figure 4.
In this proposed theoretical model, as more individuals adopt health promoting behaviors influenced by trialability, observability, and persuasion, this has an additive effect on other individuals in the society, and they are more likely to adopt similar health promoting behaviors. When the number of individuals reaches the critical mass, the adoption of health promoting behaviors by other individuals “takes off” exponentially. Nurses and other health workers interested in increasing the number of individuals who practice health promoting behaviors should consider how these health promoting behaviors not only fit into concepts outlined by HPM but also by the concepts of Diffusion.

**Figure 4.** Additive Effects of HPM+D on Self-Efficacy and Adoption of Healthy Behaviors.

**Practical Applications of HPM+D**

**School-based Health Promotion**

The additive effect of HPM+D can be seen in school-based health promotion programs where the goal is to have as many children adopt healthy lifestyles as possible. According to HPM+D, the more children who adopt health-promoting behavior, the sooner a critical mass of students will be reached and the rate of adoption will be exponentially along an S-shaped adoption curve (Rogers, 2003).
Hand washing is an example of a basic health promotion activity that fits the concepts of HPM+D and is a critical component to decreasing the spread of communicable diseases. Hand washing is observable, trialable, and only moderately complex. The goal for nurses and other school staff is to try and increase the number of children who wash their hands regularly by increasing the observability, trialability, and communication of the behavior. For example, a school nurse may wish to demonstrate proper hand washing to children providing an opportunity for observation, and then have children wash their hands, an activity which focuses on trialability. Finally, school staff needs to develop effective communication channels among students/staff to persuade others to adopt the regular hand washing. One way to increase observability and trialability is to place waterless hand cleaner inside the classroom and encourage children to use the hand cleaner regularly. Alcohol based hand cleaners are more effective (Girou, Loyeau, Legrand, Oppein, Brun-Buisson, 2002), and more compatible with classroom environments as children do not have to leave the classroom to effectively wash their hands. Self-efficacy and adoption of hand washing could be easily reached by most children early in their school careers, and then reinforced regularly.

Other health promotion activities that are being promoted as part of comprehensive school health education, including increasing physical activity and improving nutrition, are more complex. Physical activities can be designed to be observable and trialable, but school staff members need to be aware of developmental differences (heterophily) among students. Insuring that physical activities are developmentally appropriate will increase the likelihood of mastery and thereby increase self-efficacy (Bandura, 2000; Garia, Norton-Broda, Frenn, Coviak, Pender, Ronis, 1995). Nutrition education can include hands-on learning demonstrations of healthy food preparation techniques, observability, along with the introduction of new food and trialability. Nutrition education must also extend out of the classroom environment to include school policies on vending machines and low nutrient food sales (Birnbaum, Lytle, Story, Perry, & Murray, 2002).

While schools provide an excellent location for HPM+D interventions targeting children for health promotion activities, if these interventions do not include parents and other environmental influences, (‘factors’ feels inanimate, in contrast to ‘parents’) they are less likely to lead to widespread adoption (Bandura, 2000). Children have only limited control over the foods that they eat at home, as it is usually the responsibility of the child’s parent or guardian to purchase and prepare meals. A child may learn how to prepare healthy meals at school, but unless other family members adopt these behaviors, then the child will not be able to engage in these healthy eating skills at home. Similarly, physical activity skills learned at school are less likely to be adopted by children if they are not able to practice these new skills because of a lack of recreation areas in their neighborhood or unsafe neighborhoods.

The HPM+D model expands on Pender’s original HPM, but its primary focus remains on changing health behaviors in individuals. The additive effect of Diffusion will be more difficult if environmental barriers to adoption of healthy lifestyles are not addressed. Pender’s revised HPM includes the concept of situational influences which include “aesthetic features of the
environment” (Pender, 1996, p. 71). Nurses, therefore, also need to move beyond the HPM+D to address larger societal and organizational issues to insure maximum effect of HPM+D.

**New Mexico Native American Soccer Project**

Soccer has grown in popularity in the United States over the past two decades, and the growth is especially strong among young children. In New Mexico many urban areas have youth soccer programs that provide opportunities for thousands of New Mexico children to participate in physical activity that promotes team work and increases physical health (Dohrmann, 2004). Unfortunately youth soccer has not diffused to more rural areas of New Mexico, and few Native American communities have youth soccer programs. The New Mexico Native American Soccer Project (NMNASP) was begun to try and introduce youth soccer program into Native American communities in New Mexico. In New Mexico, Native Americans are three times more likely to die from diabetes and are almost twice as likely to be obese when compared as non-Hispanic whites; Native American youth in New Mexico have the highest obesity rates of any racial and ethnic group (New Mexico Department of Health, 2007). The introduction of youth soccer into New Mexico Native American communities was seen as a way to promote healthy physical activities in children that may result in lower incidence of overweight and obesity among children and increased fitness levels.

According to the HPM+D, the introduction of youth soccer in Native American communities in New Mexico would need to achieve a critical mass of adopters, children who participate in soccer, in order for youth soccer to be adopted by the community. Soccer is not a complex sport, and therefore, children can learn the basics in one lesson. The NMNASP was developed to increase personal factors including children’s self-efficacy through regular soccer clinics that promoted trialability, observability, and lead more children into adopting or participating in youth soccer programs. In addition, parents were recruited to assist coaches, an action which increased interpersonal factors including social acceptance, the homophily, compatibility, and persuasion. Adult and peer role models that participate in health promotion activities help to establish community norms that provide support to children who adopt healthy lifestyles (Garia, et al., 1995).

While the NMNASP has been successful in some New Mexico Native American communities, it still has not reached a critical mass of youth participants that are required for accelerated adoption along the Diffusion S-curve. Southwest Youth Services (SYS) is a non-profit organization based in Albuquerque that was developed to partner with Native American communities to increase participation in youth soccer programs. It has worked on the development of youth soccer programs by providing youth soccer clinics and training Native Americans from rural communities to be youth soccer coaches (Southwest Youth Services, 2007). As more and more children are exposed to and allowed to participate in youth soccer programs the greater the likelihood that a critical mass of children will adopt youth soccer and other active lifestyles and lead to lower prevalence rates of obesity in New Mexico Native American children.
Conclusions and Implications

The Health Promotion Model was developed in response to the increasing biomedical focus of nursing practice. Unfortunately there have been few changes in the health care system since that time. The United States and the world are being challenged by western lifestyles that promote high calorie diets and low levels of physical activity, which have accelerated the rates of chronic diseases. However, funding for federal spending on health-promotion and disease prevention interventions and research remains a fraction of overall health care spending.

Nurses need to look beyond individual intervention to change health behavior to increase participation in health promotion activities. The Diffusion of Innovations Model looks at how new ideas are adopted by individuals and social systems. By combining the concepts of HPM and Diffusion into an expanded model of health promotion, HPM+D, nurses may be able to accelerate the adoption of health promotion activities among individuals and social groups, ultimately impacting health status of groups accustomed to disparity.

Nurses should emphasize health promotion among children and adolescents through school-based programs because they offer the best opportunity to promote behavior change prior to the development of sedentary behavior and other negative health practices (Garia, et al., 1995). School-based health promotion activities that are compatible with school environments, developmentally and culturally appropriate, observable, and trialable, are more likely to lead to adoption of health promotion activities by a critical mass of students and staff.

More also needs to be done to insure that successful school-based health promotion programs are adopted and implemented by schools. The Diffusion model can be used to improve the adoption of programs and services by schools through the use of change agents who are homophilus to and knowledgeable of the community (Roberts-Gray, Solomon, Gottlieb, & Kelsey, 1998).

The HPM+D can also be used to expand health promotion programs for adults. Adults’ decisions to adopt health promotion activities are also influenced by the variables outlined in the HPM+D model. Nurses working with adult clients need to be aware of the elements of diffusion such as observability, trialability, and compatibility, when helping adults make positive changes in behavior. In addition, the more adults that adopt healthy lifestyles, the greater the influence will be on children who see adults engaged in health promotion activities.


Chapter Three

Orlando’s Theory of the Dynamic Nurse-Patient Relationship and Clinically Inflicted Pain: A Coming Together of Theory and Research

Hanna Krieger, RN, MSN

This paper is intended to evaluate the phenomenon of clinically inflicted pain (CIP) under the auspices of Orlando’s nursing process theory. Significant aspects of CIP can be satisfactorily explained: CIP as a form of patients’ distress and nurse patient interaction (deliberate process versus automatic response). However, questions were raised that challenge some of the most basic assumptions of Orlando’s nursing process theory: the nurse patient interaction, definition of nursing, and the role of technical skills and experience.

Introduction, Overall Purpose, Rationale, Description

The purpose of this paper is to apply Orlando’s nursing process theory to the author’s phenomenon of interest, that of clinically inflicted pain (CIP), and present an extension or modification of Orlando’s theory. A brief overview of Orlando’s theory is presented first, including a graph depicting concepts of the theory. This section is followed by a brief description of the phenomenon of CIP. The author purposely presented a more general description, as CIP has not been conceptually defined. The author viewed the material with a focus on nurses and nursing. Madjar’s (1998) “Providing comfort and inflicting pain” served as the primary source for this section. Orlando and Madjar use different terminology, yet concepts such as “good nurses & good-but nurses,” therapeutic relationship, and the deliberate nursing process are quite similar phenomena. CIP can also be placed within the context of patients’ need for help and a source of patients’ distress. But differences emerged as well. Many of these differences stem from Orlando’s broad nature of her conceptual definitions or by explicitly excluding other aspects of a phenomenon (e.g., psychodynamics in the nurse patient interaction).

The paper proceeds into an exploration of how CIP affects nurses’ definition of nursing. Nurses, rather than helping patients, identified with technical skills associated with physicians and expressed loyalty to fellow nurses. The nurses’ definition of nursing is in stark opposition to core assumptions in Orlando’s nursing process theory. It is postulated that the different concept of nursing transforms Orlando’s assumption into a set of propositions to be tested.

Lastly Orlando deemphasized technical skill and experience. Schmieding clearly states that “The nurses mind is the intervening variable …” (p. 14) referring to the deliberate nursing process. What differentiates nurses (for Orlando) is foremost a mental exercise, that of engaging
with patients. It is postulated that skills and experience are prerequisites of the deliberate nursing process, and scholars such as Patricia Benner outlined the growth of nurses in her book *From Novice to Expert*

**Background/Historical Perspective, Context for Theory/Model Development**

The primary source of Orlando’s nursing process theory for the purpose of this paper is the *The Dynamic Nurse-Patient Relationship*, which was first published in 1961 and again in 1990 by the National League of Nursing. Orlando’s nursing process theory “was the result of an extensive personal study experience” (Orlando, 1972, p. 1) which Orlando later tested in a formal research study which lead to the publication of *The Discipline and Teaching of the Nursing Process* in 1972. Orlando differentiates between “good” and “bad” nursing, which she also describes in terms of “effectiveness” (Orlando 1990, p. VII). Effective nursing is constituted by the deliberate nursing process, a process designated to explore patients’ needs. Unmet patient needs will result in distress. In contrast, the automatic response is characterized by any response unrelated to patients’ needs. Both patient and nurse are viewed as people that are in a reciprocal relationship. When interacting, both patient and nurse react and the reaction in turn is composed of perception, thought, and feelings. An autonomic nursing action is a result of an un-reflected, unexplored nursing action based on initial responses; nurses assume knowledge about the nurse-patient encounter without verifying these reactions and/or assumptions with the patient. The graph below will display these basic ideas.

- **Function of professional nursing (ie, finding out and meeting the patient’s needs)**
- **Patient’s presenting behavior (ie, verbal, nonverbal)**
- **Nurse’s immediate reaction**
  - **Automatic responder**
    - Perceptions
    - Thoughts
    - Feelings
    - Action (without patient validation)
  - **Deliberative responder**
    - Perceptions
    - Thoughts
    - Feelings
    - Action (with patient validation using a deliberative process)
- **Deliberative nursing process**
  - Nurse verbalizes own observations to patient
  - Patient validates or invalidates nurse’s immediate reaction
  - Nurse plans intervention, based on patient validation
- **Product of nursing (improvement in patient behavior)**

The process of engaging with the patient (deliberate nursing action) and discovering what meaning a statement or behavior has for the patient will allow the nurse to respond to specific needs that are very often different from the nurse’s assumptions. The process of engaging and subsequent action to address the patient’s needs will result in some form of improvement (“to grow better, to turn to profit, to use to advantage” Orlando 1990, p. 7). The following two graphs are a depiction of Orlando’s theory of the deliberate nursing process. The graphs depict nurse patient interaction as a self-perpetuating cycle in which action triggers the perception-thought-feeling cascade. In the first graph, there is no resolution and patient needs remain unmet. In the second graph, which is identical to the first, resolution (meeting patients’ needs) is achieved through exploring the meaning of a given situation for the patient. The process itself remains unchanged. It is the level of engagement by the nurse, the deliberate nursing action, which will lead to improvement.
Orlando’s work understands nursing as a form of social behavior. “The purpose of nursing is to supply the help a patient requires in order for his needs to be met” (Orlando, 1990, p. 9). The deliberate nursing process is an exploration of the patient’s need(s) and may amount to a phenomenological study of each nurse patient encounter. Orlando defines “need [as] situally defined … a requirement of the patient, which, if supplied, relieves or diminishes his immediate distress or improves his immediate sense of adequacy or well-being” (Orlando, 1990, p. 6). This interaction may also be described in terms of a therapeutic relationship, yet Orlando did not utilize this terminology. O’Brien defines therapeutic relationship as “a negotiated, individualized, but frequently invisible involvement with clients” (O’Brien 2001, p. 134). The term therapeutic relationship is more commonly associated with other nursing theorists such as Hildegard Peplau and Joyce Travelbee (O’Brien, 2001). Madjar (1998) utilizes the term “therapeutic relationship” to denote the difference between “good nurses” and “good-but nurses“ (p. 98 & p. 100). Madjar’s descriptions of “good nurses” and “good-but nurses”- despite different verbiage - are quite similar to that of Orlando.

Clinically Inflicted Pain (CIP) and Orlando’s Theory

Irena Madjar (1998) explored “pain resulting from medically prescribed procedure(s), which are often carried out by nurses as part of their everyday work” (p. VII). Madjar labels this phenomenon *clinically inflicted pain* (CIP). This phenomenon, despite its common occurrence, has received little attention in scholarly inquiry. Nagy (1994) differentiates between two types of pain:

The first type of pain is the consequence of either the disease itself or of treatment conducted by health professionals other than nurses (e.g. from surgical procedures)... this type of pain has been termed disorder-induced pain (p.25) ... The second type is the pain that is the consequence of the painful investigative and a therapeutic procedure conducted by nurses and is termed "clinically inflicted pain.” (p. 26).

Madjar (1998) studied patients and nurses on a burn unit and in an oncology clinic. The patients on the burn unit categorized nurses broadly into the “good nurses” and the “good-but nurses.” Patients described the “good nurses” as nurses that could “be trusted to not only perform the necessary procedure with skill and technical expertise, but to act with sensitivity and awareness of the impact of their actions” (p. 98) while the “good-but nurse … [were] perceived as capable … [and] lack[ing] the qualities of the truly good nurse” (p. 100). The difference between “the good” versus “the good-but nurse” is defined primarily by a lack of qualities, not by something entirely different. Madjar uses the term therapeutic relationship to further describe the good nurses who “work closely with the patient … would begin by explaining to the patient what the procedure would involve, listening to patient’s fears and concerns, discussing how the patient might participate in retaining significant control in the situation … monitor the patients’ responses closely … Madjar concludes that “The nurse-patient partnership depended on the
nurse willingness to become involved in the patient's subjective experience and on her skills in helping the patient share with her the lived experience ...” (p. 145-146). Madjar further describes the difference with words such as “sensitivity” and “expertise” (p. 147) ... “anxiety associated with painful procedures was transformed, when the voice of the person in pain could be heard” (p. 149). Madjar places the therapeutic relationship within the Patricia Benner’s work as “caring action” and an example of “expert nurse” (p. 161). Therapeutic relationship “depended on the nurse willingness to become involved in the patient’s subjective experience and on her skills in helping the patient share with her the lived experience ...” (p. 146).

Madjar and Orlando both noted a difference in nursing action, both polarize this difference with quality labels such as “good” and “good-but nurse.” While Madjar called the interaction a therapeutic relationship, Orlando used the terms effective or deliberate nursing action, the similarities of ideas are striking and assumed to describe the same phenomenon of an effective nursing intervention (action) that was perceived as beneficial by patients.

Similarly the “good-but nurse” behavior is captured to some degree by Orlando’s definition of the autonomic response. Madjar’s verbiage again is quite different from Orlando’s. Madjar (1998) describes “Strategies of detachment and objectification, the nurse becomes self-rather than patient-focused ... nurses] regard the patient as an object on whom skilled work was done [rather] than as a person with whom a difficult experience could be shared ... nurses] could not acknowledge patient’s distress nor provide comfort when it was most needed” (p. 149). Madjar places the “good-but nurses” within the specific context of strategic responses to pain infliction (p.145). Scmieding (1993) identified one of Orlando’s (1990) assumptions as “Nurses are responsible for helping patients avoid or alleviate distress” (p. 14). Anything short of alleviating patients’ distress is considered “automatic.” Orlando (1990) defines “automatic activities [as] those decided upon for reasons other than the patient’s immediate need(s). Some ... are ordered by the doctor; others are concerned with routines of caring for patients, and still others are based on principles pertinent to protecting and fostering the health of people in general” (p. 62) “doctor’s orders, health principles, policies, and so on” (p. 64). The terminology used by Madjar and Orlando again is quite different. For Madjar it is a strategic response to pain infliction, while Orlando’s definition is quite general. Yet both definitions are felt to be alike in the exclusion of patients as partners in the nurse patient interaction.

CIP a form of patient distress

“A phenomenon is not a thing in itself; it is not what exists, but rather it is organized through perceptions. ... A phenomenon remains merely a phenomenon as long as we attach no cognitive, intuitive, or inferential interpretation” (Meleis, 2005, p. 216). CIP looked upon as a phenomenon, a thing itself, does not carry meaning. CIP placed within the context of Orlando’s theory can be defined as a source of patient’s distress. Given Meleis’ definition of theory, Orlando’s theory therefore can “describe, explain, predict, or prescribe [a] response related to the discipline’s phenomenon” (Orlando, 1990, p. 12). CIP not only becomes defined as a source of patient distress, but the deliberate nursing process (or therapeutic relationship) is also
an effective means to alleviate the distress of CIP. This delineates a process Meleis (2005) calls the theory-practice-theory strategy.

Critique of Orlando’s Theory

The nurse patient interaction

CIP sharply illuminates a shadow side of nursing, that of “inflicting pain” (Madjar, 1998). While some aspects of CIP can be explained by Orlando’s theory as shown above, other aspects of CIP cannot. The medical encounter or for the purposes of this paper, the nurse patient interaction, does not happen in a vacuum. Shatell (2004) noted that issues such as power, the social and cultural context, and interpersonal competence are important for the quality of nurse–patient interaction. Shatell found that nurses exert power over patients. Aveyard (2002) raised concerns regarding nursing procedures, particularly informed consent, obedience, and endurance. Aveyard noted that nurses do not obtain formal or real informed consent from patients prior to nursing interventions; nurses claim that patients’ consent is implied. Aveyard (2002) found that implied consent signifies different things to different nurses, and, furthermore, nurses confuse implied consent with compliance. Compliance entails “submitting to the plan of another, while consent requires an active authorization” (Aveyard, 2002, p. 205). Aveyard noted that many nursing interventions are carried out following minimal or no explanation, which violates one of the most basic principles of consent: providing information. Madjar (1998) refers to social norms within a hospital. The nurse patient interaction is subject to a formative environment that extends beyond the personal interaction between nurse and patient.

Orlando (2002) acknowledges other components in the nurse patient interaction, which she labels “psychodynamics”. Orlando addresses the complexity of the nurse patient interaction by exclusion, stating that “The psychodynamics of the [nurse-patient] relationship are exceedingly complex and for this reason the material was not analyzed from that point of view” (p. 73). This exclusion amounts at a minimum to a significant gap in one of the key concepts in Orlando’s theory, or could even challenge Orlando’s theory at its core. What (really) happens in the nurse patient interaction? Even so Schmieding (1993) states “A nurse’s action is improved through self-reflection” (p. 15), and the complexity of the nurse patient interaction extends beyond the personal.

CIP Challenges Nurses to Define Nursing for Themselves

Nursing for Orlando is primarily a form of social behavior--that of helping patients. Madjar defines nursing only within the context of pain and suffering, and adopts Benner’s & Wrubel’s (1989) model of the “primacy of caring.” Inflicting pain is difficult for nurses. Nurses “came away from such situations [dressing changes = inflicting pain] feeling uptight, not nice, mean, or cruel” (Wrubel, 1989, p. 122). Inflicting pain is a problematic for nurses and patients alike. CIP challenges nurses and nursing at its core.

CIP “creates a breach not only between the nurse and the patient, but also between the nurse as a person and her being-in-the-world. To inflict pain on a daily basis and train
oneself to feel nothing of the other’s pain is to be diminished as a person; it is to compromise one’s own sense of wholeness and moral responsibility and one’s commitment to the centrality of caring in the nursing practice and for the nurses themselves, and they are too important to be left to individual nurses to struggle with in the privacy of their consciences” (Madjar, 1998, p. 161).

Madjar address this dilemma within her chapter “Strategic Responses to Pain Infliction”. Orlando does not address how nurses cope with stressful situations such as CIP. Nurses are left to discover meaning on their own.

Madjar’s analysis “found the infliction of pain [is] stressful [for nurses], while at the same time they [nurses] found a great deal of satisfaction in the performance of the procedure … nurses felt that they were given genuine responsibility and were trusted to make judgments in relation to patient care … [nurses] enjoyed the technical aspects of their work … success was credited to the nurses skill and technical expertise” (Madjar, 1998, p. 120).

Nurses in the burn unit identified with technical skills and formed an alliance with physicians that is in stark opposition to Orlando’s definition of nursing. Nursing for Orlando is (1) separate from other disciplines, (2) nursing has a distinct function and product outcome – the focus is on the patient’s immediate experience, (3) nursing is aligned with medicine (Schmieding 1993). Orlando emphasizes that medical orders are for and directed to patients and nurses assist patients to follow these orders. Nurses clearly expressed a different understanding of their role and alliances. Nurses did not identify with helping patients or with the deliberate nursing process; a patch of skin resembled/represented the nurses’ commitment, and the patient became secondary for nurses in the burn unit.

“Nurse: …how is ‘my’ skin doing …Patient: ” I wouldn’t mind, so long, as you remember that I am quite attached to it myself”… rather than responding to the lived experience of the patient, the nurse’s concern was with the meaning the pain had for her” (Orlando, 1990, p. 121).

Similarly, nurses in the oncology clinic were considered careful about venepunctures. “Each nurse was concerned not to be the one who causes local tissue damage and made the job more difficult for the next person” (Orlando, 1990, p. 127) or “nurses were also extremely vigilant with chemotherapy … the awareness that the resulting tissue damage could be extensive and that the nurses reputation might suffer as the result … there was no indication that the resulting pain for the patient was a significant concern ”… “their [nurses] satisfaction came from being part of medical therapy” (Orlando, 1990, p. 127).

Nurses’ identification with technical skill and loyalties toward physicians and fellow nurses challenges one of the most basic assumption of Orlando’s theory, that of ‘nursing is helping patients’. Nurses’ identification with technical skill and loyalties in which the patient is objectified transforms Orlando’s assumption about nursing into a proposition to be tested.
Skills

In the above section nurses identified with technical skill. Orlando’s distinction between lay and professional nurses is a distinction between being able to “identify both the cause of the distress and the individual help required to relieve the distress, and designs the activity to meet the need of help” (Schmieding, 1993, p. 11). Orlando (1990) uses many examples in her book *The Dynamic Nurse-Patient Relationship*; in many of her examples, it is the experienced nurse who is deliberate. The author here postulates that it is exactly the experience and technical competency that allows the nurse to engage in the deliberate process. It is experience that allows the nurse to go beyond the obvious, it allows for the recognition that something else is the problem. Here is one of Orlando’s examples:

“A patient refuses to do postural drainage … (nurse) “can you tell me why you won’t do it? … [patient gives graphic account why procedure is difficult] … the nurse then said, “it certainly makes sense not to do it that way … I know of a different position” (Orlando, 1990, p. 87-88).

Skills and experience are essential components of competence for nurses. Orlando does not address skills and experience, in fact Orlando may even de-emphasize skill and experience. Schmieding (1993) notes, “The nurse’s mind is the major tool for helping patients” (p…?). Scholars such as Patricia Benner (1994 theorized the “growth” or development of nurses in her book *From Novice to Expert: Excellence and Power in Nursing*. Brykczynski (2002) described *Novice* with the following critique: “There is difficulty discerning between relevant and irrelevant aspects of a situation” (p. 171) as opposed to the expert “(1) a clinical grasp and resource-based practice, (2) embodied know-how, (3) seeing the big picture, and (4) seeing the unexpected” (p. 172).

Conclusions and Implications

The author actually attempted to utilize a conceptualization of CIP to test Orlando’s theory, yet discovered that Orlando’s theory is so broad that it cannot be tested unless broken down into particular (or specific) concepts. The nurse-patient encounter (or interactions) is just that. Unfortunately, Orlando failed to examine the nurse patient encounter beyond what she conceptualized in her nursing process theory. Orlando noted “psychodynamics” and explained that this is a rather complex phenomenon. The author only could point to some of the complexities involved in nurse patient interaction, particularly in regard to nursing procedures, which in Madjar’s study are the primary source of pain for the burn patient. Patients described the subsequent treatment as more painful than the initial injury!

CIP challenges nurses to define nursing. Nurses’ strong identification with skill and association with medicine (doctors - physicians) challenges Orlando’s assumptions about nursing. Orlando’s view of nursing is very unique in a couple of different ways: (1) nursing is a form of social behavior, (2) nursing has a distinct product – “this distinct product is something the patient cannot produce alone or get from anyone else who is not trained to practice
professional nursing” (Schmieding 1993, p. 11). The author herself is challenged to define nursing.

What follows is a graphic display of the authors uneasiness associated with CIP.

Figure 1. Penguin cartoon. Reprinted from http://images.google.com/images?q=farside&svnum=10&hl=en&lr=&start=20&sa=N

Figure 1 illustrates how definitions (predominant views or common understandings) affect how we perceive the world. The penguins see only penguins. The polar bear wearing a beak matches the penguins’ definition of a penguin, and therefore the polar bear is a penguin (invisible). However, the penguins suffer consequences, and the loss of yet another penguin brings this “something” into focus. The author views clinically inflicted pain as another disguised polar bear.

For the purpose of paper: extension and modification of Orlando’s nursing process theory for application to CIP, skill and experience are certainly the strongest argument for an extension/ modification of Orlando’s theory. Skill and experience are of critical importance and a prerequisite for the deliberated nursing process.
References


Chapter Four
Self-Transcendence and Expanding Consciousness
Melanie Mayo, RN, MSN, FNP-BC, AHPN

Reed’s middle range theory of self-transcendence is derived from developmental psychology theories and Rogers’ science of unitary beings. The theory proposes that humans, when in a vulnerable state, can expand their conceptual boundaries through interpersonal, intrapersonal and temporal means and move towards a characteristic of developmental maturity called self-transcendence. Self-transcendence theory is critiqued leading to its extension, first situating it within Newman’s construct of health as expanding consciousness, and secondly super-imposing a proposed trajectory of movement from tight self-boundaries to expansion of the self as the essence of self transcendence, and giving examples of interventions to promote that process.

Introduction and Purpose

The purpose of this paper is two fold. One is to support the importance of Reed’s work on spirituality and transcendence with the dying, elderly, depressed and homeless, within the context of nursing theory and the meta-paradigm of nurse/patient relationship to human/environment interaction. The second purpose is to identify areas of Reed’s theory which can be expanded, and offer a reformulation emphasizing the existential nature of self-transcendence. Movement of the self towards expanding consciousness is an iterative, reflective non-linear process with multiple points for nursing intervention. Reed’s (1991a, 1991b, 2003), (Runquist & Reed, 2007) theory of self-transcendence is an abstract explanation of the nature of human being and becoming in response to vulnerability. The theory describes the phenomenon of self-transcendence as a healing process of improved sense of well-being resulting from the expansion of self boundaries. It has evolved over time with the relationship of self-transcendence and well-being supported by quantitative and qualitative research.

Newman’s (1994) theory of health as evolving consciousness suggests that the movement of self towards true freedom is a gradual one of differentiation, first as a distinction from physical restriction, then environmental constraint and ultimately from differentiation itself—resulting in pure consciousness. The path of the self towards health as expanding consciousness and self-transcendence is a reflexive and iterative route involving the constant interplay of self with the social environment (Giddens, 1991). An exploration into this process leads to suggestions for nursing interventions to promote self-transcendence.

This paper is organized according to the following order: background and historical perspective, evolution of self-transcendence theory with literature review, analysis and critique, reformulation, health as expanding consciousness, and conclusions and implications.
Background and Historical Perspective

Although a term new to nursing, Reed (1991a) points out that Frankl, Maslow and Erikson all used the term “transcendence” in their work. Reed started work on this phenomenon at a time when there was little evidence of it in nursing literature. A CINAHL search using the search word “self-transcendence”, limiting the date to 1990 yields 6 results, 4 of which are PhD dissertations. Reed (1991) sees transcendence as an aspect of spirituality. Spirituality has been integral to nursing in terms of health and holism since Florence Nightingale (Malinski, 2002). Historically, much of Reed’s work was done at a time when modernist philosophy influenced nursing’s epistemology, driving a more empirical type of inquiry (Reed, 1991a).

Evolution of Theory and Literature Review

Reed’s (1983) early work presented adult development as a progressive process (life span development) involving choices, or trade-offs in the move between phases. She noted that as humans age, “…solutions to problems become less egocentric, absolutist, and idealistic… and is instead more pragmatic and accepting of the relativity in life experiences” (p. 22). The process of developing this outlook on life became her phenomenon of interest.

Reed (1986a) investigated religiousness as a self care strategy during the end of life. She compared a terminally ill group to a healthy group with similar demographics to determine differences related to well being and religiousness. Her results indicated a correlation between age and sense of well –being regardless of health status. In addition she found increased religiosity in the terminally ill, but no association of well-being and religiosity in this group compared to the well, as measured by the Religious Perspective scale (Reed, 1986a). She felt this might be related to the conceptualization of religiousness— that possibly less focus on organized religion and more emphasis on the personal experience of religion would move toward the phenomenon that had demonstrated the association with well-being. She re-conceptualized this from religiosity to spirituality.

Reed (1986b) then looked at the connection between depression and developmental resources in the elderly using the Developmental Resources of Later Adulthood Scale (DRLA) in a longitudinal study comparing depressed and mentally healthy older adults. The DRLA scale consists of 36 items that include “…ability to transcend limitations of the present situation, share one’s wisdom, accept ones past-present-future and achieve a sense of physical integrity” (Reed, 1986b, p. 369). The results suggested a preventive role of developmental resources in relation to depression. Reed (1989) studied mental health of older adults. In this work she talked about the use of cluster analysis to determine to what degree different resources measured with this scale could explain the variance between mentally healthy and depressed adults. Transcendence emerged as a factor representing activities and outlook used by older adults to expand their personal boundaries as they engaged with their community “sharing wisdom and experience and finding spiritual meaning” (p.149).
Reed (1987) found that a move towards increased spiritual perspective occurred among the terminally ill when compared to the well adults. She writes that spirituality “derives from the broader concept of transcendence… defined as a level of awareness that exceeds ordinary physical boundaries and limitations” (p. 335).

Reed identified self-transcendence as a developmental resource of aging (1991a). She found 4 patterns of self-transcendence: generativity, introjectivity, temporal integration and body transcendence that were positively associated with mental health in a mixed methods study of 80-97 year olds.

Analysis and Critique

Fawcett’s (2005) framework for analysis and evaluation of nursing theories consists of 3 steps for analysis and 6 steps for evaluation.

Analysis

Step 1: Theory Scope

Self-transcendence theory is a middle range theory developed to explain a health protective phenomenon characteristic of human response to a sense of vulnerability. Initially this was those facing death, later the theory was expanded to any perceived vulnerability. The theory began descriptively noting a relationship between well being and developmental factors in the elderly and progressed to explanatory. It is not predictive or prescriptive and offers no specific nursing actions, although points for intervention are indicated.

Step 2: Theory Context

The self-transcendence theory is grounded in Martha Rogers Science of unitary human beings (Reed, 1991). Rogers (1990) writes, “… evolution of life… is a dynamic, irreducible, non-linear process characterized by increasing complexification of energy field patterning” “…unitary human health signifies an irreducible human field manifestation” (p. 8). Self-transcendence theory thus deals with the patterns of the human environment energy field. Developmental psychology was an adjunctive discipline informing the theory. Self-transcendence theory sees later life not as static or decremental but progressive in awareness and interaction with environment.

Reed incorporated psychological theories of developmental maturity in later adulthood with Rogerian concepts of homeodynamics. Homeodynamics (Rogers, 1990) is the expression of change within the human field by integrality, helicy and resonancy. Integrality refers to the nature of the human field which is continuous with the environment. Consistent with this is the life span view that change is a blend of human with context. Helicy is the continuous change, revision and increasing complexity of the human field. Looking at life span theory from a non linear perspective the phenomenon of self- transcendence does not follow a chronologic dimension, thus the awareness of impending death can result in the same move towards self-transcendence as does the awareness of inevitable death from old age. Resonancy is the
movement from lower to higher frequency rhythms moving through the multidimensional human field (Rogers, 1990). Reed sees this as the process of self-transcendence where self-imposed boundaries of the self are dissipated as the human field blends with the environment. Reed (1991) writes “…a person can step beyond and redefine traditional spatio-temporal boundaries of the ‘physical’ body” (p. 70). Revision of developmental theory through the Rogerian outlook lead to a refined definition of self-transcendence: “…expansion of self-bounds multi-dimensionally: inwardly (e.g. through introspective experiences), outwardly (e.g. by reaching out to others) and temporally (whereby past and future are integrated into the present)” (Reed, 1991, p. 71). This lead to the theoretical proposition that self-transcendence, the expansion of self boundaries, is positively related to a sense of well being. In addition self-transcendence was seen as a Rogerian pattern response to an awareness of ones mortality such as terminal illness or aging.

**Step 3: Theory content.** (See Figure 1.)

**Figure 1. Model of Reed’s Self Transcendence Theory (From Reed, 2003).**

Initially two basic concepts were involved: self-transcendence and well-being. Reed, (2003) later added the concepts of vulnerability, moderating/mediating factors and points of intervention. Self-transcendence (Reed, 1991) is “expansion of self conceptual boundaries multi-dimensionally: inwardly…outwardly…and temporally” (p. 71). Well-being is conceived of as mental health (Reed, 1991) and later more specifically, (Runquist & Reed, 2007) as “current or existential life satisfaction in terms of both cognitive and affective dimensions of general well-being” (p. 9). Vulnerability is one’s awareness of personal mortality “…an experience that can result either in compromised well-being (when coping strategies are insufficient) or enhanced well-being when strategies such as integrating and connecting are transformative.” (Runquist & Reed, 2007, p. 6). Moderating/mediating factors include age, gender, cognitive ability, life experiences spiritual perspectives, social environment and historical events (Reed, 2003). Points of intervention are perceived areas of the model where nursing interventions can take place. The theoretical propositions linking the concepts are: 1. Self transcendence is positively related to well being, 2. Personal and contextual factors that mediate or moderate relationships effect the development of self transcenende in relation to vulnerability (relational, non-directional). 3. Increased vulnerability is positively related to self transcendence. 4. Nursing interventions focus on a person’s inner process of self- transcendence or on the personal and contextual factors that mediate/moderate relationships.

**Evaluation**

**Step 1: Significance.**

Reed explicitly describes the deductive reformulation of developmental theories within Martha Rogers’s paradigm. Reed herself is a noted scholar. This middle range theory has
connected concepts and suggested ways of supporting a human response to vulnerability and has been expanded by empirical research to consider different ages and situations.

*Step 2: Internal Consistency*

Reed’s theory of transcendence is presented as a capacity of humans for well being despite physiologic disease and is described with congruence, consistency and semantic clarity. “Moderating/mediating factors” however, need more explanation, and in fact this is where the phenomenon of human response occurs. Age, gender, cognitive ability, life experiences spiritual perspectives, social environment and historical events comprise too broad a list to be useful. The nature of the movement towards self-transcendence and consideration of the environment in which this occurs would expand self-transcendence theory.

*Step 3: Parsimony*

This theory meets the criteria for parsimony due to its limited concepts, few propositions and ease of developing a visual model.

*Step 4: Testability*

High statistical correlation between self-transcendence and well-being is well established in the literature across a variety of settings. The concepts of personal and contextual factors and vulnerability are not sufficiently operationalized for empiric testing. However, Rogers, upon whose work this theory is based stated “It (science of unitary human beings) cannot be measured by the parameters of biology or physics or the social sciences and the like” (Rogers, 1990, p.10). This is confusing, and appears to imply the type of research and approach to the phenomenon that Reed has used would be considered reductionist according to Rogers.

*Step 5: Empirical Adequacy*

The theory of self-transcendence asserts that there is a high correlation of well-being with self transcendence, that increased vulnerability is associated with self transcendence and that personal factors affect this dynamic. Empiric evidence supports the association of self-transcendence with well being. Research with vulnerable populations expanded the connection of self transcendence and well-being to include women with AIDS (Coward, 1995), women with breast cancer (Coward, 1991), the homeless population (Runquist & Reed, 2007), and family members caring for those with dementia (Acton & Wright, 2000). The results do not suggest a causal, predictive or prescriptive relationship.

*Step 6: Pragmatic adequacy*

These findings do not support a causal relationship and in fact may suggest that a correlate of self-transcendence is well-being. This possibly deflates the usefulness of the theory. Nurses reading the research will have a greater appreciation for the relationship between health and a person’s outlook on life (the more open one’s personal boundaries the more opportunity for self-transcendence and accompanying sense of well-being), but there are no particular psycho-
motor skills or special skills that have been identified, nor have particular interventions been identified within this theory.

Reformulation

The strength of this model and Reed’s research is the empirical support of the association between emotional growth that moves towards greater acceptance and concern for others, as well as the association between health and well-being. The question that continues is “What is the nature of this phenomenon that seems to give a sense of well-being to humans in the face of adversity?” The model shows the general process that occurs but does not explain why some people arrive at self-transcendence and others do not, except within the broad category of personal and contextual factors.

The theory is based on developmental psychology and Reed (1991b) noted the difference between ontogenesis—change developing over a long period of time-- and microgenesis which is a change in response to a specific event such as birth, death, or a health crisis. These experiences that brought one to a greater awareness of his/her mortality and the reality of death had the capacity to almost supersede whatever developmental level that had existed. It is interesting to note that Kolko-Rivera (2006) proposed that the hierarchy of needs was revised towards the end of Maslow’s life as he struggled with the paradox of self-transcendence requiring a grounding of self-actualization. The result was the realization that self-transcendence is not a stage but a process that can happen at any level of self-motivation, i.e. one could be starving and homeless and experience self-transcendence. The implication is that anyone at any stage has the capacity for self-transcendence once self-identity is established.

Those who do not self-transcend presumably respond in other manners: depression, demoralization, apathy, etc. As described above, self-transcendence is a state of being and therefore a concept enmeshed in issues of mind, consciousness and intentionality that is not addressed by the model other than the implicit underlying paradigm of Roger’s philosophy. The consideration of the person as continuous with the environment is not explored. It does seem to flow intuitively with Newman’s (1994) theory of health as expanding consciousness (which has Rogers as its stimulus) with regard to pattern disruption and reorganization as well as evolution of consciousness. Neil (2002) did in fact study women with rheumatoid arthritis using Newman’s framework.

Newman (1994) proposed that health expands along with consciousness leading to unbinding and freedom. Frankl (2000) believed that instead of pleasure or homeostasis, the driving factor in humans is self-transcendence, which he described principally as the desire to find and fulfill a meaning in life. He saw this as thwarted by industrialization and materialism which produced a movement from values transmitted through traditions to a way of life that promotes a sense of futility and meaninglessness (the existential void). “By virtue of…the pre-reflective ontological self-understanding, he (a human) knows that he is actualizing himself precisely to the extent to which he is forgetting himself and he is forgetting himself by giving
himself be it through serving a cause higher than himself or loving a person other than himself. Truly, self-transcendence is the essence of human existence.” (Frankl, 2000, p. 138).

These threads of thought elaborate on Reed’s observation that as humans grow older “There is an expansion of self boundaries and an orientation to broadened life perspectives and purposes” (Reed, 1991, p 64). Although the theory of-self-transcendence has been important in its empiric support of the human ability to transcend diversity, the actual process of this has not been described. It is proposed that by placing the process of self-transcendence within the framework of evolving consciousness, the roles of self-identity, meaning making and external environment become clearer.

Health as Expanding Consciousness

Newman (1994) defines consciousness as, “the information of the system” (p. 33). Each one of us is a center of consciousness with our own pattern of energy and information. She proposes that we do not have consciousness but we are consciousness with the capacity to interact with the environment extending the wisdom within our patterns with the potential to further expand when new information arises. This incorporation of information occurs from the sub-atomic interplay of electrons, identification of antigens at the cellular level, and even from our interactions with family, community and universe. What we see as real depends upon where we fall within the spectrum of consciousness.

Understanding and insight are processes of pattern recognition leading to higher levels of awareness and consciousness. Life threatening diseases are at once evidence of interaction with the environment and catalyst to pattern recognition.

Newman (1994) describes her model of health using Young’s spectrum of the evolution of consciousness, beginning with potential freedom, moving toward loss of freedom and regained freedom (see Figure 2). There are 7 proposed stages: loss of freedom, binding, self determination, choice, de-centering, unbinding and real freedom. The process begins with birth, complete dependence on care givers, continues to a phase of physical development and high regulation with little opportunity for initiative leading to the development of self-conscious individualism and break with authority at the centering stage. At this point of individualism and self-identity the author proposes that a turning point exists, described as choice. This involves the recognition of self-, the seeking of opinions from others, and reflection on laws of science and philosophical inquiry. The 5th stage occurs when the laws or new patterns are adopted, the person is competent in his or her field, and the movement is towards dedication to something beyond the self—community, science, theory development, etc. Unbinding and real freedom reflect self-transcendence and presumably a purely spiritual state.
Decreasing Freedom                              Increasing Freedom

1. Potential freedom                             7. Real freedom
2. Binding                                      6. Un-binding
3. Centering                                    5. De-centering
4. Choice

**Figure 2. Evolution of Consciousness**

Pain, for example can be seen as putting one at the binding stage and centering one's focus on oneself—preoccupation with pain and physical immobility. Identification of this as a disruption to the previous order and pattern can lead to the stage of choice—seeking out new information, ways of managing and integration of support systems, all of which result in pain management and evolving consciousness. Newman describes this with mobility towards more and less freedom depending upon circumstances. Thus a person operating at a higher level of consciousness can be brought by pain or illness to a more binding level of consciousness, then with nursing intervention, move to the previous level, and possibly higher in response to pattern recognition and change.

Newman (1994) believes that our patients engage the health care system when the old rules no longer work. The nurse-patient relationship is then established to identify these disrupted patterns and reestablish a new more inclusive pattern. In this way nursing is a spiritual process of expansion of self-boundaries and engagement in the process of expanding consciousness. Self-transcendence can be looked at in the scheme of human potential as a possibility with every nursing interaction.

The theory of evolving consciousness suggests an evolution of an individual’s sentience in a world of constantly changing patterns. Reflection upon the environment in which that occurs is important. Giddens (1991) approaches this theme from a sociological perspective. Our electronic age can be stultifying in the amount and speed of information available. This leads to an existentially troubling situation for many people where the volume of information and rapid change actually undermines its value, and can leave deep doubt and skepticism. There is no certainty to knowledge and in fact much of our knowledge and experience is vicarious, mediated through, radio, television and the internet.
The interaction of the self with the environment in its move towards expanding consciousness and health has many barriers. Not only can the “information of the system” be overwhelmed, but our emotional response can be delayed because of our uncertainty of the validity or meaning of the information. This can lead to philosophical confusion. There is a reality of brute facts, but beyond that is a socially constructed system of value and meaning (Searle, 1998). It is hard to extricate oneself from this social construction. Our construct focuses on commerce, power and ownership which are values promoting the self and individual. It takes a critical event or “vulnerability” to see how tightly wound our patterns are around the self and self-promotion. Disruption of those patterns and re-patterning towards others, community and environment in an expansion of consciousness seems truly liberating towards an authentic existence, and what Reed calls self transcendence. If health is indeed expansion of consciousness, we have these barriers to address.

One approach of assisting the self towards greater understanding of pattern is through the process of searching for meaning. Questions about meanings, purpose, and fulfillment all have at their root problems with pattern identification. In Newman’s language, the rules no longer fit—the current pattern of organization cannot fit the escalating increase of information. Giddens (1991) proposes that against the backdrop of industrialized society, which produces difference, exclusion and marginalization, there “…is a reflexive project of the self, which consists in the sustaining of coherent, yet continuously revised, biographical narratives, takes place in a context of multiple choice as filtered through abstract systems” (p.5). This continues themes of the self in relation to the transcendent, and the role of narrative and self-reflection in the process of evolution of consciousness.

The struggle for expression of the self in narrative can be seen in a religious context. Noting that “considerable numbers of people suffer from a sense of emptiness and fragmentation” (p.8), Nino (1990) argues Augustine’s confessions provide a paradigm for restoration of the self. The process includes recognition of self-fragmentation, return to interiority, and recollection in dialogue with God, movement beyond the boundaries of self and creative responses. He emphasizes self as an open system with the capacity for the inner experience of God. What is interesting is the similarity between this process and Newman’s (1994) proposed series of changes a human self experiences on its way to health, specifically self-fragmentation with de-centering. Narrative pulls together the process of meaning change and pattern reorganization.

Stark (2003) proposes a mid range theory of meaning based on the work of Victor Frankl and the premises that search for meaning is one’s primary motivation in life that we have choices, and that a person’s life has meaning in every moment and situation. Frankl’s technique of logo therapy is used to stimulate reflective thought and the patient’s appreciation for unique life events. Specific ways of doing this include de-reflection, paradoxical intention and Socratic dialogue. Of particular interest is Frankl’s (2000) distinction that we are spiritual with a psychophysical overlay. Self-transcendence is distancing from oneself, in contrast to self awareness, which is a focus on the self. He suggests that times of transition lead to the potential for existential void. Although this theory proposes logo-therapy as a specific therapeutic
intervention it supports the importance of reflective thought for the ongoing process of self-definition in a changing world.

In another example of use of narrative, Smith and Liehr (2003) propose a mid range theory of attentively embracing story. This seeks to elicit a narrative from the patient regarding a health-related event with the purpose of eliciting self-reflection and the patient’s interpretation of patterns for the purpose of change. It is based on unitary transformative theory, seeing the unfolding-becoming process of the patient.

Jolly, Weiss & Liehr (2007) demonstrated the effectiveness of attentively listening to story in the development of the concept of adolescent voice. This is “the power to express self through dialogue with a non-judgmental listener who gives and receives feedback” (p.11), based on the Freirian assumption that adolescents are oppressed and emotionally dependent and only when they participate in their liberation do they become able to believe in themselves.

Providing and assisting with information interpretation is a foundation of empowerment theory. Considering the increasing complexity of health care systems, personal inquiry and assistance with information gathering can make a difference. Evolution of consciousness can be seen in the work of public health nurses (Falk-Rafael, 2001) as a ripple effect of establishing a trusting nursing relationship, leading to increased self-confidence and self esteem, and changing relationships with family, leading to self advocacy and likely impacting the community. This supports the interpretation of self-transcendence within Newman’s (1994) framework of health as expanding consciousness.

McCormick, Holder, Wetsel, and Cawthon (2001) proposed a system of interventions to assist patients with HIV/AIDS that incorporates intra-personal, inter-personal and transpersonal strategies for facilitating self-transcendence, (See Figure 3.) The interventions represent information supplied to integrate patterns at the cellular level (pathophysiology, medications) with the social and spiritual patterns.

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Strategies</th>
</tr>
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<tbody>
<tr>
<td>Promote hope</td>
<td>Encourage reciprocal social support—significant others, family, friends, peer support groups, clergy, pets</td>
</tr>
<tr>
<td></td>
<td>Encourage involvement in a supportive faith community</td>
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<tr>
<td></td>
<td>Encourage client to focus on the small joys of life</td>
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<tr>
<td></td>
<td>Encourage client to maintain significant work or hobbies as able</td>
</tr>
<tr>
<td>Teaching</td>
<td>HIV pathophysiology</td>
</tr>
<tr>
<td></td>
<td>HIV transmission and prevention methods</td>
</tr>
<tr>
<td></td>
<td>HIV medications—dosing schedules, side effects, food/drug interactions</td>
</tr>
<tr>
<td>Share information</td>
<td>Local HIV resources and social services</td>
</tr>
<tr>
<td></td>
<td>Local spiritual resources and supportive faith communities</td>
</tr>
<tr>
<td>Create a sense of empowerment</td>
<td>Encourage adjunct therapies—vitamins, nutritional supplements, exercise, massage</td>
</tr>
<tr>
<td></td>
<td>Encourage use of rituals—prayer, meditation, guided imagery, visualization</td>
</tr>
<tr>
<td></td>
<td>Encourage helping others with similar concerns</td>
</tr>
<tr>
<td></td>
<td>Encourage participation in HIV research studies/clinical trials when applicable</td>
</tr>
<tr>
<td></td>
<td>Promote self-determination by completing a living will/health care power of attorney when applicable</td>
</tr>
</tbody>
</table>
Self-transcendence theory was proposed by Reed (2003) to describe the relationship between expanded self boundaries and a sense of well-being that co-exist, with disease and terminal illness. This supports Newman’s (1994) theory of health as expanding consciousness. Nursing interventions that promote pattern recognition and integration of change promote health. Since health is a process of expanding consciousness, as one gets healthier his/her interaction and participation in family and community expands. Consciousness is continuous with the environment which means that the more expanded our consciousness the more we are connected to community and world. Industrialization and the modernizing of the world have had a tremendous effect on available information and information processing. According to Newman (1994) consciousness is the information of the system. Under this assumption, difficulty with information processing can be a barrier to health. Nursing interventions aimed at information processing and the incorporation of that information into personal insight lead to new patterns of understanding, which in turn expand consciousness and health. Expanding consciousness is not a linear, continuous process but instead one that can vacillate between expanded and restricted self-boundaries.

This is not the dominant view of health or healthcare in our society so if self-transcendence/health as expanding consciousness is the framework one wants to use for practice, the interventions available promote the establishment of a trusting relationship, respect for individual voice and a commitment to holistic practice within the present institutional structures.

References


Chapter Five

A Middle-Range Theory of Stigmatization and Unpleasant Symptoms Experienced by Deployed Military Service Members

Stephen Hernandez, RN, MSN

I have chosen to adapt and extend the Modified Labeling Theory Approach to Mental Health Disorders. The Modified Labeling Theory Approach explains the labeling of patients with a mental health disorder, as well as the responses, consequences, and vulnerability experienced by the labeled patient. In order to extend and modify this theory, I have incorporated the middle-range nursing Theory of Unpleasant Symptoms into the process. The Theory of Unpleasant Symptoms offers an interactive view of multiple symptoms experienced by patients. The resulting theory is a middle-range theory of stigmatization and unpleasant symptoms experienced by deployed military service members that will be instrumental to exploring my future research interest.

Introduction and Purpose

Middle-range theories offer valuable structure and direction to the practice of nursing. In order to provide structure for my future research, I have chosen to adapt and extend the Modified Labeling Theory Approach to Mental Health Disorders (see Figure 1). The Modified Labeling Theory Approach (MLTA) is not a nursing theory; however, theory derivation can occur when a theory is borrowed from one profession and made to meet the needs of another profession (Walker & Avant, 2005). This theory seeks to explain the labeling of patients with a mental health disorder, as well as the responses, consequences, and vulnerability experienced by the labeled patient (Link, Cullen, Struening, Shrout, & Dohernewend, 1989). In order to extend and modify this theory, I will seek to incorporate the middle-range Theory of Unpleasant Symptoms (see Figure 2) into the process. The Theory of Unpleasant Symptoms (TOUS) offers an interactive view of multiple symptoms experienced by patients. The resulting theory will be instrumental to exploring my research interest.

My current research interest involves examining the role of stigma in a deployed military service member’s decision to utilize available mental health services (MHS). Stigma is “a mark of disapproval placed upon an individual by themselves or by society” (Hernandez, 2007, p.16). Over 1.6 million service members have been deployed for, or in support of, Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) since 2001 (The War List, 2008). Approximately 19% of service members returning from Iraq were found to be at risk for a mental health disorder (Hoge, Auchterlonie, & Milliken, 2006). The same study showed that 35% of
OIF veterans sought MHS within the first year of returning from their deployment (Hoge et al., 2006). Stigma has been identified as a deterrent for service members to seek MHS (Hoge, Castro, et al., 2004; Castro & McGurk, 2007). In a future study, I hope to measure the level of stigma perceived by these returning service members and to identify any link between their perceived level of stigma and use of MHS. An adapted MLTA will be a valuable guide to illustrate the process of stigmatization.

**Background and Context for Model Development**

In this section, information and context will be provided that will lead to an adapted MLTA. First, stigma experienced by deployed service members will be discussed. Next, the individual models that will be utilized to establish an adapted MLTA will be discussed. This discussion is important to provide a clear understanding of these models prior to pursuing an extension of the MLTA in the next section of this paper.

**Stigma Experienced by Service Members when Utilizing MHS**

Stigma is a term first used by the Greeks that refers to a “mark of disgrace or infamy” or a “sign of severe censure or condemnation” (Oxford English Dictionary, 1989, no page). A prominent sociologist, Goffman (1963), defined stigma as an intensely discrediting characteristic. A concept analysis by Hernandez (2007) concluded that stigma is a perceived or actual mark of disapproval placed upon an individual by himself or by society. This mark of disapproval can lead to the individual experiencing anxiety, exclusion, fear, isolation, and shame (Hernandez, 2007).

Stigma may be experienced by patients with mental illness (Bagley & King, 2006; Barney, Griggeths, Jorm, & Christenson, 2006; Corrigan, 2007). Deployed service members are exposed to many stressors that potentially affect their mental health. Researchers have identified that stigma is a deterrent to military service members seeking MHS (Castro & McGurk, 2007; Hoge, Castro et al., 2004; Lamberg, 2004; Magnezi, Zrihen, Ashkenazi, & Lubin, 2007; Stecker, Fortney, Hamilton, & Ajzen, 2007). Stigma related to service members seeking MHS can cause unique problems for these individuals. For instance, Castro and McGurk (2007) stated that stigma related to a service member’s mental health problem is perceived to cause the member to be treated differently by leaders, be perceived as weak, decrease confidence in personal abilities, and harm an otherwise promising career. Furthermore, fears continue to endure that seeking mental health services will lead to labeling or poor career progression (Stecker et al., 2007).

As with other wars, the mental health of OEF/OIF service members involved in combat operations, and those directly supporting them, may be impacted by their experiences during a deployment. Impaired mental health for these service members is manifested by depression, generalized anxiety, substance abuse, and post-traumatic stress disorder (PTSD) (Bilmes, 2007; Hoge, Castro et al., 2004). Hoge et al. (2006) performed a retrospective study of 493,888 service
member’s post deployment health assessment. This assessment has multiple questions that assess for alterations in mental health, including PTSD. The study found that a significant number of service members returning from an OIF or OEF deployment reported mental health problems (Hoge et al., 2006). This study also found that 35% of the service members returning from an OIF deployment accessed MHS within one year of returning home (Hoge et al., 2006).

**Modified Labeling Theory Approach to Mental Health Disorders**

The MLTA is a modification of Scheff’s labeling model (Link et al., 1989). In contrast to Scheff’s model, Link et al. (1989) focus on the results of labeling patients that seek MHS. When an individual is labeled, s/he is subject to the preconceived norms of society (Link et al., 1989). As labeling occurs, an individual conforms to society’s expectations for the mentally ill, and becomes limited by society’s constraints (Link et al., 1989). As this role is adopted and becomes a part of one’s personal identity, chronic mental illness occurs (Link et al., 1989).

The MLTA is composed of five steps. The first step of the model focuses on the internalization by all individuals of their society’s perceptions of mental illness (Link et al., 1989). This perception will include a varying level of negative attitudes regarding mentally ill individuals (Link et al., 1989). These negative perceptions will include society’s reduction or devaluation, as well as social distancing or discrimination towards individuals with mental illness (Link et al., 1989). Because individuals with mental illness have internalized society’s norms, they understand how other people will view them as mentally ill (Link et al., 1989). These preconceptions impact the remaining steps in the MLTA.

The remaining four steps describe the impact of labeling. During the second step, labeling can occur (Link et al., 1989). Labeling occurs when the patient that seeks MHS perceives that society’s norms and the resulting devaluation and discrimination will now be applied to him or her (Link et al., 1989). After labeling occurs, the patient chooses his/her response to stigmatization (Link et al., 1989). The individual may respond by concealing the illness, limiting social contact, or acknowledging the illness and attempting to teach others about the disorder (Link et al., 1989). In the fourth step, the labeling process and the chosen response to labeling will cause consequences for the stigmatized individual (Link et al., 1989). These consequences can include shame, distancing from others, self-limitation, and other adaptations to labeling (Link et al., 1989). Finally, these adaptations can leave the patient vulnerable to future disorders (Link et al., 1989). The continued mental illness and the patient’s response to labeling may leave the individual more likely to have reoccurring exacerbations of a disorder (Link et al., 1989).
Evaluation of MLTA

The MLTA is a theoretical framework that describes the process of stigmatization. The MLTA provides a clear illustration of the process where an individual internalizes society’s meaning of mental illness, as well as the process where an individual becomes stigmatized and experiences the consequences of stigmatization. The authors tested the theory using a sample \(n=503\) of New York City residents and psychiatric patients (Link et al., 1989). The authors used a Likert scale to measure these individuals’ perceptions of several variables, including the experience of devaluation and discrimination. Their findings confirmed the negative attitudes associated with mental illness, and secrecy or withdrawal as a means of coping with stigmatization as described by the MLTA.

The MLTA has been cited in other articles. A search of the JSTOR database showed that this theory was cited in eight articles within the database (JSTOR, n.d.). A subsequent search in the CINAHL database did not elicit any citations of this theory. I did not find any published work that used MLTA as a theoretical model for research or practice.

While the MLTA is an excellent theory for explaining stigmatization, the theory’s focus is the result of labeling patients that seek MHS (Link et al., 1989). Stigmatization occurring because of mental illness is only one aspect of the service member’s alternation in health. The MLTA does not address the symptoms being experienced by patients with a mental illness. These symptoms must be addressed as an interactive part of the stigmatization process. Erbes, Westermeyer, Engdahl, and Johnson (2007) report that patients with PTSD will also have other associated physical and psychiatric alterations in health. In addition, Hoge, Castro, et al. (2004), report that these service members will exhibit “depression, substance abuse, impairment in social functioning and in the ability to work, and the increased use of health care services” (p. 14). In order to explore these additional symptoms experienced by the service member, a theory will be evaluated for its ability to explain the impact of symptoms upon individuals with mental illness.

The Theory of Unpleasant Symptoms

The TOUS is composed of three key components. These components are experienced symptoms, these symptoms’ consequences, and influencing factors (Lenz, Pugh, Milligan, Gift, & Suppe, 1997). Lenz et al. (1997) assume that symptoms share sufficient complex characteristics that a theory is essential to explain the need for multiple symptom management. The patient’s symptoms represent a change from the patient’s standard functioning (Lenz et al., 1997). Single or multiple symptoms may be experienced by patients. These symptoms are experienced concurrently, and each additional symptom increases the discomfort of the patient exponentially (Lenz et al., 1997). Also, the cumulative impact of multiple symptoms may cause the individual to have difficulty in differentiating between these symptoms (Lenz et al., 1997). Each of these symptoms is understood to have four qualities.
Each symptom has four constituent characteristics. First, the intensity of the symptoms represents the force of the perceived symptom (Lenz et al., 1997). Second, the characteristic of timing reflects varying levels of experienced duration and/or frequency of an acute or chronic symptom (Lenz et al., 1997). Next, the level of distress caused by symptoms will be variable. The level of distress experienced may be debilitating to one individual, but only troublesome to another person (Lenz et al., 1997). Finally, quality is a subjective experience of the symptom and it is described in the patient’s own words (Lenz et al., 1997).

The second component of the TOUS is comprised of factors that will influence how a symptom is experienced. These influencing factors are physiological, psychological, and situational (Lenz et al., 1997). The three types of influencing factors in the TOUS are related and interact with each other. The final component of the TOUS is the consequences of symptom experience. These consequences are the result of symptom occurrence (Lenz et al., 1997). These consequences will affect the individual’s functional and/or cognitive performance (Lenz et al., 1997). The authors illustrated the relationship between/among these components.

The relationships involving unpleasant symptoms, performance, and influencing factors are illustrated and described by the authors. In the model, symptoms are displayed as a cylindrical column of joined experiences. Each individual symptom in the column has a depicted quality, timing, distress, and intensity. The influencing factors are displayed as having a bidirectional interaction between the factors, as well as a joined effect on each symptom (Lenz et al., 1997). The cognitive and functional performance of the individual is influenced by the experienced unpleasant symptoms (Lenz et al., 1997). Also, the performance provided reciprocal feedback to the influencing factors and the unpleasant symptoms (Lenz et al., 1997).

**Evaluation of TOUS**

The TOUS provides a theoretical framework that is capable of successfully guiding nursing practice to understand symptom management. The identification and management of a patient’s symptoms is an important aspect of nursing practice. The TOUS framework provides a clear and concise multidimensional framework that can utilize nursing practice to understand symptoms and to develop interventions that will increase patient comfort. These symptoms are experienced in the context of psychological, physiological, and situational factors, and symptoms that impact the functional and cognitive performance of the patient. Clear and familiar concepts are linked to explain the effect of symptoms upon the patient that is experiencing an alteration from their normal level of health.

Another measure of the importance of TOUS is its utilization in nursing practice and research. The TOUS is being used to describe unpleasant symptoms in nursing and allied health literature, and as a theoretical framework for research. The TOUS has been cited in 52 articles since it was published (Ovid, n.d.). A majority of these articles have discussed the TOUS and its contributions as a theory to addressing unpleasant symptoms. In addition, the TOUS has been used as a theoretical framework for research. The TOUS has been used as a theoretical
framework for research in studies of heart failure, quality of life after surgery, COPD, and fatigue in African American women (Parshall, Welsh, Heiser, Brockopp, Schooler, & Cassidy, 2001; Spector, Hicks, & Pickleman, 2002; Kapella, Larson, Patel, Covey, & Berry, 2006; Williams, Crane, Kring, & Daria, 2007). The TOUS has been widely utilized as a reference and as a guiding theoretical framework for research.

Extension of the MLTA

In order to provide a theoretical framework for my research interest, I have chosen to extend the concepts within the MLTA (see Figure 3). The modification of the model includes the integration of the TOUS to describe the experience and impact of experienced symptoms of service members seeking MHS. Other alterations to the theory include the addition of cultural conceptions to the meaning of mental illness and the separation of labeling and stigmatization. These modifications will be discussed individually and integrated at the close of the section.

Societal and Cultural Conceptions of Mental Illness

Link’s et al.’s initial step is retained in the modified MLTA. Societal conceptions remain important to how individuals understand the devaluation of the mentally ill. However, to reflect the preconceptions of a military service member, this step must be extended. In addition to societal conceptions, the ideation of mental illness as perceived by the military culture must be included. These conceptions will supplement the service member’s societal preconceptions of mental illness. Castro and McGurk (2007) stated that stigma related to a service member’s mental health problem is perceived to cause the member to be treated differently by leaders, be perceived as weak, decrease confidence in their abilities, and harm their career. These perceptions are caused by the service member’s internalization of the military’s norms, and his/her understanding of how other service members will view the mental illness.

Deployment and Traumatizing Events

These steps have been added to focus the model on the mental illness developed by deployed service members. Studies have shown that the rate of developing mental illness will vary by location of deployment. For example, Hoge, Castrol, et al. (2004) found that there is a significant difference in mental health impairment between service members deployed to Iraq (17.1%) and Afghanistan (11.2%), when compared to service members awaiting deployment to Iraq (9.3%). A key factor may be the length of the deployment. Castro and McGurk (2007) found that service members deployed for longer than six months were one and a half times more likely to develop a mental health concern when compared to a shorter duration deployment.

The exposure to traumatic event(s) during a deployment is another step that I have added to the MTLA. The level of combat exposure has been shown to be a determining factor for the development of mental health concerns. Castro and McGurk (2007) found a direct relationship between the level of combat stress and the development of mental health concerns. These
researchers found that high combat stress can increase the likelihood of the development of impaired mental health by a factor of 2.4 to 4.6 times, when compared to a service member experiencing low combat stress (Castro & McGurk, 2007). Based upon these findings, the exposure to traumatic event(s) is a key step to this model.

The Onset of Symptoms and Addition of TOUS

The fourth and fifth phase of the extended MLTA is the onset of unpleasant symptoms and the experience of symptoms as described by the TOUS. In Link’s et al.’s MLTA, symptom onset and the experience of the symptoms are neglected. In the extended model, the assumption is made that service members will have symptoms of their impaired mental health. These symptoms may be psychological in nature, such as depression, insomnia, and anxiety. However, it is also important to remember that these service members may also be recovering from physical wounds and may be experiencing additional physiological symptoms such as pain.

The addition of the TOUS to MLTA will allow for an understanding that these patients are experiencing unpleasant symptoms, and that the symptoms will have a cumulative impact on the individual. The TOUS will also guide the understanding that other factors may play a role in the service member’s experience of the symptoms. These factors may include marital difficulty after a deployment (situational), the amputation of a limb (physiological), or alcohol abuse (psychological). The experience of these symptoms can play a role in labeling.

Labeling and Stigmatization

In the MLTA, step two recognizes that labeling can occur. Labeling occurs when the patient that seeks MHS perceives that society’s norms and the resulting devaluation and discrimination will now be applied to him or her (Link et al, 1989). In the extended model, I have chosen to separate labeling from stigmatization. Labeling would be the recognition that the individual is outside of society’s norms, and stigmatization is the resulting devaluation and discrimination that is applied to the individual. Another extension of the second step of the MLTA is the recognition that labeling and stigmatization may be applied to the service member by him/herself or by others. Stigma could be perceived as discredited, a known difference, or as discreditable, a difference that is not yet evident (Goffman, 1963). Therefore, the label and/or stigma may be applied by the individual because s/he is aware that s/he does not fit the norm, or the label and/or stigma may also be applied externally because society realizes that an individual is not “normal”.

Response, Consequences, and Continued Vulnerability

The response and consequences of the MLTA will remain the same. For the vulnerability to a new or continued disorder, a link will be added to the TOUS. A continued mental illness and the patient’s response to labeling and stigmatization may leave the individual more likely to have reoccurring exacerbations of a disorder (Link et al, 1989). The addition of the link of this step
with the TOUS will add acknowledgment that because the mental disorder may continue and be exacerbated, the experienced symptoms will also continue to be experienced and exacerbated, as well.

**Summary**

I have chosen to extend the MLTA to guide the labeling and stigmatization of service members that are impacted by alterations in mental health. This extension includes adding the norms of the military culture to existing preconceptions of the meaning of mental illness, and the addition of the exposure of service members to a traumatic event or events occurring during a deployment. Once the service member begins experiencing symptoms, the TOUS can be used to explain the impact and experience of these symptoms on the individual. Once the symptoms are recognized, the service member may be labeled and stigmatized by self or others. The individual will choose a response to stigma and stigmatization will have consequences. Failure to address the consequences will allow for the service member to become vulnerable to continued/ongoing or new disorders. This vulnerability will impact the experience of symptoms experienced by the service member. The result of the extension and modification of the MLTA is a middle-range theory of stigmatization and unpleasant symptoms experienced by deployed military service members.

**Conclusions and Implications for the Nursing Discipline**

The MLTA and TOUS are valuable, but separate theories. By adding the TOUS, as an extension of the MLTA, the resulting theory may be renamed the middle-range theory of stigmatization and unpleasant symptoms experienced by deployed military service members. This adapted theory allows for a more accurate and holistic view of individuals with mental illness that experience stigma and recognizes the impact of symptom experience upon the individual. The resulting theory has several implications for me and the nursing discipline. These implications include:

1. The extended and modified theory will help guide my future research that involves examining the role of stigma in a deployed military service member’s decision to utilize available MHS.

2. The extended and modified theory allows for a more holistic representation of the individual with a mental illness. This representation explains the process of stigmatization, as well as, acknowledging the effect(s) of symptoms on the mentally ill patient.

3. Nursing and public health interventions may be focused on several points in this model. Education can be focused upon modifying public perceptions of mental illness. Once service members are deployed, preventative health and early intervention may focus on recognition and early treatment for alterations in mental health. Finally, aggressive and appropriate treatment can be focused on symptom relief and the restoration of mental health in order to prevent chronic illness or the onset of new illness.
While I have focused the extended model on the deployed service member, I believe that the second and third step of the extended model may be removed to generalize the model to any patient with a mental illness. It is my hope that the addition of this extended middle-range model to nursing theory will help offer valuable structure and direction to the practice of nursing.

References


**Figure 1.** A Modified Labeling Theory Approach to Mental Health Disorders. ¹

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Figure 2. The Middle-Range Theory of Unpleasant Symptoms

Figure 3. A Middle-Range Theory of Stigmatization and Unpleasant Symptoms Experienced by Deployed Military Service Members (Hernandez, 2008).
Chapter Six
Modification of Feminist Standpoint Theory

Susan Steel, RN, MSN

“I am part of a process, a community of women. As we move beyond the old social norm with our new visions and support systems, we will experience the joy that comes from being seekers.”--Judith Finlayson, 1993:

This paper will review the history and background of feminist standpoint theory and will explore it with the intention of utilizing the method to establish research in the women veteran population. This theory is primarily based in the social sciences and has not been utilized extensively in nursing. I propose to incorporate its tenets into woman-based research with a focus on women military veterans.

This paper describes the feminist standpoint theory and its use in determining the perceptions of women in their society. Women are considered a marginalized segment of society, commonly subservient members who view the world from a different perspective than men. The feminist standpoint theory helps to bring their views to the forefront in order to understand their perceptions and perspectives.

Introduction

Health care disparities between men and women are still present in today’s society despite the rhetoric to the contrary. Although there is the will to be sensitive to the divergent needs of the minorities and genders, there still exists a clear inequality in the health care available to the sexes, specifically to women. It was only late in the 1970’s that health researchers began to address these inequalities with a feminist view. Women have been almost wholly neglected within the social framework of health status determined by men (Annandale & Hunt, 2000).

Inherent in current medical practice is the means of controlling lives while appearing to be scientifically based and socially neutral (Annandale & Hunt, 2000). However, the knowledge of the physician may not be scientific, but instead be a message about the proper behavior of women, such as the notion that an unhappy woman is designated as sick (Annandale & Hunt, 2000).

Feminism emphasizes differences between men and women. Liberal feminism puts less emphasis on the body and structural power, while socialist feminism and radical feminism not only focus on the physical differences, but also their relationships to the social power base of each (Annandale & Hunt, 2000). Social and radical feminism essentially focus on the patriarchal dominance and determination of relationships within society. For this paper, the focus will be on the health care structure and dynamics as they pertain to women.
Health care discrepancies are present in the private sector of health care, as well as in the public domain. The government health care system for veterans, its availability, and its long-term impact on the well-being of women veterans is the goal of this research methodology. It is my belief that women veterans have experienced, and are currently experiencing gender bias, making it emotionally difficult for them to transition back into civilian life after serving in the military. These women are required to transition from civilian to military life and then back again, often at a young age, making them particularly vulnerable to exploitation on many levels. The youth of these women combined with the clearly masculine environment of the military adds to the marginalization and suppression of their military society. Utilization of transition theory may also apply when working with these veterans. However, I think it is imperative that if this theory is utilized, it be amplified with the feminist standpoint theory. Feminist standpoint theory illustrates the importance of the perspective of the woman in relation to social location (http://www.plato.stanford.edu/entries/feminist-social-epistemology).

Feminist standpoint theory

Feminist standpoint theory was initially developed in social sciences other than nursing. The standpoint theory was in the process of development in the 1980's when feminism was becoming a legitimate topic. Dorothy Smith, Nancy Hartsock, and Hilary Rose are credited with making important contributions to feminist standpoint theory. Sandra Harding’s publication in 1991 described her interpretation of the standpoint theory. Harding describes this theory as one which focuses on gender differences, between women’s and men’s situations (Harding, 1991). A standpoint theory must begin with the women’s lives as an objective location from which research originates. Observation of the world from the viewpoint of women who live there is important to the research question.

Since men are dominant, with patterns and ways of thinking that fit closely into the predominant ways of thinking, women are virtual strangers to the social order in which they live because they have been excluded from the design, direction and knowledge development (Harding, 1991). Women’s different lives have been devalued as a focus for scientific research or knowledge claims (Harding, 1991). Men and women have different roles in society, and therefore, they experience their lives differently. These experiences may translate into different perspectives for women than for men, but that does not mean that they are inferior. They are simply dissimilar. Since men have generally developed the rules of the society, their view has often dictated the primary focus of society’s needs. Therefore, the perspective of women in society has often been perceived and designated as insignificant, making them oppressed, dominated and feeling exploited.

Background and Historical Perspective

The development of feminist theory has its roots in the philosophy of Georg Hegel. Philosopher Hegel was instrumental in the insight into the master and slave relationship and many feminists have based their theories on this idea. Hegel’s students, Engels and Marx, expanded this thought, and it was ultimately Marx’s theory of economic determination that rejected the unequal division of labor in society and eventually steered feminist thinking. He deemed that the oppressed members were servants of the more affluent or stronger members of the society (Law, 2007). Feminists adopted and refined this theory to explain the role of women in society. They declared that women are enslaved, socially repressed members of the work force, morally wronged in society (Bromberg, 1997). All women are members of oppressed groups according to Marianne Janack (Janack, 1997). Women’s perspectives on the world are not only different from that of the ruling class (men), but are also more advantageous because their view encompasses a broader array of experiences (Janack, 1997). Finally, women’s experiences provide the answer to the question of how the social order works rather than providing the solution to social ills (Janack, 1997).
A standpoint provides a mechanism to mobilize forces in order to better women’s positions in the social order. It supplies a shared discourse of and by women, a unitary feminist viewpoint in the hopes of strengthening a sisterhood. The standpoint is not a completed or inflexible theory. Rather, it is flexible and adaptable in order to transact whatever emerges to eliminate sexism. This flexibility lends itself easily to my proposed work with women veterans because it allows the perspective of a select group of women to focus on their military-related health care issues, without necessarily impacting other areas of social life.

Harding described the feminist standpoint theory as one that concentrates on gender differences, on the variations between men’s and women’s situations (Harding, 1991). She justifies the approach as one which originates in Marx’s definition of the “proletarian standpoint”, one which describes the relationship between the master and the slave, and one which sets limits on human understanding (Harding, 1991).

Critique

Harding is one of the more moderate feminist thinkers in her construction of the standpoint theory. Although she explains women’s insertion into the divisions of labor, she avoids much of the radical feminist writings that reference lesbian epistemology and women’s positioning outside of masculine discussion (Zita, 1988). The omission of these important components of feminine accounts is one problem identified because there is the question of what kind of feminism should be considered.

The explanation and theorization of gender for feminist work is explained by the social construction of gender, which is described as organization of social activities created by each gender, the division of labor by gender, and the individual gender. The social construction of gender, however, links itself to the dispersion of power, which makes heterosexuality mandatory (given social norms and values), while enforcing the male dominance in the areas of reproduction and practices of sexual violence. Omitting these factors makes the experiences of women who have encountered and lived destructive events seem unimportant, and the experiences are minimized or erased (Zita, 1988).

Literature Review

A literature review was done to assess the standpoint theory including its origins and usages in research methodology. Although a thorough search was undertaken, no relevant studies or surveys were found that utilized this theory in the medical profession with professionals, patients or women. I was particularly interested in locating any information about women veterans and their views of the health care experience but was unable to locate any literature on this subject.

A literature review of the use of the standpoint theory within the judicial system, however, was located. I will explore it here because I believe that there are some valuable parallels to the health care system as it relates to women veterans.

Data from Florida’s Gender Bias Study of attorneys and judges suggests that both men and women are aware of gender inequality, but that women are more conscious of it because they occupy a devalued gender status, and therefore, have more negative experiences in their lives (Martin, Reynolds, & Keith, 2002). Historically, the legal system was created by men, based on concepts by men, and written by men, because women were considered to have delicate physiology, lesser mental capacity, and were (according to male thinking) naturally suited for home and family life. Extrapolation from social role to intellectual capacity seemed to follow. Therefore, men were considered to have higher intelligence (Martin, Reynolds, & Keith, 2002).
The standpoint theory suggests that women are more sensitized to the gender-based discrimination because they have more lived experience with this type of discrimination. As the gender bias study discovered, although men were aware of gender biases on some level, women were much more conscious of the gender inequality. This was attributed to the societal role of women, which is generally determined at an early age, with expectations of behavior based on the child’s gender (Martin, Reynolds, & Keith, 2002). Girls are generally expected to be the homemakers who have family responsibilities. Girls are therefore not taken seriously when they express interests in topics or careers that are not oriented in this direction. Boys, however, are given much more liberty and opportunity to explore other options in life. They are encouraged to expand their knowledge in the world and to succeed in the career of their choosing.

Daily experiences of women in a subordinated or marginalized position give them the knowledge of “how the world works”, which may differ from those in a more privileged position. Women are told how the world works, but in their reality of experiences, they have a different interpretation and perspective of how the world actually works. They know how it operates for the “masters” but they also know how it works for those who are in a marginalized position. They therefore possess a more global and complete outlook regarding the society in which they live.

The gender bias study found that women judges were more feminist in their thought processes than men when it came to cases of rape, domestic violence, and property rights of women after divorce (Martin, Reynolds, & Keith, 2002). The study also found that although male judges and lawyers were apt to sometimes inappropriately insert gender or sexuality into their practice of law, women were more astute at noticing these behaviors (Martin, Reynolds, & Keith, 2002).

I believe that parallels to this study exist in the medical community and the way it relates not only to its members but also to its clients. The medical profession was created by men, policies were written by men, and it was structured to primarily serve men. Examples of this may be seen in the Civil and Crimean Wars, where men directed the work and the women performed the work of nursing the sick. Nursing’s own Florence Nightingale, was forced to deal with hostility and anger from doctors when she attempted to improve the sanitation in the hospitals (Nightingale, 1992).

Suppression of female healers by the medical establishment was a notable political struggle, first in that it is part of the history of gender struggle, in general. The status of women as healers rose and fell with the status of women. Women healers were attacked as women, but when they fought back they did so with the fellowship of all women (Ehrenreich & English, 1973). This example of the structural relationship domination has been present in the medical community, which unavoidably overlaps into the public domain as well. All women are members of oppressed groups (Janack, 1997).

In terms of quality and quantity of appropriate health care services, women clients are as underserved as many of the underprivileged, or minority, clients in the mainstream community. As such, they are highly sensitized to the discrimination and gender biases that they have experienced and that they currently experience. However, they are often so accustomed and acculturated to this as a lifestyle that they are reluctant or unable to challenge it.

**Current Surveys**

An exhaustive literature review was done for this paper. In researching available surveys and questionnaires related to women veterans, this author was not able to locate any that were specific to women. There were queries that generally utilized only one question to ascertain the respondent’s gender, but nowhere were there questions related to a woman’s specific perception of the issues being researched. This affirms my belief that there is not a concerted effort in the research community to identify what women or women veterans think or need from their perspective.
The only woman focused survey that was located was the on-line survey posted by the AFL-CIO. Their working woman’s survey is distributed yearly and is available to anyone who wishes to respond. This survey is specific to the needs of working women, asking questions about how much time they have for themselves, what their work lives are like, and whether men they work with make more money for the same jobs (http://www.laborradio.org).

Conclusions and Implications

The literature review that was done for this paper revealed a major lack of utilization of this theory as applied to research. There has been a lack of interest in women’s issues and very little funding available. The current war in Iraq has raised awareness of the needs of these women. Nurses are in an enviable position to capitalize on the funding for research that I believe will be forthcoming.

Future Endeavors

The researcher interviewing women veterans utilizing the feminist standpoint view must use a different approach to the subject. Instead of the formal consent forms, determination of subject selection and measurement in terms of validity, the feminist researcher will be best served by using a framework that establishes reciprocal, collaborative, trusting and friendly relations with the subject (Denzin & Lincoln, 2003).

I propose to utilize the standpoint theory by developing a questionnaire specific to women veterans. Utilizing the standpoint theory and incorporating some components of the transition theory should yield information to identify the perceptions of the women veterans who utilize the veterans health facilities and services.

The implications for utilization of this methodology are impressive. It lends itself to research in multiple women’s issues and has broad implications for qualitative nursing research. Further research is needed to ascertain the effectiveness of the process of feminine standpoint theory and its utilization for outcomes measures in improving the lives of women.

“From the founding of our nation, women have protected America's freedom and will continue to do so in ever increasing numbers. Women veterans remain historically under-represented in using available benefits and may be more reluctant than their male counterparts to embrace their status as veterans” (www.http.dva.state.wi.un/womenvets.asp).

References


Chapter Seven

A Change Model for Community Empowerment

Carol J. Bett, RN, MN, MA

A paradigm shift is called for regarding the means by which nurses facilitate the development of healthy communities. Traditionally health promotion methods targeting communities placed nurses in a dominant role, resulting in a dependency mentality which resulted in widespread health disparities. There are numerous examples of projects which initially appeared viable, yet were not sustainable without outside personnel and resources. A key determinant of successfully addressing health disparities depends on the community being involved in the health promotion process through collaboration, participation and cooperation between health professionals and community residents. Modification of Persily’s and Hildebrandt’s Community Empowerment Model was achieved by the addition of elements from Lewin’s Change Model and principles from the Anderson, Guthrie and Schirle Nursing Model of Community Organization for Change. The Change Model for Community Empowerment is designed to help communities to gain control over their health through a process of intentional change and empowerment.

A Change Model for Community Empowerment

Over the past century, health care has begun the shift from a curative focus to a preventative and health promotional centered approach. The movement towards health promoting practices has been hindered by a focus on individualized care, rather than determining the underlying causes of health disparities among groups. This reductionistic approach has proved to be ineffective in that it overlooks the essential holistic, cultural, political and contextual environments that impact health (Engebretson & Littleton, 2001; Whitehead, 2004).

Persily and Hildebrandt (2003) developed the Theory of Community Empowerment to address the need for an organizing framework to increase community involvement in the health promotion process. The model focuses on the necessity of empowerment as a means of developing improved health in communities. The goal of health promotion can be met through a process based on the involvement of lay workers who act to facilitate reciprocal health (Persily & Hildebrandt, 2003). Community empowerment enables the development of local capacity to improve health through identification of needs and active participation in the change process. By moving from an individual and behavioral focus to a community-based orientation, the process of empowerment can occur (Fitzpatrick & Wallace, 2006; Whitehead, 2004).
The Theory of Community Empowerment was designed to develop an interventional community empowerment framework through the use of three main concepts: involvement, lay workers and reciprocal health (Persily & Hildebrandt, 2003). Involvement refers to the process of empowering communities to identify their own needs, available assets and barriers to optimal health. Generating lay workers refers to the development and training of people within the community who are enabled to provide assistance to the community. Reciprocal health refers to an emerging praxis of empowerment and health promotion. The community works together to determine a positive outcome through the relationship between individuals in the community and health professionals (Persily & Hildebrandt, 2003).


**Figure 1.** Middle range theory of community empowerment

The Community Empowerment Model sought to provide a framework for research and practice in community settings. It was designed to develop a knowledge base and promote decision making capacity in rural settings and developing countries with limited resources in order to effect change through empowerment. The model has the potential for being generalized for use in the improvement of health care in vulnerable populations as well.

Empowerment involves a process of community residents taking control of their lives and environment. Powerlessness has been identified as a risk factor for disease, and it has been hypothesized that empowerment has a protective element against illness (Anderson, Guthrie & Schirle, 2002; Leonard, 2008). The holistic elements of empowerment are congruent with nursing values and have the power to effect change on a larger scale. The Community Empowerment Model was selected for analysis because of its focus on health promotion, holistic approach and usability in different cultural settings. Theories developed by nurse theorists from Western countries often exhibit a cultural bias that makes them unsuitable for use in cross-
cultural settings. Models that demonstrate a holistic and relationship-based approach are more likely to be successfully adopted in other countries.

Background of Model of Community Empowerment

A community can be described as a group of people who share common social, cultural, geographic, political, or economic values and concerns (Anderson & McFarlane, 2008; Chinn, 2008; Gibson, Gibson & Macaulay, 2001). The health of communities is impacted by the social, cultural, political, and environmental contexts in which people live. Because communities are the milieu in which individuals and groups function, they also provide the social structure which has the potential to facilitate or restrict health (Hildebrandt, 1996; Lynam, 2005). The reduction of health disparities in vulnerable populations depends on the ability of communities to address health risk factors and prioritize health promotion activities (Whitehead, 2004). If communities are unable or unwilling to take ownership of health promotion activities, then projects that are initiated by outside professionals are unlikely to be successful.

A paradigm shift is called for regarding the means by which nurses facilitate the development of healthy communities. Traditionally health promotion methods targeting communities placed health professionals such as nurses in the dominant role (Engebretson & Littleton, 2001; Hildebrandt, 1994; 1996; Whitehead, 2004). There are numerous examples of projects which initially appeared viable, yet were not sustainable without the support of outside personnel and resources (Hildebrandt, 1996). A key determinant of successfully addressing health disparities depends on the community being involved in the health promotion process through collaboration, participation and partnership between health professionals and community residents (Hildebrandt, 1996; Running, Martin & Tolle, 2007). When a community actively participates in the decision making process they gain power over their lives which is a step towards becoming empowered (Falk-Rafael, 2001; Rodwell, 1996; Tengland, 2006).

Empowerment is related to the process and outcome of autonomy, self-determination and control. Paulo Freire (1970) envisioned the disenfranchised people of Brazil as being able to liberate themselves from poverty and oppression by means of empowerment through education. Freire used the term praxis to describe the activities and collective awareness of needs of a particular group or society. Praxis of empowerment can be described as self-determination, intentionality and the practice of critical reflection that results in enhanced well being (Freire, 1970; Hage & Lorensen, 2005; Nyatanga & Dann, 2002).

Empowerment is defined as enabling people through knowledge, resource and power attainment (Kuokkanen & Leino-Kilpi, 2000; Rodwell, 1996). It is a complex phenomenon which includes self-efficacy, self-determination and a translational process of reciprocity (Jewell, 2007). It can also be seen as a psychological state of self-determination, decision making and community participation in change. “Empowerment is a synergistic paradigm of mutually beneficial interactions that strengthen the individuals and the community within the sociological context of that community” (Jewell, 2007, p. 51). As a concept, empowerment is most often
seen as emphasizing individual autonomy and self-capacity, which exhibits a Western cultural bias towards the primacy of the individual. Empowerment in a global perspective integrates community networking, improved relationships, creativity and resource allocation as essential ingredients for health promotion, rather than focusing on the abilities of a single person or family. Empowerment can be seen as a process that not only impacts an individual community but may also result in global change (Tengland, 2006).

The Model of Community Empowerment was developed as a structured approach to community involvement in health promotion by merging empowerment theory with community participatory action research (Fitzpatrick & Wallace, 2006; Persily & Hildebrandt, 2003). Hildebrandt (1994) operationalized the concept of community involvement in her Community Involvement in Health (CIH) model by identifying the necessity for the recipient rather than the provider to be the central force in health promotion projects. Hildebrandt’s model was based on the assumption that the development of trust between the community and health care provider was essential in order to overcome health disparities and promote quality of life. The model identified the two strategies for empowering communities: enabling the community to identify their own needs and facilitating a self-care/self-help strategy based on Orem’s self-care theory. Orem described self-care as those activities that individuals or in this case communities perform in order to maintain their health and well-being (Fawcett, 2000). The CIH model identified five basic principles of community-based intervention:

(a) People have a body of beliefs and experiences on which they base their actions; (b) People act within the context of their sociocultural environment; (c) The sociocultural environment is made up of facilitating and restraining forces that define how people live; (d) The options open to individuals for meeting self-care needs are those that fall within the range of where individuals beliefs and experiences overlap or are compatible with the sociocultural environment; and (e) Nursing is an effective, available strategy for empowering individuals and communities (Hildebrandt 1996, p.157).

Eugenie Hildebrandt developed the CIH model in the 1990s as a means of community-based intervention for use in projects developed for black South African townships. This model was further refined in association with Cynthia Persily, a nurse researcher at the University of Pennsylvania School of Nursing. Persily researched the use of lay providers for rural pregnant women, and as a result of findings from the pilot study, recognized the need for more community involvement. While researching the topic she discovered Hildebrandt’s CIH model, and they collaborated to combine the model of community participation with the use of lay workers as a means of developing community empowerment (Persily & Hildebrandt, 2003).

The concept of community empowerment and involvement in health dates back to the proclamation by the World Health Organization Alma Ata Declaration in 1977 which stated that people have the right and responsibility to participate in the planning and implementation of their health care (Falk-Rafael, 2001). Over the next 30 years, concepts of community participation, use of lay workers, and primary health care continued to expand both conceptually and
geographically. Several studies support the use of lay workers to improve communication between communities and health professionals. Running, Martin and Tolle (2007) describe the use of a participatory community health assessment project in Honduras and a number of studies using lay health advisors/workers in Japan, Ecuador, among nomadic Somali in Kenya and a Latino group in Los Angeles.

The Community Empowerment Model can be applied in a variety of ways. Lay health advisors can work with communities to identify health needs, develop solutions, educate residents about health risks, empower communities to care for vulnerable members such as pregnant women, children and frail elders, and suggest solutions for access issues such as transportation problems in rural and isolated areas. Lay workers and nurses can work in partnership to develop community involvement and attain reciprocal health. The term *reciprocal health* describes the outcome of purposive healthy behavior and is defined as the “actualization of inherent and acquired human potential” (Persily & Hildebrandt, 2003, p. 114).

**Critique of Community Empowerment Model**

Application of the Community Empowerment Model demonstrates its efficacy as a means of facilitating community involvement in health promotion. Empowering communities enables the group to prioritize needs, identify resources and recognize potential hindrances to the health promotion process. By enabling the community to attain control over positive health outcomes they will be able to develop and carry out appropriate strategies (Falk-Rafael, 2001; Persily & Hildebrandt, 2003).

The central causal agent in the Theory of Community Empowerment is the role of the trained lay worker who acts as a community resource and as a liaison with health care professionals. Lay workers are chosen from a local community, and if selected by the community itself, they would be more likely to have a trusted relationship within the group. They would have a respected role, have a similar cultural understanding of health issues, and be linguistically competent and knowledgeable about available resources. Their primary role is to provide information about health promotion and facilitate access to health care services (Persily & Hildebrandt, 2003).

Although, the use of indigenous lay workers is reported as overwhelmingly beneficial, there are a few concerns with their position. If lay workers are not selected by the community as a whole, but instead by an outsider or by a small faction of residents, then there is a potential lack of respect and trust of the individual. Some communities would even prefer an outsider who would be less likely to break confidentiality or participate in internal conflicts. If a lay worker belongs to a subsection of the population, she/he risks the possibility of being perceived to favor one group while neglecting another. As lay workers have limited training, they are unable to handle more complicated issues and should be aware of their limitations. In some instances, lay workers may be unable to empower a community due to sociopolitical barriers that limit their effectiveness, such as gender or caste. This could result in their inability to provide
adequate support for empowering communities. If empowerment depends on the effectiveness of the lay worker then there is a potential for misuse of position, lack of accountability, lack of sufficient skills and misuse of resources. The lay worker may act as a facilitator for empowerment but should not be considered the sole driving force behind the change process.

The desired outcome for community empowerment is reciprocal health, an emerging framework of self-managed, healthy behavior. Emerging health is evident when partnerships develop between the community and health professionals. The process of self-reliance and self-determination is an essential driving force behind the potential for change in a community’s health status.

The diagram of the Community Empowerment model does not show a direct connection between involvement and expanding options which occurs as a result of individual and community forces. It also does not connect individual and community health outcomes with reciprocal health. Without a clear connection between these concepts, the influence of involvement as a precursor to expanding options is not clear and the relationship of outcomes to reciprocal health is indeterminate. The model assumes the influence of driving and restraining forces as being part of the empowerment process, but these forces are not depicted in the model.

Components of a Modified Community Empowerment Model

The Community Empowerment model is based on the assumption that successful outcomes depend on community participation and leadership when a trust relationship exists between health professionals and community residents. Efficiency of the community involvement process leading to reciprocal health requires change on a larger scale. The modified model of Community Empowerment will include concepts from Lewin’s force field analysis of change and the process of implementation of that change as a central outcome of reciprocal health. Kurt Lewin’s theory of change identified the necessity for recognition of the need for change (unfreezing) to occur prior to a change actually starting to take place (Schein, 2008). The model will be further expanded by the inclusion of concepts from the Anderson, Guthrie and Schirle Nursing Model of Community Organization for Change.

Lewin’s change theory includes the concept of force field analysis which identifies driving and restraining forces that motivate or hinder the change process (Miner, 2005). Driving forces include the empowerment process, the identification of needs and the desire to improve health, while restraining forces include resources, knowledge, and level of trust. Lewin’s model of the change process describe change as requiring movement from the status quo or equilibrium through an increase in the driving forces and decrease in restraining forces (Accel-Team, 2008; Robbins, 1997; Schein, 2008). Once the driving forces overcome the restraining forces, then the unfreezing process allows the initiation of the change process. After the change has been implemented, a stabilization process then is required to reinstate equilibrium and a refreezing must stabilize the situation.
The process of building community participation to facilitate empowerment presupposes several assumptions: first, that the empowerment process can be learned and that experiencing the learning process is the best method of attaining competency. Involving a variety of community stakeholders is essential to successfully create change (Persily & Hildebrandt, 2003). Specific strategies for empowerment in the Community Empowerment Model are based on trust, shared information, partnership and interaction. However, the central piece of the model exhibits extensive dependence on only one aspect of the process designed to result in the outcome of reciprocal health. This dependence on the lay worker as the single focal point could be considered a weakness of the model, as it does not allow for strategic flexibility in methods. To overcome this potential weakness, the model will be extended by including a specific description of the change process, including the community organization development process. In addition, the concept of reciprocal health is inadequately defined and could be interpreted in several ways.

Change Process

Kurt Lewin developed a theoretical model which describes the process of change and how group decision making can impact that process (Miner, 2005). Although Lewin was a social scientist who studied organizational structure, this model has been used widely in a number of disciplines. Lewin theorized that underlying any change are driving forces which favored change and restraining forces which favored the status quo. In order for change to occur, driving forces would either be required to overcome restraining forces or restraining forces would have a diminished resistance to the change. When movement away from the status quo or equilibrium occurred, this was termed ‘unfreezing’. Most states of equilibrium are maintained by equal tension between the forces promoting change and those resisting change. When equilibrium is disrupted, movement takes place until the desired result is obtained; then a process of refreezing is required to stop the process and stabilize the change. (Accel-team, 2008; Minor, 2005; Robbins, 1997).

The Community Empowerment Model identified the involvement of both individual and community forces as integral to expanding options available to the community for health promotion (Persily & Hildebrandt, 2003). The driving forces can be identified as community involvement in the process of identifying needs, resources, barriers and developing strategies to obtain necessary information, determining and delegating tasks and appointing appropriate personnel to be participate in and be responsible for projects. An evaluation process should also be developed in order to assess progress towards selected goals and outcomes.

Identifying restraining forces that inhibit community empowerment such as cultural mores, gender role restrictions, lack of education, inadequate resources, and disinterest in change activities is an important part of assessment. The process of unfreezing integrates with the expanding options concept delineated in the Community Empowerment Model. Although the use of lay workers is an effective method of health promotion, it should be part of a more extensive empowerment process that requires the participation of the community as a whole. For example, in a Community-Based Health Care program in the South Pacific, a village desiring
to participate in the project was first asked to complete specific activities before the program could be initiated in their area. The village was required to meet a set of basic preliminary tasks, such as each household building a pit toilet before the program facilitators would work with the village to identify more specific needs and train village health volunteers. If the community was not able to initiate an adequate level of cooperation and demonstrate an adequate motivational level, then the project would be delayed or cancelled.

In order to promote purposeful change, the process of empowerment can be initiated through intentional action by the community. According to Burks (2001), intentional action or goal-related action can be described as the determination to aspire to a particular outcome. By developing a process of intentional action, behavioral change can occur. Intentional action includes the development of a plan and the subsequent performance of an action in order to reach the desired goal (Burks, 2001). A combination of both internal and external factors influences the performance of the expected outcome. These factors occur whether the intentional action is performed by an individual or a group. Internal factors impacting community action may consist of motivational issues and self-concept of the group. External factors may involve societal pressures, availability of resources and cultural belief systems. The balance between positive and negative factors impacting the change process is similar to Lewin’s freezing and unfreezing force field model of change. In order for the community to initiate purposeful action, positive factors must outweigh the negative factors. The importance of intentional action is illustrated by numerous projects which have failed to create long-term change in health disparities, all due to a lack of community involvement and ownership.

One of nursing’s signature roles has been health education. The main purpose of health education is to provide people with the information necessary to make life changes which will improve their health status (Whitehead, 2004). Nurses educate people with the expectation that the information will be used to make positive life changes; however, it is an unfortunate reality that health education alone has proven to be insufficient to make the changes necessary to impact health on a global scale. There are numerous instances in which behavioral change does not occur despite sufficient knowledge.

Nursing Model of Community Organization for Change

An empowered community has the potential for change if residents have the capacity to adequately overcome restraining forces that limit change and organize a means to promote improved health. The Nursing Model of Community Organization for Change provided additional theoretical support for the process of facilitating the change process. Anderson, Guthrie and Schirle (2002) use a nursing process model combined with a community organizing framework utilizing systems theory, social learning theory, diffusion theory and social support theory. The model emphasized the importance of the community working as a social unit in order to address influences on health determinants, such as access to health care, environmental issues and socioeconomic influences. The social learning theory expanded this model by conceptualizing the interrelationships among behavior, environment and people. Change in one
part of the system has a ripple effect on another part of the system, so behavioral change could be initiated by the use of role models, social networks, formal and informal communication routes (Anderson, Guthrie & Schirle, 2002). The social support theory describes an exchange process of support and guidance within a social network system. Aspects of supportive behavior include emotional support- expressions of trust and caring; instrumental support- tangible resources and services; informational support- suggestions, advice, information; and appraisal support- advice designed to develop self-evaluation strategies and adjustment of interventions as required (Anderson, Guthrie & Schirle, 2002).

The Nursing Model of Community Organization for Change identifies assumptions that are essential for understanding how incorporating concepts of empowerment, partnership, participation, cultural responsiveness and community competence can have a positive impact on health. The assumptions include the following: (1) Developing community competence enables the community to manage potential and actual problems which impact health. (2) Participation of the community in the process of identifying needs, resources and interventions increases learning and the probability of success and sustainability. (3) If programs are culturally congruent, it increases the probability of the community adopting health-promoting behaviors (Anderson, Guthrie & Schirle, 2002).

In order to facilitate community empowerment, a sense of increased self-efficacy by the community must be established. Community participation is at the core of this process. In order to develop a successfully empowered community, a partnership based on trust must be established with the health care professionals acting as a catalyst for change. It is also necessary for the community to participate by identifying problems, developing programs and policies, and delegating power which enables the community to organize itself as a problem-solving entity.

Another important concept in the Nursing Model of Community Organization for Change is cultural responsiveness, which incorporates community cultural factors into the process of health promotion. The community health nurse is responsible to develop an understanding of the cultural and historical factors which impact interpersonal relationships and the influence of cultural beliefs on health-seeking behaviors (Anderson, Guthrie & Schirle, 2002). The community’s ability to integrate cultural beliefs and health promotion concepts appropriately will support the development of competency in the process of establishing a healthy society.

**Figure 2.** A Nursing Model of Community Organization for Change.

The community organization process described in the Nursing Model of Community Organization for Change requires several stages similar to the nursing process. These phases are set in a non-linear, cyclic pattern to allow change to occur at various points of the process. The assessment/reassessment phase initiates data collection, definition of the community of interest and identification of the community’s felt needs. The planning/design phase enables the community to set goals and develop appropriate interventions including selection and training of lay workers. The implementation phase starts with the development of a project timeline, securing of necessary funding and resources, and initiating interventions. It is essential for sustainability that communication channels be clearly established and mentoring of local leadership occurs during this phase. The evaluation phase is necessary to identify the successes and failures of the objectives and assess the participation of the community members. The process of evaluation is especially important in the process of developing community competence as it is a means of identifying what works and what does not work (Anderson, Guthrie & Schirle, 2002).

**Description of a Change Model for Community Empowerment**

Modification of Persily and Hildebrandt’s Community Empowerment Model was achieved by the addition of elements from Lewin’s Change Model and principles from Anderson, Guthrie and Schirle’s Nursing Model of Community Organization for Change. This modified framework is designed to enable communities to gain control over their health through a process...
of intentional change. By empowering communities to participate in the process of developing and implementing strategic interventions designed to create change resulting in a progression towards improved health.

**Key Concepts**

Central concepts of the Change Model for Community Empowerment include participation, partnership, change, empowerment, and reciprocal health. Participation is the involvement of the community in the process of assessment, planning, implementation and evaluation of interventional strategies to promote change. Partnership refers to the relationship between the community and health professional which should be based on trust, respect and mutual support. Effective leadership and collaborative skills can only be developed in a community in which authority is shared and communication is encouraged. Persily and Hildebrandt (2003) describe ‘expanding options’ as resulting from individual and community forces. These expanding options can only occur if community members and health professional work together in partnership. Change is a necessary part of the process of transforming a community from status quo to an improved quality of health and life (Leonard, 2008). Due to the unique culture and context of each community, an assessment of the driving and restraining forces is necessary. The process of discovering these forces enables the community to determine the pre-existence of health risks and health promoting behaviors as well as determining strategies that would promote successful change. Part of the change strategies may include means for developing community competency by determining educational needs, providing training for community members and lay workers and strengthening social networks (Anderson, Guthrie & Schirle, 2002; Persily & Hildebrandt, 2003). Change is more likely to occur if certain assumptions and norms, such as sociocultural practices/beliefs are explicated. The impact of cultural issues on health behaviors must be incorporated into any strategic plan for success.

Empowerment is the process by which a community develops control over quality of life issues resources, self-care, problem solving proficiency, and resources. One aspect of empowerment is the development of community competence, which is defined as the ability of the community to improve collaboration in the process of goal attainment (Anderson, Guthrie & Schirle, 2002). The desired outcome of community empowerment is reciprocal health that is derived from achieving an interdependent relationship between the community and health professionals. The concept of reciprocal health could also be defined as the outcome of reciprocal interaction between community members.

**Assumptions for Expanded Model**

The identification of the assumptions underlying a theory is an important element in the process of promoting understanding of a model through the provision of the context for the theory and facilitating its application in various settings (Anderson, Guthrie & Schirle, 2002; Meleis, 2007). Assumptions include the underlying presuppositions that form the basic underlying truths of the theory. Assumptions include: (1) The health status of a community
exists in a state of equilibrium, which exists due to a balance between driving and restraining forces. For change to occur this equilibrium must be disrupted (Minor, 2005); (2) To empower communities, nurses do not act directly to create change, but work with the community to develop an environment in which change can occur (Leonard, 2008). (3) Broad-based community participation promotes learning, develops leadership skills and increases the probability of the success and sustainability of a project (Anderson, Guthrie & Schirle, 2002; Hutchinson, Anderson & Gottschalk, 2008); (4) Culture influences community health-seeking and health-promoting behaviors (Anderson, Guthrie & Schirle, 2002; Hildebrandt, 1996).

Phases of the Change Process

The methods of integrating the concepts of the Change Model for Community Empowerment with the promotion of community competence requires a framework designed to enable the organizational process to occur. This framework is adapted from the phases of Community Organization developed by Anderson, Guthrie and Schirle (2002), utilizing the nursing process to guide strategic development by empowered communities. The Assessment/Information Seeking Phase enables the community to initiate identification of needs, driving/restraining forces, existing social networks and the availability of resources. This initial step should involve the community as a whole and begin to establish the promotion of community partnerships (Leonard, 2008).

The Planning/Design Phase involves setting goals, determining outcomes and developing appropriate interventions. This phase requires the continuing development of partnership between the community and the health professional. Ownership of a community-based health project is determined by the community working to set its own goals, designing appropriate interventions, and being accountable for the programs outcomes. The nurse’s role in this process is to provide educational support, enhance communication, be available for technical assistance and work as a mediator if conflict occurs.

The Initiation/Intervention Phase involves the activities related to the implementation of the program. During this phase interventional strategies need to be organized and initiated. A continuing process of assessment needs to occur during this phase to determine the progress or lack of progress of the interventions. If progress toward the outcomes is not occurring, then modifications can be developed and integrated at this point.

The Evaluation/Dissemination Phase examines the attainment of selected outcomes and assesses the level of accountability taken by the community. Evaluation data can be used to assist in the modification of interventions and determination of the progression of the project. This phase provides an effective means by which community competence can be enhanced. Dissemination of the program depends on adequate communication channels and adoption of the healthy practices by the community at large (Anderson, Guthrie & Schirle, 2002).
Implications for Use of a Change Model for Community Empowerment

There is both local and global potential for use of an organizing model for community change based on the principle of empowerment. Rural, impoverished, underdeveloped communities or vulnerable population groups would benefit from a community empowerment method of health promotion. Since the model utilizes human and material resources already present in the community, the participants work in partnership to make contextually appropriate changes designed to improve their health.

Conclusions

Empowerment resulting from a partnership model has the potential for positive local transformation of health issues in communities who struggle with health disparities. By changing the focus of health promotion from the individual to the community there is a greater potential for success. A model which integrates change theory and community empowerment techniques can lead to long lasting improvement in health. Effective measures or strategies for evaluation of success could be developed jointly by communities and researchers.

Research studies based on participatory methods of community-based health use a collaborative approach designed to improve local health indicators, decrease health risk behaviors, and build capacity for management of health problems and empowering groups. Research focused on a particular health issue should involve the entire community if possible and work with the community to develop cooperative, synergistic skills in order to make appropriate changes in the social structure.

Empowerment is gained through a process of education directed by community needs and reflection designed to transform the status quo. Learning occurs as a result of the developing relationships between community health nurses and the community as well as between community members. While the provision of education provides resources which contribute to driving forces in the change process, information dissemination alone does not have the capacity to change health behaviors. There are a number of factors which must be integrated into the sociopolitical and cultural environment of a community to cause change to occur.

Leadership structures are also impacted by the process of community empowerment. Inherent in the model is the development of the leadership role through the practice of partnership and collaboration. As the community is empowered to take responsibility for health concerns and other needs, it will also develop skills in self-care and competence.

The success of community-based health projects that the author has observed in South Pacific nations such as Papua New Guinea, Vanuatu, Fiji and the Solomon Islands was determined by the ability of the community to take ownership for the project and the ability of the facilitator to delegate authority, resulting in local empowerment. Some projects had unfavorable outcomes due to community members being unable or unwilling to allow change or
because outside health professionals mandated interventions that were unsuitable because of cultural belief systems. Developing countries frequently suffer from limited access to health care, insufficient resources and an inadequate educational base among the population. If a community focuses only on the barriers to transforming their quality of life, then it is unlikely that sustainable change will occur. Empowerment without community-guided change is inevitably futile and change without empowerment is unsustainable. However, if a community is empowered to discover their inherent strengths and participate in the change process, then a more positive outcome can occur.

References


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