

# The Nature of Theoretical Thinking in Nursing

Second Edition

Hesook Suzie Kim

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Theoretical Thinking  
in Nursing**

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# Preface

It has been more than fifteen years since the publication of the first edition of this book. During this period there has been tremendous growth and enrichment in the theoretical work in nursing. Several grand theories and conceptual models that were initially presented by the early 1980s have been revised, reformulated, and refined either by the original theorists or their followers. A great deal of nursing's theoretical work also focused on the development of middle-level theories as well. In addition, there has been significant growth in the delineation, clarification, and refinement of concepts in nursing from various perspectives. Furthermore, serious debates and discussions regarding epistemological and other philosophical underpinnings of nursing knowledge developed during the last decade. As a discipline, nursing is evolving and maturing into a knowledge system that is becoming clearer in delineating its subject matter and in dealing with its problems as a science.

Because I published a revised version of the typology of the nursing knowledge system into four domains in an article in *Scholarly Inquiry for Nursing Practice* in 1987, I believed for a time that the original book could stand as it was with the revised ideas presented in that article. As the book went out of print, however, many colleagues and students began to voice a great need for a revised version of the book. I also became aware of the need to incorporate new ideas and revised thinking on the way we ought to deal with theoretical issues in nursing.

Although we have taken large strides in developing nursing concepts and theories, we are still struggling with theoretical clarification of essential features regarding phenomena of interest to nursing, their conceptualizations, and theorizing about them. There still are enough tensions existing within the field that call for an integrated approach to theoretical thinking in nursing. This book is intended to provide conceptual tools that can be used to delineate the world of nursing in theoretical terms. Any serious student or scholar concerned with theory building in nursing, at one time or another, would ask: "What is nursing concerned with in a theoretical sense?" It seems that for one to answer this question satisfactorily,

it is necessary to have a systematic framework for the analysis of theoretical elements in the field of nursing.

I propose in this book a systematic framework that can be used to examine elements in the field of nursing and to posit important concepts in a system of order and within a boundary of specific meaning. The purpose of this volume is to understand how conceptualizations and theoretical statements are developed and refined in nursing. The primary aim of the book is to offer a typology of conceptual domains that can be used to delineate theoretical elements essential to nursing. In this second edition, I have clarified the typology of four domains as the way to structure conceptual fields for nursing, incorporating current advances. The revised typology now stands as *the domain of client, the client-nurse domain, the domain of practice, and the environment domain*. I believe this typology as a conceptual mapping device is a useful analytic tool for delineating and theorizing about phenomena of interest to nursing, as it has done for many students and scholars in nursing since its initial publication.

The book is mainly designed for graduate students in nursing who are struggling with conceptualization and theoretical analysis of nursing phenomena. However, many colleagues have shown that the first edition was also useful in introducing undergraduate students to nursing conceptualizations. My goal is to show how empirical elements in the world of nursing are translated into theoretical terms, and in turn, how theoretical concepts are specified in the real world of nursing. Specification of concept delineation is proposed within the typology. The book shows how both inductive and deductive expositions may be used in theoretical thinking in nursing. Although I discuss and analyze many conceptual and theoretical ideas expressed by nursing theorists, namely, Rogers, Roy, Johnson, Orem, and King, I do not make systematic evaluations of the values and applicabilities of their theoretical systems. I have not attempted to evaluate or criticize theories, both nursing and those from other fields of study, in a systematic or comprehensive manner. I have included in the book those appropriate aspects of nursing and other theories mainly to illustrate, expand, and apply the ideas under discussion. The purpose of the book is not to show the adequacies and inadequacies of theories for nursing as a scientific theory, but to show how such theories are similar and different in their uses of abstraction, conceptualization, and subject matter.

I focus on delineating and describing essential concepts in nursing that are thought to be important for development of theoretical systems. I contrast similarities and differences in conceptualization of nursing and elements in nursing in order to show how the same elements and phenomena are perceived differently from different perspectives, and how the same idea is concealed in many different conceptual disguises. Furthermore, the book has no specific "clinical" orientation. This reflects my bias and conviction that theoretical development in nursing should follow universally

applicable conceptual strategies, regardless of the specific ways nursing problems are classified. The main emphasis is on the how to and the what of theoretical analysis in nursing. In this edition, I have added in the last chapter my ideas regarding what the nature of *nursing epistemology* should be within the current scene of pluralism. We must look to the 21st century for theoretical advances in nursing with a synthesizing framework that addresses the multifaceted and complex nature of knowledge required for nursing as a discipline and practice.

I have been fortunate to be associated with many colleagues and graduate students who have stimulated my thinking on this typology over the years. Many serendipitous ideas and insights were gained from working with them. Among them, I must acknowledge continued support from colleagues at the University of Rhode Island, and many classes of doctoral students who were often exposed to my “under-baked” ideas. With them, I was never hesitant to grapple with even the most elementary theoretical questions. I owe much gratitude to Professor Donna Schwartz-Barcott who has spent endless hours debating and questioning with me many of the ideas presented in the book. The faculty at the Institute of Nursing Science, University of Oslo has also continuously encouraged me to pursue the line of thinking that I was discussing with them. Their support especially has given me the courage and hope in putting myself through this revision.

For granting me the most scholarly and enhancing atmosphere that any scholar could want, I am most grateful to the succession of Deans at the College of Nursing, University of Rhode Island, especially to Dean Barbara L. Tate, who was the staunchest supporter of my effort during the initial period. I believe it was this atmosphere of creative warmth, more than anything else, that enabled me to write both editions of this book. As with most good things in life that need special grace, my interest in theoretical thinking initially received a special push from Professor Martin U. Martel of Brown University during my graduate studies there. I thank him for showing me the way to question theoretically.

In writing this type of book, one must draw a great deal of support from one’s personal resources. I had the most wonderful support from my family and friends over the years. Most of all, my husband, Hyung, has been the true source of support for the mental energy that was so necessary and critical during the writing of this second edition.

My appreciation also goes to Ruth Chasek, my editor at Springer, who was willing to examine the manuscript for the second edition without much hesitation.

I hope this book can provide readers with insights and ideas that propel them to venture into deep theoretical thinking and work, challenging them to forge toward the systematization of nursing knowledge.

HESOOK SUZIE KIM  
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# 1

## *Introduction*

The discipline of nursing has gone through three decades of struggle, which was both internally and externally directed, in order to gain recognition and legitimacy as a field of science and a profession. Many eminent voices of the earlier times have provided a backdrop from which nursing leaders and scholars of these more recent decades have been able to extract the characteristics and essences of the discipline of nursing as a knowledge system. In addition, the conceptual and cognitive foundations of nursing had their origins in the writings of early scholars. Florence Nightingale (1859, 1992) with pioneering foresight insisted on a formal training for nurses which became an impetus for building a body of knowledge for nursing, while Virginia Henderson's ideals (1966) have sustained nursing's emphasis on humanizing care. Rozella Schlotfeldt and Rosemary Ellis were important advocates in strengthening nursing's quest for scientization: Schlotfeldt insisted early on for nursing to become an independent academic field of study (1978, 1987), whereas Ellis (1970) abhorred casualness in scholarly pursuit and instilled analytic seriousness into nursing studies.

In addition, the political force within the nursing profession found its roots in the spirit of self-determination, professionalization of work, equal rights movement, and feminism. As the discipline of nursing moves into the new age of its maturity, coming out of the jubilant, energetic but confused pubescence into a more self-examining, responsible adulthood, it needs to formulate a comprehensive view of its cognitive identity as a specific practice discipline. What is of significance at this juncture in the development of nursing discipline is a need to step back and examine the current status of (a) what it means to be in nursing practice; (b) what knowledge that we hold as a collective and as individuals is essential for our practice; and (c) what ideals are embedded in nursing practice as well as in the generation of nursing knowledge.

Nursing practice of the 1990s has formed a firm alliance with the culture of scientific knowledge and technological advances that are aimed at controlling health problems. At the same time, there is a strong sentiment developing within nursing's discourse that points out the need for nursing



to stand away from that culture. Nursing practice encompasses both the scientific problem-solving orientation and the human-practice orientation. Nurses are not only dealing with and seeking solutions for clients' health problems but are also concerned about how to help clients in their "living with" certain health-related situations. This means that the essential features of nursing knowledge required for practice must embrace the science of control and therapy as well as the science of understanding and care. This also means that nursing as a scientific discipline must delineate its specific nature as a human practice science, distinguished not only from the natural and social sciences, but also from the so-called human sciences.

The image of nursing as a science has been in the making for the past three decades, and nursing is emerging as a field rich in empirical knowledge. However, it is continuing to struggle to define its subject matter and approaches with which nursing can develop the knowledge it needs. The development of theoretical knowledge in nursing began with rich rhetoric in the 1950s and 1960s followed by grand-theorizing in the 1970s and the early years of the 1980s, and continues with the effort focusing on developing middle range and micro-theories.

One of the central problems in nursing theory development has arisen from the difficulty that the discipline has been experiencing in arriving at a definition of nursing that encompasses the nature of nursing from both the academic as well as the practice perspectives. While the ambiguities that existed during the earlier decades seemed to have been clarified as we entered the 1990s, the current struggles in the health-care arena in the United States have resurrected the question of definition in recent years. Nursing is again faced with having to clarify its role within health care and to rethink its definition in light of (a) the creation and installation of various technical/assistive health-care roles, especially in acute care settings; (b) the shifting of major settings of nursing practice from acute care hospitals to home-care and long-term care settings; and (c) the implementation of many forms of standardization and streamlining of health-care practice, such as through critical paths, care-maps, and managed care.

Although we have been amply supplied with many versions of rhetorical definitions of nursing throughout its history, such definitions were only able to furnish a weak foundation for the generation of scientific knowledge, positive impact on society and the profession notwithstanding. As a matter of fact, such rhetorical definitions were the ones exactly needed as general guides for understanding what nursing is all about as a social role in the minds of the public as well as in the minds of members of the profession. A rigorous and exact delineation of nursing as a role and as a scientific discipline in definitional terms is necessary specifically when it is used as the conceptual basis for the development of nursing's theoretical knowledge.

Two kinds of efforts are found historically in the works of nursing scholars, both of which deal with the definitional ambiguities in nursing. On the one hand, several grand theorists in nursing have proposed conceptual models of an all-encompassing type beginning in the early part of the 1970s. These models are used to describe in general three points: (a) what aspect or aspects of human conditions the discipline is concerned with; (b) in what ways we can understand and/or explain the key phenomena of concern; and (c) what the members of the discipline do as the practitioners of a scientific field. Some nursing scholars, on the other hand, have focused on developing elementary theoretical statements that deal with a few selected concepts relevant to nursing. Although such efforts, especially throughout the last twenty-five years or so, have contributed to an increasingly rich body of knowledge, we must admit, albeit regretfully, that nursing as a scientific discipline is continuing its struggle to specify its subject matter.

One of the major confusions in the discussions regarding nursing knowledge is the ambiguity with which authors treat the differences between knowledge possessed by individual practicing nurses and that of the discipline of nursing as a whole. Knowledge thus exists in two sectors as *private* and *public* knowledge in the discipline of nursing, because in practice disciplines practitioners are not only the users of knowledge of the discipline, but also the possessors of certain sets of knowledge. Hence, there is knowledge that is held by practitioners as private knowledge, and knowledge that belongs to the public sector, i.e., to the discipline. While there is an intimate connection between these two sectors of knowledge, nursing knowledge development basically is for the knowledge at the disciplinary sector, i.e., the public knowledge. Confusion exists because often nursing scholars are both practitioners and scientists who contribute to the development of the public knowledge and at the same time are generators of their own private knowledge.

One can view this partitioning from Popper's epistemology of "world 2" and "world 3" (Popper, 1985). Popper proposed three worlds of universe: "world 1" referring to physical world, "world 2" as the world of states of consciousness that belong to specific subjective humans, and "world 3" referring to "the world of objective contents of thought" (Popper, 1985, p. 58). From this, two types of epistemology are considered: one originating from world 2 as knowledge in the subjective sense, and the other belonging to world 3 as objective knowledge consisting of theories, objective problems, and objective arguments. Scientific knowledge thus is considered to belong to world 3 and is not tied to specific, individual-knowing subject. Scientists are concerned with the growth of knowledge in world 3, but are dependent upon processes of world 2 as the basis for that growth.

Drawing from these notions advanced by Popper, it is possible to partition nursing knowledge into two sectors: private and public. Private knowl-

edge refers to the knowledge that belongs to specific individuals gained through one's consciousness and mental processing of experiences and responses. It thus belongs to Popper's world 2. On the other hand, public knowledge aligns well with Popper's world 3 as knowledge that exists at large. Public knowledge, although gained through private processes of scientists, is objective and is oriented to systematization.

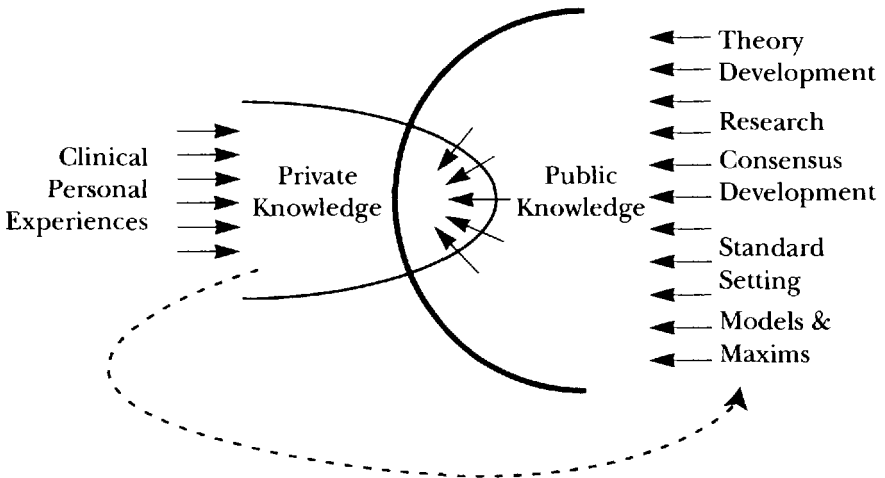
Benner's work (1984, 1996) has especially created a somewhat comforting idea that nurses can come to possess that holistic knowing of clinical situations through experience and exposure to problem-solving situations. Each practicing nurse is a possessor and generator of knowledge, and each nurse possesses and generates a unique set of knowledge that is different from all others' private knowledge. Each nurse has a private nursing knowledge that is generative and dynamic as well as ideographic. At the same time, some parts of nurses' private knowledge have shared elements with other nurses' private knowledge and with the disciplinary knowledge at large (that is, the public nursing knowledge). Knowledge considered from this private, personal perspective, points to the workings of processes individual nurses are engaged in that either expand or stagnate their private knowledge. Hence, what constitutes nurses' private knowledge and how it becomes constituted and generated are not questions of epistemology (that is, of philosophy) but of cognition requiring answers from specific types of scientific inquiry. Benner, Tanner, and Chesla (1992) are attempting to provide answers to such questions from the perspective of phenomenological hermeneutics, while others are considering these questions from the perspective of cognitivism or of social structuralism. On the other hand, Silva and her colleagues (Silva, Sorrell, & Sorrell, 1995) have adopted an ontological orientation in addressing such questions focusing on knowledge of reality, meaning, and being.

Professional education, certainly, is the starting point at which each student or trainee gains an access to the public knowledge of a discipline and moves to build a private knowledge that initially is more standardized than ideographic. Enrichment of private knowledge can be from personal experiences, and self-referential and reflexive constructing at individual levels, or may draw from the knowledge at the public sector that is continuously enriched through activities within nursing's scientific community. Conceptually, thus, the private knowledge that refers to knowledge held by and generated through individual nurses is different from what Carper (1978) called "personal knowledge" which refers to the knowledge of self. Personal knowledge in the sense of the knowledge of oneself is the knowledge of introspection and is a part of the private knowledge. The private nursing knowledge constitutes those cognitive elements that are required and used in nursing practice, including the knowledge of nurse-self.

On the contrary, the public knowledge refers to knowledge of the discipline that is available at large and has the characteristics of systematization and generalization. However, the level of systematization and generalization may vary according to the maturity of a discipline and the degree with which a discipline is able to integrate new knowledge into a system of coherence for its epistemological questions. When nursing scholars discuss nursing knowledge in general, they are referring to the public nursing knowledge that exists in various forms such as theoretical, descriptive, ideological, or philosophical. Nursing knowledge development is oriented to enriching the public knowledge, as it is the source and foundation for the discipline's performance at individual and aggregate levels. The theory-practice gap we often talk about refers to the apparent lack of matching between what is available in the public sector and what is being used in individual practice (Kim, 1993).

Figure 1.1 shows the interrelatedness between the knowledge in the private and public sectors in the development of nursing knowledge. Hence, in practice disciplines public knowledge is not only gained and developed through scientists' work but by accessing what becomes accumulated and refined in practicing nurses' private knowledge.

My exposition in this book, therefore, deals with how we may systematize nursing knowledge in the public sector, although the private knowledge held by practicing nurses is a rich source for such systematization. Nursing knowledge in general may refer to knowledge that is related to any epis-



**Figure 1.1 Relationship between public and private knowledge in nursing.**

temic aspects of nursing. However, nursing knowledge considered in this book focuses only on the core of nursing related to nursing practice, and ignores those aspects of nursing knowledge considered in a broader sense, such as knowledge about nursing history or its professional organizations. The focus here is on epistemological issues rather than on professional issues. I address specifically the knowledge that is directly related to understanding and explaining nursing practice and its relationship to clients and outcomes of practice.

Nursing certainly has made a great deal of progress in accumulating the scientific and theoretical basis for its practice, yet a systematic view of that knowledge remains fuzzy. Confusion still exists regarding what classes of phenomena should be included in a system of theoretical understanding and explanations in nursing. However, one must remember that the boundaries of subject matter for scientific fields, even for the well-established ones such as mathematics, chemistry, or economics, become revised through an evolutionary process. A scientific field goes through stages of boundary-redefinitions that are partly based on the kinds of major phenomena or subject matter it deals with, such as money flow in economics, energy and matter in physics, or personality development in psychology, and partly based on what is happening in the scientific fields in general. This idea agrees with Shapere's position (1977) regarding formation and reformation of a scientific domain as constituting a unified subject matter. Well-established associations between phenomena in a scientific field are exposed to scientific scrutiny under a variety of methodologies and in entirely different perspectives. This is an ongoing process that occurs in scientific communities. Eventually, the propriety of categorizing scientific problems into a field of scientific knowledge may be questioned, and reformulation of the boundary may occur.

The grounds used for deciding boundaries of fields may also be considered superfluous or ambiguous. Thus, subject matter may be reclassified or redescribed in different fields, especially with the emergence of new scientific fields. This happened in the nineteenth century for sociology when it differentiated from economics. On this evolutionary basis, nursing as a scientific field has to go through the process of claiming certain classes of phenomena as its subject matter, and subsequently abandoning and reclaiming other subject matter as the field becomes clearer in the definition of what major scientific problems it seeks to answer. In addition, it appears that the monistic claim of a theory to be completely general and universally relevant is neither fruitful nor appropriate for nursing. Since a diversity of phenomena can be claimed as nursing's subject matter, and since the field is yet to be organized to have a definite claim to a set of specific knowledge, multiple theories are not only useful but also necessary.

With these ideas as background, I propose a framework that is to be used to delineate theoretical elements for the field of nursing. My main attempt is to show how one can examine relevant phenomena systematically with a nursing perspective using this framework. This framework is offered as *the metaparadigm framework for nursing* that draws out the boundaries for nursing's subject matter. I propose a backtracking, for I believe we are ready for a thoughtful reconsideration of what we have said about nursing in theoretical terms. We are now at a juncture after fervent discussions concerning what kinds of theories nursing should be developing and from what philosophical perspectives we must address nursing's subject matter. During the past ten years, the field of nursing knowledge has progressed in a truly multifaceted, pluralistic manner. That situation has resulted from the development of multiple theories with various scopes, the adoption of pluralistic philosophical orientations in developing nursing knowledge, and the application in nursing studies of various scientific methods. We are at a point in our scientific development that requires a careful examination of and reflection upon the construction of the theoretical foundation of nursing based on a unifying framework.

One of the major reasons for the apparent lack of a systematic view of nursing knowledge, I believe, is the continued use of the so-called four metaparadigm concepts, i.e., *health, person, environment, and nursing*, in discussing nursing theories and nursing's conceptual issues. These concepts served as the starting points in thinking about nursing's emphasis when they were introduced by Yura and Torres (1975) and reinforced by Fawcett (1984). However, these are merely key concepts that nursing may need to formulate meanings from which various ontological and explanatory positions may emerge. These concepts cannot be used as four cornerstones that set up the conceptual boundary for nursing's subject matter as some nursing scholars have been trying to do. They are empty as boundary-specifying constructions, but are useful in asking nursing scholars to formulate specific conceptual orientations for further theoretical thinking. The proposed metaparadigm framework for nursing hence is different from these "metaparadigm concepts," as the proposed framework is a boundary-specifying guide for delineating conceptual and theoretical issues regarding nursing's subject matter.

This metaparadigm framework is a typology that includes four distinct conceptual domains of *client, client-nurse, practice, and environment*. This typology is an analytical tool to be used to classify and posit concepts and phenomena within specified boundaries. By doing this, conceptualizations and theoretical statements can be derived or examined with a conscious knowledge of the empirical locality of phenomena. This will help nurse scholars to conceptualize and theorize about observations of the nursing world, and to derive scientific explanations in whatever philosophical or

theoretical perspective they may take. The idea is to show how phenomenal elements relevant to nursing study are translated into theoretical terms, and in turn, how theoretical concepts are specified in the real world of nursing. Therefore, both inductive and deductive approaches are considered appropriate for expositions in nursing based on this typology. The approach adopted for the specific exposition used in this book is a combined approach of induction and deduction. This combined approach is the first step necessary for systematic thinking and an indispensable method of abstraction in developing and using theories. The "use of theories" here indicates many ways of expanding, refining, and testing that scientists do through research, critical evaluation, and theory construction.

Starting with conceptualization as the first step in theory building, my intention is to begin theoretical thinking, freed from any specific theoretical bias or philosophical bent. Thus, I shall not provide formal guidelines for evaluating nursing theories, nor provide synoptic discussions and summaries of "major nursing theories."<sup>1</sup> Specific detail of major nursing theories and conceptualizations will be analyzed and discussed in appropriate sections as examples of theoretical thinking.

In Chapter 2, the terms and concepts used in concept development, theoretical expositions, and theoretical analysis are defined to the extent that they are used in this book. The coverage in this chapter regarding definitions is far from comprehensive. There are many fine writings on this subject, and readers are referred to several original sources for understanding terms in a variety of perspectives and uses.<sup>2</sup> This chapter is intended to clarify the meanings of the theoretical terms that are used throughout the book.

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1. There are several books and articles written with these purposes as the primary focuses. See for example, Hardy, M. E. (1978). *Evaluating Nursing Theory. In Theory development: Why, what, how?* (pp. 75–86). New York: National League for Nursing; Barnum, B. J. S. (1994). *Nursing theory: Analysis, application, evaluation* (4th ed.). Philadelphia: J.B. Lippincott; Fawcett, J. (1994). *Analysis and evaluation of the theoretical models of nursing*. Philadelphia: F.A. Davis; and Meleis, A. I. (1997). *Theoretical nursing: Development and progress* (3rd ed.). Philadelphia: J.B. Lippincott.

2. Among the many published works for this subject area, the following classical books may be of help to serious students of theory construction: Hempel, C. G. (1952). *Fundamentals of concept formation in empirical sciences*. Chicago: The University of Chicago Press; Popper, K. R. (1959). *The Logic of Scientific Discovery*. New York: Harper and Row; Kaplan, A. (1964). *The conduct of inquiry*. San Francisco: Chandler Publishing; Reynolds, P. D. (1971). *A Primer in theory construction*. Indianapolis: Bobbs-Merrill; Dubin, R. (1978). *Theory building* (Revised ed.). New York: The Free Press; Blalock, Jr. H. M. (1969). *Theory construction: From verbal to mathematical formulations*. Englewood Cliffs, NJ: Prentice-Hall; and Suppe, F. (Ed.). (1977). *The structure of scientific theories* (2nd ed.). Urbana, IL: University of Illinois Press.

In Chapter 3, the rationale for the typology of four domains for nursing as *client*, *client-nurse*, *practice*, and *environment* are presented. This framework is an organizational construct, developed for systematizing many classes of phenomena that are important for nursing studies. The typology is presented here as a general guide in separating out the aspects of the real world we encounter and think about into coherent sets of theoretical elements. It provides reference points for the analyses that follow in Chapters 4–7.

Chapters 4–7 are the main focus of the book and consider conceptualization of important phenomena at several different theoretical levels. Chapter 4 deals with the domain of client; Chapter 5 deals with the domain of client-nurse; Chapter 6 deals with the domain of practice; and Chapter 7 deals with the domain of environment. In each of these chapters, a general conceptual map that is specific to each domain is delineated and discussed, and conceptualizations vis-à-vis the map are given. Applying the concept analysis method specified in Chapter 2, key concepts are analyzed as examples of concept development in the domains.

Attempts are made in Chapter 8 to show how concepts delineated within the four domains can be developed into systems of theoretical statements. Here the purpose is not to propose a theory, but rather to show what happens to an array of singular and isolated theoretical constructs when they are put into theoretical statements. Theoretical statements linking phenomena within each domain and across domains are examined in order to indicate that relevant and critical relationships may be brought together in “theories in nursing” and in “theories of nursing.” For each domain, models of explanation are presented as guides that can be used to develop theoretical ideas.

The last chapter addresses the next step in theoretical thinking following from the exposition in this book. An epistemology for nursing is presented as a way to tie various sorts of theoretical thinking that are possible in dealing with nursing’s subject matter. Some of the problem areas and issues in theoretical thinking in nursing are discussed, highlighting areas for future emphasis and concern.

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# 2

## *Terminology in Theoretical Thinking*

### OVERVIEW

This chapter presents the definitions and meanings of the terms and concepts used in theory construction and theoretical analysis. The intention is to clarify the meanings of theoretical terms and to provide the reader with clear definitions of them as they are used throughout this book. The meanings presented in this chapter have been taken freely from several scholars and indicate ideas and understandings of the terms that are in accordance with the accepted usage in the scientific field. The terms discussed in this chapter are: phenomenon, concept, theory, theoretical statement (i.e., proposition and hypothesis), measurement of concept, level of conceptual description and analysis in terms of holistic and particularistic modes, and method of conceptual analysis. Additionally, the terms, metaparadigm, metatheory, and paradigm are defined in terms of the meanings attributed to them in this book.<sup>1</sup>

### PHENOMENON

The term *phenomenon* is used to designate reality, i.e., what exists in the real world.<sup>2</sup> A girl's love for a certain boy is as good an example of a phenome-

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1. See also: Kim, H. S. (1997). Terminology in structuring and developing nursing knowledge. In I. M. King, & J. Fawcett, (Eds.), *The language of nursing theory and metatheory* (pp. 27-36). Indianapolis, IN: Sigma Theta Tau International Center Nursing Press.

2. One comment about the debate that is going on for a differentiation between "absolute" reality and "conscious" reality may be in order. Many philosophers of science have debated over the definition of reality. The history of scientific discovery

non as an apple ripening on a tree or a patient's grimace at seeing his wound. However, this term in the scientific usage refers to the aspects of reality that are relatively regular and enduring, rather than fleeting rare occurrences that may exist in reality. Since phenomena exist even when they are not recognized to exist by any humans or named by scientists, it is the role of science to discover, identify, and delineate general features of phenomena in order to gain systematic descriptions and explanations about them. Woodward suggests that phenomena are "relatively stable and general features of the world which are potential objects of explanation and prediction" and data "play the role of evidence for claims about phenomena" (1989, p. 393). In scientific consideration of reality, we are often, in fact almost always, exposed to multiple phenomena having similar or different meanings and characteristics. Throughout human history we have used various means of communication, especially with language, to form ideas about phenomena we encounter and shared such ideas with each other for intersubjective understanding. We take for granted the meanings and labels we attach to various phenomena we encounter in our ordinary lives. However, phenomena of interest for scientific studies are established through specific scientific language so as to be understood and used in a more strict and rigorous sense.

As the first step in looking at reality in such a restricted sense, scientists must adopt a classification system by which each phenomenon is considered a member of a kind. Both the exactness of a class definition and the scope of a class depend on the person who is categorizing, as well as on the historical conventions that have become accepted in the scientific world. By using a classification system, we are able to categorize many aspects of reality broadly or narrowly, depending upon the context in which phenomena are studied. For example, general systems theorists will categorize many different types of phenomena, such as the ecological environment on earth, the life cycle of a butterfly, or the circuit of a computer into system/nonsystem categories. On the other hand, biologists will categorize the life forms of jellyfish, scorpion, salamander, and whale into the classification system of coelenterates/arachnids/amphibians/mammals. This "naming of phenomena" into the same kinds gives order to the perceiver

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tells us that we are ever encountering phenomena that we were unaware of in our past. This suggests that there exists the "absolute" reality to be discovered, to be aware of. A contrasting view to this is the argument that what we cannot perceive to exist is not reality, and that reality is bounded by the consciousness and perceptiveness of humankind at a given time, for what we cannot fathom to exist cannot be real to us. Such arguments are interesting and paradoxical. But for now, let me ask for the readers' indulgence to accept my position for the duration of this book that a reality needs to be conceptualized in the human mind for it to be problematic.

of reality. In fact, the phenomenon of jellyfish refers to the exact same thing as the phenomenon of coelenterates. The only difference is that the phenomenon of jellyfish is a class within the phenomenon of coelenterates. This means that as a phenomenon is thought of as having certain entities, that phenomenon is expressed as a concept, that is, through language. Hence, this “naming of phenomena” is concept formation. Gillett states that “in grasping a concept we are mastering the use of a term in the interactions and practices of those with whom we have to do . . .” (1987, p. 103), hence through concepts referring to specific classes of phenomena we are able to share the meanings and identity of the phenomena.

## CONCEPT

The term *concept* refers to the outcome of a procedure of labeling and naming things, events, ideas, and other realities we perceive and think about. In our ordinary lives, we know numerous concepts through our language and use them in communicating with others and in thinking about reality and ideas. Hence, humans are born into the linguistic culture that has evolved through the history of our existence. Human’s linguistic culture is based on established conceptual systems used in our ordinary lives. However, concept and conceptual thinking are important aspects of science at another level as scientists use them to formulate and understand phenomena of interest for scientific investigation.<sup>3</sup>

A concept is a symbolic statement describing a phenomenon or a class of phenomena. Therefore, it is expressed by a definition. Gillett (1987) suggests that “a *concept* is a semantic and cognitive tool that unifies a set of experiences . . . and allows one to repeat acts of judgment within and across situations.” And, concepts embed specific meanings. While a phenomenon exists in the real world, a concept of that phenomenon is articulated in a symbolic construct, having a semantic value, formulated through the workings of the scientist’s mind. Because a concept is derived from conscious

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3. Concept formation refers to three different senses. The first sense is the formation of concepts for a linguistic culture, that is, how concepts within a linguistic cultural system become formulated and transmitted through its history. The second sense is the formation of concepts in individuals as we learn language, that is, how an individual comes to establish and make connections between what is perceived and thought of and terms that refer to them. This second sense refers to the process of linguistic learning in humans. The third sense is concerned with how terms are established within scientific disciplines and how terms come to have specific intersubjective meanings for scientific understanding. This third sense of concept formation is of interest in this book.

efforts to name aspects of the world, concepts may refer to a single, unique case or to a class of phenomena having the same properties that are specified in definitions or according to what Wittgenstein (1968) called "family resemblances."

There are several different theories of concepts, such as the classical view that a concept refers to a category of phenomena that share a set of properties necessary and sufficient for membership, the prototype view that aligns with the Wittgenstein's "family resemblances" idea, and the exemplar view that uses an exemplar as the key referent for a concept (Margolis, 1994; Medin & Smith, 1984; and Rodgers, 1993). The concept of Christ, for example, refers to a single, unique entity, while the concept of crime refers to a class of deviant behaviors that violate certain legal and ethical codes of a society. Categorizing phenomena into *a class of phenomena* allows a concept to be narrow (i.e., limited) or broad (i.e., all encompassing). Hence, pain, as a concept is broader than headache, in that pain is inclusive of the phenomenon of headache.

A concept may refer to a class of abstract phenomena or to that of concrete phenomena. Abstract concepts are ideas of reality and have no specific spatio-temporal referents. They refer to general cases. In contrast, concrete concepts refer to phenomena having exact references to time and space. Thus, a concept of disability, as an example of an abstract concept, may be defined as "a state in which a person is unable to carry out human actions that are normally expected," while a concept of quadriplegia of Korean War veterans is a concrete concept since it refers to a class of certain people in the world. Both abstract and concrete concepts may also take on varying levels of specificity. For example, health is a more general abstract concept than the concept of mental health, whereas fetal death in a hospital is more general than Ann Smith's miscarriage as concrete concepts. The level of generality of viewing a given set of reality is thus a matter of choice. A conceptual ladder of abstraction, suggested as the class-subclass perspective by Blalock (1969), is a way of increasing abstractness. One can link mental images about a class of phenomena from very concrete to most general. Blalock (1969) suggests that the class-subclass perspective specifies a mode by which a generalization about a class of phenomena is made, linking more concrete subclasses to a general, highly inclusive class.

Concepts are used in theoretical statements to refer to phenomena of concern. Thus, dream is a concept in Freud's psychoanalytic theory, as are unconsciousness, id, and sleep-preservation. Rogers (1980) proposes unitary humans, energy field, homeodynamics, helicy, resonancy, and complementarity as the major concepts in her theoretical model. On the other hand, Roy (Roy, 1984; Roy & Andrews, 1991; Roy & Roberts, 1981;) identifies adaptation level, adaptive mode, focal stimuli, contextual stimuli, resid-

ual stimuli, cognator, and regulator as the major concepts in her adaptation model.

Because they are constructions of the mind, concepts result from a process called *conceptualization*. Conceptualization refers to an intellectual act of delineating aspects of reality into like categories in order to give them specific "names" (i.e., labels or terms). Since such delineation depends on the range of focus that is used in the intellectual act, objects of conceptualization vary across different scientific disciplines.

For our concern, the frame of reference is always nursing. This means that our interests in the real world and conceptualization of them are limited to what happens to people in need of nursing care or receiving nursing care, and how whatever happens in such situations occurs in particular ways. Thus, the phenomena of interest and concepts of them for the theoretical, scientific studies in nursing are those aspects of reality that are critical to regulating nursing behaviors.

Although there are many different ways of categorizing concepts according to their characteristics,<sup>4</sup> for the exposition in this book I have adopted a classification scheme of "*property*" and "*process*" concepts. This classification comes very close to the differentiation used by Abell (1971). Nursing is basically concerned with two kinds of reality: (a) *the state of things*, such as whether or not the patient has abdominal pain, what the anxiety level is, or what the patient knows about the emergency care of bleeding, all of which refer to the characteristics of property; and (b) *the way things happen*, such as how a person learns to take blood pressure, what a patient is experiencing when he says "I don't care," or what becomes of the digitoxin a patient takes, all of which are concerned with the nature of occurrence. The first kinds of phenomena are labeled property concepts, while the latter are considered process concepts. In this way, some phenomena may be conceptualized in both ways, as property and process concepts, depending on the posture taken in conceptualization of the phenomena. For example, the concept of stress has been used by many scientists as a property concept that is expressed in terms of amount, expansiveness, or types of stress. In contrast, others have used it as a process concept by which the phenomenon is identified in action terms. The course of happenings associated with the impingement of noxious stimuli on objects including humans is inclusively described in such definition. Similarly, "thought" is a property concept, while "thinking" is a process concept. As is true of any classification schema, this is also an arbitrary construct that appears to meet the test of mutual exclusiveness and exhaustiveness criteria of typology formulation.

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4. For example, cf. Dubin, R. (1978). *Theory building* (Revised ed.). New York: The Free Press, and Kaplan, A. (1964). *The conduct of inquiry*. San Francisco: Chandler Publishing.



This classification system of concepts into property and process types is useful in an analytic sense. By questioning the essence of a conceptual definition in terms of property and process, we are also questioning the focus with which conceptualization is carried out. This is theoretically important, for concepts are the main building blocks of theory. Explanations of relationships between two concepts become different according to the definitions of the concepts.

### **Measurement of Concept**

Concepts are variables in theoretical statements. Therefore, it is natural to expect concepts to take on some designation for measurement. This is especially necessary when scientists have to make logically sound linkages between theoretical concepts (T-concepts) and observational concepts (O-concepts). Abell (1971) uses this distinction of concepts, and it is useful when one wants to differentiate concepts in empirical studies. This is one way of distinguishing concepts used in theoretical statements and could be useful in rigorous operationalization. Abell (1971) declares that theoretical concepts must ultimately be expressible in terms of observational concepts. The process by which scientists make such linkages is through deduction, following a hierarchy of conceptualization. This process is often referred to as the operationalization of concepts and means designations of observational concepts having immediate referents in the real world as sense impressions and as the counterparts to the theoretical concepts. A concept can take several different types of values or character: *nominal*, *ordinal*, *interval*, and *ratio*. These are commonly accepted methods of measurement, each representing different kind of scales of measurement (Reynolds, 1971). Regardless of the concept type (i.e., property or process type), a concept has to be expressible in one of these measurement terms in order for it to be tested in the context of a proposition or hypothesis.

Nominal scale refers to measurement of concepts characterizing the different values a concept can take on in a discrete state, such as black/red, rich/poor, dying/recovering, etc. Ordinal scale is based on the measure of ranking and ordering of distinct states of a concept in a hierarchical manner so that units may be compared to one another in their rank-positions only. The difference between nominal and ordinal scales may be shown by taking the concept of "health" as an example. Health measured as a nominal scale may take on such values as sick or healthy. In contrast, health measured as an ordinal unit may take on such values as highest level of health, higher level of health, moderate level of health, etc.

Interval scale refers to measurement of states of a concept on a constantly distributed rating rule. One position on an interval scale has the same distance from the one below and the one above. Interval scale is usu-

ally constructed in nursing research through index construction, such as empathy scale or function index. In contrast, ratio scale refers to measurement strategy in which a real and theoretical zero exists for the inferring of a ratio of any two members on a scale. Many scales in physical sciences are ratio scales, such as measurements for time, weight, length, etc. Scales of measurement are important so far as they provide the means to align the meanings of concepts in terms of the reality.

While these are several different ways concepts can be expressed in measurement terms, concepts are expressed in a descriptive way as a starting point. As scientists move from this descriptive starting point to gain inter-subjective agreement about the variable nature of concepts, quantification becomes an issue. There are debates regarding the points that (a) all concepts must be operationalized in quantitative terms; (b) some concepts are quantifiable whereas others are not quantifiable because of the nature of the phenomena to which they refer; or (c) quantification is an artifact of human construction and has no connection to the genuine nature of phenomena. These are philosophical questions deeply related to the nature of theories and the role of scientific understanding. In the human sciences, this debate is much more complex because of the subjective nature of many human phenomena.

### **Level of Conceptual Description and Analysis: Holistic and Particularistic Modes**

The most fundamental difficulty a serious scientific thinker encounters in conceptualizing certain “happenings” of interest is deciding the level or the limit at which such happenings (i.e., phenomena) should be considered. The level of description one selects influences the kinds of theoretical questions and outcomes that are generated in the analysis of phenomena. Hofstadter (1979) treats this issue as “holism” vis-à-vis “reductionism.” Holism is an analytical approach that looks at the object as a whole without paying attention to its parts. In the holistic mode, one’s focus is on the generic property of object as a totality. In contrast, Hofstadter’s reductionism is a mode of analysis by which the meanings of an object’s parts are brought into focus. In describing these modes in a situation of listening to a Bach fugue, Hofstadter states that “the modes are these: either to follow one individual voice at a time [reductionist mode], or to listen to the total effects of all of them together, without trying to disentangle one from another [holistic mode].”<sup>5</sup>

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5. This Hofstadter story labeled as “prelude” should be of interest to readers who want to follow the arguments for holism and reductionism. See Hofstadter, D. R. (1979). *Gödel, Escher, Bach: An eternal golden braid* (p.282). New York: Vintage Books.

The issue is this: A set of phenomena can either be viewed as a global happening or as a collection of several discrete happenings. These two approaches to viewing a set of phenomena will direct and differentiate what follows in terms of description, explanation, and measurement. For example, scientists may study humans as a whole, composed of many parts, or humans in terms of different parts. It is necessary to have a global concept of humans if one is interested in understanding humans as a totality, a unified entity. A holistic view of humans is concerned with human operations as involving the totality of the person and having meanings with respect to the total being. On the other hand, it is quite possible and sometimes desirable for scientists to study many aspects of human affairs separated out as singular or discrete occurrences without explicitly making a global reference to the wholeness of humans. Again, this is not a matter of right or wrong, but of *perspective*. For the exposition and analysis in this book, the terms *holistic* and *particularistic* have been adopted as two levels of description and analysis applicable to theoretical thinking in the nursing framework.

The *holistic* view of a situation, a happening, or an object is directed to perceiving and conceptualizing the characteristics presented by the situation, the happening, or the object as having meanings as a totality. In contrast, the *particularistic* view of a situation, a happening, or an object disaggregates the situation, the happening, or the object and selects out the aspects that are of particular interest for description and analysis. In a particularistic mode, the scientist takes as a given those aspects of the situation or object that exist outside of the conceptual realm of particular interest.

### Method of Concept Analysis

The first analytical technique scientists use in theoretical thinking is concept analysis. While conceptualization refers to the act of arriving at an abstract understanding of a phenomenon, concept analysis refers to critical evaluation of conceptualization that has already occurred. Therefore, conceptualization is an active theoretical thinking, whereas concept analysis is a reflexive theoretical thinking. Concept analysis is a critical evaluation of the product of conceptualization vis-à-vis scientific criteria of sound conceptual characteristics. In this book concept analysis is used as a method of evaluating the stage and rigorousness of conceptualization that has taken place regarding selected concepts.<sup>6</sup>

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6. See for other approaches to concept analysis and concept development in nursing: Rodgers, B. I., & Knaf, K. A. (1993). *Concept development in nursing: Foundations, techniques, and applications*. Philadelphia: W.B. Saunders.

Criteria for concept analysis are guidelines for examining the characteristics of a concept. Reynolds (1971) proposes three desirable characteristics of scientific concepts: (a) abstractness, indicative of independence of time and space, allowing concepts to have more universal and general meaning-complexes that make them nontrivial and essentially important for scientific pursuits; (b) intersubjectivity of meaning, specifying definitional clarity and agreement among scientists with regard to phenomenal references; and (c) operationalization and intersubjectivity of operational measurements, indicating congruity between theoretical and operational definitions, and agreement in the methods selected to express the meanings of theoretical concepts in empirical terms. Definition of concept serves as the basic tool to indicate and reduce the meanings of abstract concepts symbolically. Kaplan (1964) also suggests that one may use either or both indicative and reductive strategies in defining conceptual terms.

The method of concept analysis adopted in this book uses Reynold's criteria for scientific concepts. The specific components of concept analysis involve (a) definitional clarification of the concept selected for analysis, (b) differentiation of the concept from related concepts, (c) operationalization and measurement of the concept, and (d) relationship of the concept with other concepts. All of these steps are carried out through a comprehensive review of the literature and with an insight gained through clinical experiences or other related scientific work.

Concept analysis can be done within a specific theoretical system or without a specific orientation to a particular theoretical system. Concept analysis carried out within a theory is less complex since the theoretical orientation directs conceptualization toward a specific predisposition in selecting out characteristics of phenomena. Analysis of a concept without a specific reference to a theory is thus far more complex, since the concept has to be analyzed for its meaning and operationalization according to various theoretical orientations. Nevertheless, a comprehensive concept analysis allows progression toward theory construction as well as consequent theory analysis.

## **THEORY AND THEORETICAL STATEMENT**

Scientists use theories and theoretical statements as the basic tools for explaining problems of concern. Conceptualization of reality is linked into theories and theoretical statements for scientific descriptions and explanations. At this point, it might be useful to clarify what is meant by theory and how it is used differently from related terms such as theoretical statement, proposition, and hypothesis.

*Theory* is defined as a set of theoretical statements that specify the nature of phenomena or relationships between two or more classes of phenomena

(and therefore, concepts) in order to understand a problem or the nature of things. In general, a well-formed theory contains at least three components (*assumptions, concepts, and theoretical statements*) that are integrated together to provide a specific type of scientific understanding. A set of assumptions of a theory (which are also referred to as premises, presuppositions, and suppositions by some authors) are foundational, general belief statements about (a) the world views that undergird the theory; (b) the theoretical perspectives and the rationale with which the theory's perspectives are formulated; (c) the scope of the proposed theory; and (d) the style or form of scientific explanation adopted in the theory. A set of concepts identified and defined in a given theory specifies the phenomenal boundary with which the theory is formulating scientific statements. And, a set of theoretical statements provides the exact nature of scientific understanding proposed in a given theory.

The purposes of theory are multifaceted. Theory is an intellectual tool used to understand and explain the world in which we live. The ultimate motivation, though, is in our desire to "control" the world to our benefit. Theory provides a systematic basis for sorting out regularities from irregularities. By knowing what is happening (i.e., having descriptive knowledge), and then finding out how something occurs (i.e., having explanatory knowledge), we are able to move toward knowing the kinds of changes we must make for some things to occur. While conceptualization is mainly directed toward descriptive knowledge, theory is oriented to understanding, explanation, and prediction. As we become able to explain and predict certain phenomena, both control and prescription become possible for us. Certain phenomena can be produced by manipulating components (e.g., elements, factors, or variables) of theoretical formulations. However, the idea that theory should be oriented only to explanation and prediction leading to control and prescriptions has been challenged and rejected by many philosophers and scientists in recent years. Scientists are increasingly considering theories rich in their scientific value even when they are oriented basically to description and understanding.

In practice sciences, the role of theory extends beyond simple description, explanation, and control of phenomena. Practice sciences need prescriptions for intervention. Prescriptive theories (situation-producing theories as designated by Dickoff, James, & Wiedenbach, 1968) are used to develop intervention strategies. Approaches to solving practical problems are "prescribed" according to theoretical knowledge. In nursing, Dickoff and James' classification of theories into (a) factor-isolating, (b) factor-relating, (c) situation-relating, and (d) situation-producing types has been subjected to many debates.<sup>7</sup> There is general agreement, thus far, on the need

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7. Dickoff, J., James, P., & Wiedenback, E. (1968). Theory in a Practice Discipline: Part I. Practice Oriented Theory. *Nursing Research*, 17, 415-435.

for prescriptive theories, which can be applied to “regulate” nursing therapies, as the highest level of theoretical formulation in nursing. However, nursing theories may be considered in terms of three types: *descriptive*, *explanatory*, and *prescriptive* theories, each type serving different sorts of scientific understanding.

The focus of theory is usually on unexplained phenomena considered to be problematic or important. A problem is a phenomenon that is thought to exist when connections or contrasts are made between two or more concepts, and which requires explanation and solution. For this reason, many theories are not simply drawn out of “thin air” but are derived from other theories. Theory is a systematic way of designating orderliness between or among elements of reality. Theory is always tentative to a certain degree, since it is based on logically derived conjectures.

A good example of a theory is Freud’s dream theory. He proposed as the main theoretical statement that a dream is an imagery manifestation having a latent meaning of an unconscious wish that is projected in a disguised form during sleep states, and that the dream is an indirect, substitute, and nonthreatening mode of expressing unconscious impulses in a sleep-preserving way (Strachey & Freud, 1953). Although these are rather simplified definitions of his complex theory, these statements indicate the relationships he posed between the phenomena of unfulfilled wish and the phenomena of dream. Thus, dream as a variable encompasses that class of phenomena of which many different types of imageries appear and register in a person while the person is asleep. Freud considers the contents of the dream as having an important variable meaning, hence his famous work, *The Interpretation of Dreams*. Of course, it is necessary to delve further into Freud’s other theoretical statements relating the unconscious and the preconscious in order to understand the main theoretical statements fully.

As can be abstracted from this example, at the most elementary level a theory consists of *concepts* and *theoretical statements*. Theoretical statements in a theory are merely notations that designate relationships among the conceptual elements. Theoretical statements may be descriptive or explanatory. Descriptive statements express the nature of things and characteristics of phenomena. In contrast, explanatory theoretical statements specify relationships in a causal or an associational manner among two or more concepts. Such explanatory statements are termed either propositions or hypotheses. Propositions are statements of relationships between concepts in the theoretical system. In Freud’s dream theory, two concepts are specified: dream and unfulfilled wish. The proposition indicates a causal relationship in which unfulfilled wish is postulated to cause dream. Many theoretical statements interlinked with each other make a complex theory in which several concepts are considered simultaneously in a comprehensive fashion for an explanation of phenomena.

A *proposition* is a theoretical statement that specifies relationships among general classes of concepts. A *hypothesis*, in comparison, is a theoretical statement that is to be tested in a specific empirical situation for verification.<sup>8</sup> Thus, a hypothesis has a referent proposition from which it is drawn. While a proposition deals with more general classes of the phenomena in question, a hypothesis is concerned with subsets of the same classes of the phenomena. All theoretical statements have to be testable or verifiable and should have empirical referents implied in the statements. A logical deduction is the method used to derive empirical statements from many levels of abstract theoretical statements. This indicates that concepts in propositions tend to be broader and more general than concepts in hypotheses.

An example of a theoretical statement in nursing theory would be Roy's adaptation-level proposition: "The greater the adaptation level, the greater the independence in activities of daily living."<sup>9</sup> The concept of adaptation level, expressed as a quantitatively varying concept, is related to another concept, independence in activities of daily living, which is also expressed as a quantitatively varying concept. This statement by itself contains very little information, and a reader would not be able to understand the full meanings of the proposition. This is because the statement is derived from a theoretical system in which a special language has been developed for terms such as adaptation level. In this statement, whereas the concept of adaptation level is quite abstract and holistic, the concept of independence in daily living is not. The abstract and holistic concept of "independence" has been somewhat reduced to refer to certain aspects of an individual's functioning freedom, i.e., activities of daily living. By defining the exact meanings of the two concepts in the statement and specifying empirical referents of the concepts, it is possible to deduce a hypothesis of the proposition in order to test it in the empirical world.

The scope of a theory is determined by the nature of the phenomena the theory is intended to explain and the complexity of the theoretical statements that comprise it. Thus, subject matter for a theory may be very broad and all-inclusive or very narrow and limited. For nursing, four levels are identified: *grand theory*, *meso-theory*, *middle-range theory*, and *micro-theory*. The term *grand theory* is usually used to refer to a theory that tries to handle phenomena in a general area of a scientific field, such as Parsons' general theory of action, Einstein's theory of relativity, Freud's theory of

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8. I do not believe it fruitful to debate over what are proper meanings and definitions of these two terms. While there are many different ways and different levels of specificity with which these terms are used in the scientific community as well as in nursing, the distinction proposed here seems the most accepted way of their uses.

9. Roy, Sr. C., & Roberts, S. L. (1981). *Theory construction in nursing: An adaptation model* (p. 35). Englewood Cliffs, NJ: Prentice-Hall.

psychoanalysis, or Rogers' theory of unitary humans. In most instances, grand theories require further specification and partitioning of theoretical statements for them to be empirically tested and theoretically verified. Grand theorists start their theoretical formulations at the most general level of abstraction, and it is often difficult to link these formulations to reality. In a sense, theoretical efforts for "theories of nursing," such as the works of Rogers, Roy, and Johnson, seem to have focused on developing grand theories in nursing.

The term *meso-theory* is proposed to designate nursing theories that are less general than grand theories but more general than middle-range theories in their scope. This term is proposed because nursing deals with phenomena that are located empirically in four different domains as discussed in this book. Since grand theories refer to those theories dealing with the subject matter of nursing in an all-encompassing way, it seems necessary to have a term that refers to theories that deal with a broad spectrum of phenomena in a specific domain. Such theories are not middle-range in the sense the term is used by Merton (1968) and accepted in nursing, and are more abstract and deal with broader classes of phenomena. King's theory of goal-attainment (1981), Watson's theory of human care (1988), and Newman's theory of health as expanding consciousness (1994) may be considered meso-theories of nursing. The nursing phenomenon of interest for King's theory is "transaction," referring to the phenomena between the client and nurse. Transaction is used to explain the nature of goal attainment in the client. King's theory deals with the phenomena of goal-attainment that is generally applicable in all nursing practice situations, while Watson's theory deals with general features of the client-nurse relationship. Newman particularly addresses human health from the notion of expanding consciousness.

A more realistic and testable level of theory is what was proposed as the theories of middle range (Merton, 1968). *Middle-range theories* in sociology, such as the theory of reference group, theory of social exchange, and theory of power, have been developed and tested rather successfully during the past twenty years, although many of these theories have not been integrated to form a grand theory that explains social reality in a comprehensive manner. In nursing, very few middle-range theories were developed and tested in the early years of its theoretical development. During the past ten years however, there has been an increasing level of interest among nursing scholars for the development of middle-range theories. Many middle-range theories have been developed by applying either the inductive or deductive method, such as the theory of self-transcendence (Reed, 1991), the theory of uncertainty in illness (Mishel, 1988, 1990, 1997), and the middle range theory of unpleasant symptoms (Lenz, Pugh, Milligan, Gift, & Suppe, 1995, 1997).



*Micro-theory* is a term used by some scientists to refer to a set of theoretical statements, usually hypotheses, that deal with narrowly defined phenomena. There is a great deal of debate as to whether this should be called a "theory," as such a theory by itself tends to be rather limited in its explanatory power and is composed of mere postulations of hypothetical thinking. The difference among these levels of theory is not only in the level of abstraction with which concepts are delineated, but also in the range of explanation the theory is trying to attain. Thus, a theory can be characterized both in terms of the sophistication of its explanation and its scope.

Theory development as the central focus of scientific work can be pursued by either an *inductive* or a *deductive* approach. An inductive approach refers to developing or constructing theories beginning with empirical data or phenomena as they exist in actual situations. In the inductive approach, regularities, both descriptive and explanatory, that exist in reality are discovered, and generalizations about the discovered regularities are formulated into theoretical statements. On the other hand, the deductive approach begins with generalized ideas about phenomena. The deductive approach is based on a set of foundational notions about the nature of explanation, and proceeds using a system of deductive logic to come up with a theory that moves from general ideas about phenomena to more specific theoretical relationships. In recent years, scientists are increasingly combining both approaches to develop theories with an approach that aligns with what Hanson (1958) called *retroduction*. Retroductive approach is oriented to reconstruction and revision of theories. Theories are viewed as emerging mostly from existing theories, and the needs for reconstruction of theories originate from anomalies and deviations observed in reality. Such observations give ideas inductively about other ways in which a given theory may need to be revised and reconstructed. This inductively derived understanding thus becomes the basis for deductive reconstruction of a given theory.

In nursing during the past two decades, we have been struggling with and debating not only about what classes of phenomena should be included in a system of theoretical explanations in nursing science, but also what approaches may be most fruitful and appropriate for developing that knowledge. We also have been engaged in debates about the differences between "theories of nursing" and "theories in nursing," and their respective propriety, legitimacy, and relevance in the scientific study of nursing. Scientific knowledge in nursing can be expanded and enriched by studying, developing, testing, and refining *both* types of theories. This should not be viewed as a disadvantage but as an advantage for the field of nursing.

By definition, *theories in nursing* develop through the process of borrowing. Nursing as an applied scientific field has the responsibility to bring forth theories and knowledge developed in other fields. Such "borrowed"

theories can be used to describe, explain, and predict specific phenomena which we confront in our work. This involves translating and using the theories for nursing-relevant phenomena, treating them as subclasses of those for which the original theories were developed. For example, the motivation theory of learning can be applied to study patients' difficulties in learning to carry out specific self-care procedures. A modification of the theory through repeated empirical specifications in nursing situations will thus result in the motivation theory of patient's learning. The responsibility for the selection of relevant and important ideas from such theories and for the codification into "theories in nursing" rests with nurse scientists. These individuals make theoretical connections between original theories and phenomena of importance to nursing, and specify the linkages, both theoretical and empirical, between them. Because nursing is concerned with several different aspects of human life, many theories from the fields of biological, social, psychological, and other behavioral sciences can be refined and reconstructed as theories in nursing.

In contrast, *theories of nursing* are those developed to describe, explain, and predict "nursing" as a class of phenomena proper. For such theories, it is necessary to define and differentiate nursing phenomena from the subject matter of other fields. It involves identifying the conceptual properties of selected phenomena in a specific way—that of nursing. There have been many attempts at this by such nursing theorists as Rogers, Roy, Orem, Neuman, and Parse at the grand-theory level, others such as King, Watson, and Newman at the meso-theory level, and many more at the middle-range level. We are progressing steadfastly in developing theories of nursing as we are gaining headway in naming and describing distinct classes of phenomena as specifically nursing. It is necessary to incorporate both kinds of theories into the discipline of nursing in order to aim for comprehensive understanding within the field.

### PARADIGM, METAPARADIGM, AND METATHEORY

The term *paradigm* made fashionable by Kuhn (1970) is used in this book to refer simply to scientific perspective that encompasses specific orientations and approaches adopted for a given subject matter. It includes the perspectives about the nature and form of explanation and the dominant methods of scientific work. From this usage, it is possible to identify several different paradigms actively pursued in nursing, such as holistic paradigm, systems paradigm, behavioral paradigm, phenomenological paradigm, interpretive paradigm, and critical paradigm. This usage is a very much simplified version of the one originally proposed by Kuhn. Kuhn (1970) emphasized two specific meanings of paradigm, one denoting "the entire

constellations of beliefs, values, techniques, and so on shared by the members of a given community" (p.175) and the other referring to the specific models of puzzle-solutions adopted for solving scientific problems.

The term *metaparadigm* has gained usage in the nursing literature during the past ten years to refer to generic features of nursing science. Here, *metaparadigm* refers to the epistemological considerations at a higher and more general philosophical level. The "meta" in this word is adopted to mean "beyond" and "transcending" paradigms to a higher and broader epistemological level. Metaparadigm is concerned with general issues of the subject matter of a discipline in terms of what the general contents are, how such contents are organized, and what a discipline is concerned with as a knowledge structure. In nursing, metaparadigm is commonly used in talking about metaparadigm concepts. Health, client, nursing, and environment as the metaparadigm concepts for nursing have been used as the key concepts nursing must define and incorporate into theoretical work. While this is one usage of the term, it is a limited usage. In this book, the term *metaparadigm* is used not in conjunction with concepts but as an adjective in referring to epistemological, disciplinary concerns that transcend paradigms, theories, and methods.

Although the term *metatheory* is not in vogue in nursing, this term is being discussed fervently in other social, behavioral sciences. *Metatheory* is most commonly defined as the analytical work regarding issues associated with theory development and knowledge generation germane to a given discipline, such as a systematic study of the underling structure of theory in a given discipline (Ritzer, 1992). Ritzer (1988) proposes a typology of metatheories. Fuhrman and Snizek (1990) identified cogent areas of metasociological work in sociology (metasociology including metatheory) as mapping of sociology's cognitive structure, debates on sociology's core-concepts, discussions on various assumptions about human nature and their implications on the study of society, and ideological investigations that link sociology to other disciplines and philosophy. On the other hand, Turner (1990) insists that metatheorizing should be limited to directing the development of better theories. In nursing, metatheorizing has been active during the past twenty years as evidenced by the articles assembled in a book edited by Nicoll (1997) and numerous books published in analyzing theoretical works in nursing such as those by Meleis (1997) and Barnum (1994). Nursing knowledge will be developed most richly through both metatheorizing and substantive theorizing, metatheorizing providing the necessary critiques, reflections, and formulations about what the discipline's knowledge should be about while substantive theorizing advances specific contents of that knowledge.

In summary, I have presented common theoretical terms, omitting comprehensive discussions of various semantic, disciplinary, and scientific usage of the terms. The terms also take on somewhat different analytic meanings

in the field of philosophy of science. In addition, there are many more terms and concepts used in theory development literature. A comprehensive discussion on the subject requires another kind of passion. Thus, they are not pursued here, not for a lack of passion for such a pursuit, but because they are beyond the scope of this book.

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# 3

## *Conceptual Domains in Nursing: A Framework for Theoretical Analysis*

*Social facts cannot be adequately explained by psychological facts; psychological facts cannot be adequately explained by physiological facts; physiological facts cannot be adequately explained by chemical facts. The facts at any level of integration need to be explained and can only be fully explained in terms of that level.*

—William A. White

### OVERVIEW

This chapter presents a typology of theoretical domains for nursing. The typology is composed of four domains: client, client-nurse, practice, and environment. It is an organizational construct, developed for systematizing many classes of phenomena that are essential for nursing studies. The rationale for the typology and the theoretical meanings of the four domains as boundary-maintaining devices are discussed. The typology is presented as a device that can help us to make sense of reality in a frame of reference that is nursing. The intellectual and theoretical preoccupation we have for understanding nursing phenomena forces us to view reality with a nursing angle of vision. By doing this we can bring forth those elements needing critical attention to the center of the field of vision, while pushing away those with less importance and little significance into the peripheral region or to the area outside of the field of vision. The typology is a tool and a guide that can be used to separate out the aspects of the real world we encounter into coherent sets of theoretical elements. In this book, the typology is used as the framework with which theoretical ideas are analyzed from the nursing perspective, and as the organizing guideline for the presentation of theoretical ideas in the following chapters.

This typology as a metaparadigm framework for nursing's conceptual system is an analytical device proposed for systematizing phenomena and concepts of interest to nursing study. As Turner (1986) suggests, development of analytical schemes is an important and necessary aspect of theorizing in a discipline. A typology divides the universe of interest into an order so that each phenomenon or concept can be located within a conceptual boundary specified within the typology. It is a classification schema by which relevant phenomena of interest to nursing are delineated, differentiated, and studied within the perspective of the discipline. In this typology, four "domains" as four specific conceptual areas of study are proposed. The term *domain* is used to refer to an area of study that is identified by a common phenomenal boundary.<sup>1</sup>

A scenario is used in the first section of the chapter to show how one arrives at theoretical notions from the nursing perspective as opposed to other perspectives. The scenario is used as the basis for an examination of elements in this "reality" through the process of focusing on the nursing angle of vision. The typology of four domains is then presented, focusing on the general meanings and theoretical applicability of the domains. For each domain, examples of relevant phenomena and concepts have been delineated to show the process of conceptualization on the holistic and particularistic levels. The last section deals with the utility of the typology in conceptual development and theory construction.

## SCENARIO

Mr. Harold Smith, a 63-year-old man, sits in a bed by the window of a semi-private room of a university-affiliated community hospital. It is six o'clock in the afternoon, and it is his second day since admission to this hospital. He appears somewhat flushed, weak, and is coughing intermittently, bringing

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1. Shapere (1977) defines a scientific domain as being composed of "related items for scientific investigation," constituting a unified subject matter that poses important problem(s) for scientific investigation and having the quality of "readiness" in a scientific sense to deal with the problem the subject matter presents (pp. 518–527). Although this definition can be thought of as referring to a discipline, it is possible to apply this definition to specify sub-areas of study within a discipline that is concerned with a complex array of phenomena. Thus, domains in this typology refer to sub-areas of nursing study, specifying locality of phenomena that need to be studied in nursing. Although this differentiation of nursing's subject matter into four separate domains is appropriate since each domain contains concepts that are related to each other and poses a unified problem specific to each domain, the separate domains may still need to be combined into a larger "domain" if the larger domain poses a distinct problem that cannot be independently addressed by the subdomain solutions for the domain-based problems.

up large amounts of brownish, mucoid sputum. He has an intravenous line in his left arm and is receiving 40% oxygen via nasal cannula. He looks haggard, seems to have some difficulty breathing, appears depressed, and is dozing on and off. His dinner tray remains on the bedside table; there is little evidence of the tray having been touched by the patient, except for the half-empty cup of tea. He has been passing liquid, greenish stools today, and feels discomfort and soreness all over the body.

His wife sits by the bed, talking little, but appearing attentive to her husband's needs and every movement. Ms. Carol Dumas, an RN who is the primary nurse for Mr. Smith, notices the following facts about this patient. He was admitted with a medical diagnosis of bacterial pneumonia with a question of Legionnaire's Disease. He had been diagnosed as having chronic lymphocytic leukemia 7 months prior to the current admission, and was put on daily doses of chlorambucil, prednisone, and allopurinol, which apparently made him fatigued and caused abdominal discomfort. He had discontinued the drugs for a few weeks after taking them for 3 weeks, but had resumed taking them after a bout of flu, under the pressure of the nurse practitioner who saw him at the office for the treatment of influenza.

He had experienced three bouts of flu during the last 3 months, and had been treated by the physician and the nurse practitioner with erythromycin on an ambulatory-visit basis. He also has a history of chronic obstructive lung disease, associated with heavy smoking.

Ms. Dumas also noted several physical signs of significance:

Chest examination at admission showed rales, rhonchi, and egophony over the left anterior part of the thorax.

The latest readings on specimens taken on the second day of admission are:

Hematocrit . . . . .	21%
WBC Count . . . . .	760,000
Sputum culture . . . . .	Negative
Blood culture . . . . .	Negative
Partial pressure of oxygen . . . . .	48 mm Hg
Partial pressure of carbon dioxide . . . . .	32 mm Hg
Serum pH . . . . .	7.52

Latest Vital Signs:

Temperature . . . . .	39.6°C
Pulse . . . . .	82/minute
Respiration . . . . .	28/minute
Blood pressure . . . . .	106/64
Weight . . . . .	162 lbs
Height . . . . .	6'2"



At admission, the patient was put on cefamandole intravenously and a maintenance dose of allopurinol. In addition, erythromycin was started on the second day orally. He received two units of packed cells on the second day of admission.

He is a mailman by occupation and has been with the U.S. Postal Service since 1965. His wife works as a clerk in a small manufacturing firm. They have two sons who are married and live in the same town.

Ms. Dumas, the nurse, enters the patient's room with the IV dose of cefamandole to be put through the IV line and notices the uneaten dinner, signs of a quiet, depressed mood, and coughing. Mr. Smith's roommate is in a great deal of pain, having had abdominal surgery on the preceding day. He moans and groans aloud at times. Ms. Dumas administers the medication through the IV line and talks to Mr. Smith about his discomfort and coughing. Both Mr. and Mrs. Smith show helplessness and a degree of resignation. They appear to be very close to each other and talk about their sons and daughters-in-law in an affectionate manner. It appears that they are getting a great deal of support from their children, and there seems to be a sense of closeness in the family.<sup>2</sup>

### **Appropriateness as Nursing's Subject Matter**

The first question we need to address in considering and analyzing this scenario in a nursing context is to establish that there are some aspects of this reality that can be claimed to have nursing "meanings." Of course, one might say that it is superfluous to pose such a question, since the reality is occurring in a hospital to a patient, and one of nursing's important places of action is in a hospital with patients. Such obviousness notwithstanding, we shall make a formal claim upon this situation by applying the definition of nursing.

Nursing is a service to people for the promotion of health. Thus, a situation requiring services or interventions of health promotion is a legitimate place for nursing. Since Mr. Smith's situation requires interventions that are unique to nursing, it is justifiable for us to claim this reality as having nursing phenomena. Yet this does not mean that the situation cannot be

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2. Many details of this scenario were borrowed from Case 28-1980 of the Case Records of MGH as published in the *New England Journal of Medicine* by Pennington and Mark. Many facts were also altered and created. Thus, the total scenario does not depict an actual case. See: Pennington, J. E., & Mark, E. J. (1980). Case-Record of the Massachusetts General Hospital: Case 28-1980—Pneumonia in a 62-year-old Man with Chronic Lymphocytic Leukemia. *New England Journal of Medicine*, 303, 145-152.

claimed by other scientific disciplines as having unique meanings and problems that are only applicable to their fields. This possibility is the main reason for the necessity for a specific angle of vision, a selected frame of reference, in studying a given phenomenon. While nursing is concerned with health and health care, not all aspects of health and health care constitute the proper subject matter for nursing. By adopting Berger's phrase (1963), we might state that nursing does not study phenomena that another field is unaware of, but it examines and studies the same phenomena in a different way, from the perspective of nursing.

### **Meaning in Non-nursing Perspectives**

In an effort to make clear the later discussions concerning the perspective of nursing in analyzing the scenario, let us examine possible claims of phenomena in the scenario by other non-nursing perspectives first. We will look at the perspectives of medicine, pharmacology, social service, medical science, and psychology in order to contrast the meanings of studying the same reality in different ways with different angles of vision.

First, let us take the perspective of medicine. The medical frame of reference in pursuing problems of health is based on a number of carefully delineated models of normal and abnormal human conditions and of modus operandi for diagnosing and handling such human conditions as diseases and pathologies. In the medical frame of reference, a physician will pose the following questions related to the scenario because these or others similar to these are important aspects of the phenomena to medicine.

1. Mr. Smith's blood and sputum cultures that were performed at the time of admission and on the second day of the admission were reported with negative growth. Why were the cultures negative when it is apparent that he has inflammation in the lungs and bronchi?
2. How did the taking of immunosuppressive drugs influence the prognosis of Mr. Smith's pneumonia?
3. How did the characteristics of lung sounds and sputum change over the course of treatment?
4. Why did the patient have diarrhea while remaining febrile?
5. Should erythromycin be given orally or intravenously? How long should the patient be on antibiotics, in the light of repeated pulmonary infections?
6. Should Mr. Smith receive a packed-cell transfusion?

These questions point out the medical frame of reference; the reality of the scenario presents itself in the phenomena of abnormal findings (e.g., lung sounds, sputum, diarrhea, vital signs, blood counts, plasma oxygen,

and carbon dioxide levels, etc.), confirmations of and deviations from ideal-type diagnosis, and susceptibility and/or appropriateness of medical treatments. Therefore, the medical frame of reference directs attention to studies of medical diagnosis, pathological findings, and treatment protocols necessary for removal of pathologies.

The pharmacological frame of reference will question the problems of possible interaction between cefamandole and allopurinol, the excretion rate of erythromycin in a patient with possible liver pathology, and the compatibility of erythromycin with cefamandole, however unimportant these questions may be to other scientific fields. A pharmacological orientation calls attention to drug-interactions, absorption and excretion of drugs, and drugs' effects on physiological functioning. Hence, the situation with Mr. Smith is a case in which such pharmacological questions may be raised.

In contrast, the social service frame of reference will view the reality of the scenario in terms of: (a) Does Mr. Smith have disability insurance coverage that will assure continued income for the family? ; (b) Is the family going to need some kind of assistance with social welfare services in the event of Mr. Smith's discharge from the hospital?; or (c) What type of health insurance does Mr. Smith carry? The frame of reference for social service is in effective and efficient utilization of private and public resources in case of crisis and disruption in individual and family life. Thus, it is appropriate for this perspective to examine the reality of the scenario with such questions as the ones presented above.

These examples of questions based on different frames of reference indicate to us how the same situation may be perceived in many different ways for solutions of specific kinds. These questions can become the basis for an inductive study of phenomena, posed in the different perspectives and seeking different solutions. On the other hand, these questions may be answered by drawing from theoretical knowledge established in the specific discipline.

Another way of linking the reality of this scenario with scientific studies is through a deductive system in which scientists identify appropriate aspects and elements of the reality as empirical counterparts to theoretical concepts they are investigating. For example, a medical scientist who is interested in relationships between immunosuppressive drug use and occurrence of infection can easily include Mr. Smith as a possible sample in such a study. In a similar way, a psychologist who is interested in studying relationships between the concepts of locus of control and decision making may want to investigate Mr. Smith's smoking behavior in that perspective.

Different definitions of a situation made in the context of scientific angles of vision allow divergent theoretical questioning and multiple empirical conceptualizations. This is indeed what is meant by studying the same phenomenon in different ways.

### **Perspective of Nursing**

We now turn to the question of how nursing should perceive the phenomena in this scenario. We can pose many questions haphazardly as the questions were presented from other perspectives in the above section. However, since the aim is to present a systematic view of this reality from the nursing perspective, I propose a method by which the phenomenal elements in the scenario are dissected and disentangled rather than conceived as a conglomerated, global phenomenon. This does not mean that the scenario cannot be perceived and conceptualized as one global phenomenon; yet, the theoretical usefulness of such an approach may be too complicated at this point, or meaningless for nursing explanations.

It is somewhat like viewing Picasso's *Les Saltimbanques* (The Entertainers; see Figure 3.1). A viewer as a lover of art appreciates the total mystery and beauty of the painting as a piece of work that moves the heart



**Figure 3.1** PICASSO: *Les Saltimbanques*

and one's aesthetics. He or she feels a certain message from the painting, such as "solitude," "pathos," or "waiting." Whatever message the viewer perceives, he or she perceives it from the totality of the painting as it is presented to him or her. This is the holistic mode of perception as defined in Chapter 2. In this mode, the viewer is totally involved in the piece of art as a whole thing representing a specific meaning as a whole.

However, another viewer may attain quite a different kind of appreciation and understanding of the painting by dissecting the painting and viewing it in one of many possible different meaning-systems. These may include: (a) the physical attitudes depicted in the painting—how each person in the painting stands and looks to another; (b) the emotional tones of the painting—how the emotions are depicted by the painter in different expressions assumed by the "entertainers;" or (c) the blending of color tones—how colors are used for the personage and the background. This second viewer uses a specific guideline for viewing art (i.e., a particular mode of perception and analysis within a frame of reference that is art) in order to understand the meanings of the given phenomena. This second viewer's understandings would be specific to interrelatedness of objects on canvas, the mixture of emotional tones as depicted in images with figures and colors, or the use of color. This viewer has thus adopted the particularistic mode of perception.

In essence, the quality of impressions attained by viewers of a painting, such as the first viewer, would depend on the extensiveness and refinement of the general knowledge the viewer has acquired about painting, art, and beauty. In contrast, the second viewer adopts an analytic posture for understanding what is presented before him or her, making it possible for the viewer to appreciate the art in the context of its selected meanings and qualities.

Thus, the proposed method here is to adopt the analytical mode of examining a phenomenon so that we may be able to understand the hidden aspects of the reality and examine various elements in a phenomenon with different frames of reference. Since this analytical method is akin to the particularistic mode of description and analysis, it is necessary to make an eventual consolidation with the holistic mode of analysis. The essential distinction between holistic and particularistic analysis is in the focus of description. Holistic analysis is aimed at examining properties and forces of an object or a situation as a whole. Particularistic analysis, on the other hand, is aimed at focusing on a specific aspect or element of a situation or an object without having an explicit regard for the whole. Therefore, for any particularistic level, there is a related holistic level, and for any holistic level there is a more global holistic level, making the first holistic level particular.

These thoughts on analytical modes indicate that it is possible to pose questions regarding the scenario from the nursing perspective on various

levels. We can abstract the following elements from the scenario that are directly related to Mr. Smith, the client:

1. Mr. Smith is tired, anorexic, underweight, and generally uncomfortable.
2. He suffers from chronic nonreversible damage to the lungs, and is experiencing a long-term debilitation requiring continued compliance with medical treatments.
3. He has a history of self-discontinuation of drug treatment, as well as a history of resuming the treatment under professional pressure.
4. He is attached to an IV line and oxygen therapy, which limit his activities and prevent him from smoking at present.
5. His respiration is labored, he has a productive cough, and he is diarrheic.
6. He is repeatedly attacked by respiratory infection.
7. He is depressed and appears helpless.

These are major elements of the scenario requiring explanations and understanding in order for nursing to provide effective care to Mr. Smith.

Viewed from what is going on between Mr. Smith and Ms. Dumas, we can also delineate several different phenomenal elements of interest from what goes on between the client and the nurse.

1. Mr. Smith and Ms. Dumas exchange greetings, talk about discomfort brought on by diarrhea, etc. Mr. Smith answers in short sentences while Ms. Dumas is animated and illustrative in giving answers to questions.
2. Ms. Dumas stays quite close to the bedside of Mr. Smith. The nurse holds the patient's hand and gently examines the site of IV injection as she is getting ready to add medication.
3. Mr. Smith and Ms. Dumas collaborate on deciding about the kind of food that may be tolerable to the patient.
4. Ms. Dumas is gentle and kind but semiformal in her approach toward Mr. Smith whereas Mr. Smith is restrained in talking with the nurse.

These statements refer to phenomena that exist or could be apparent when the client and the nurse are together as an interactive pair. They raise important questions for explanation and understanding from the nursing perspective, as nursing involves a service delivered to humans (i.e., clients) by other human agents (i.e., nurses). Phenomena in the client-nurse interaction belong to general categories of human-to-human contact and interaction phenomena but are a particular sort specific to the context of nursing.

In addition to these two sets of phenomenal elements in the scenario that are important to nursing's understanding of Mr. Smith's care, the following questions must be posed with specific regard to nursing interventions and practice:

1. How did the nurse organize the data on Mr. Smith?
2. What are the specific problems Ms. Dumas has identified in Mr. Smith as requiring nursing approaches and interventions?
3. What are the alternative approaches the nurse has formulated for the delivery of nursing care during Mr. Smith's hospitalization?
4. What are the priorities that need immediate attention from nursing staff for Mr. Smith?
5. What should the nurse do in adding the medication to the IV line?
6. How could the nurse assist Mr. Smith to cope with the effects of immunosuppressive drugs and with the repeated respiratory infection?
7. What are therapies that can be carried out to ease Mr. Smith's discomfort caused by diarrhea?
8. What are the plans the nurse has made for Mr. Smith regarding follow-up care and recovery?
9. How should the nurse assist Mr. and Mrs. Smith to handle the chronicity of his illness?

These questions are related to the kinds of nursing activities the nurse needs either to carry out or to consider carrying out for the patient. Although knowledge related to some of these questions depends on understanding obtained regarding the client and the client-nurse, these questions point out the need for a specific set of knowledge that pertain to nursing practice itself.

Supplementing the phenomenal elements in the client, the client-nurse, and nursing practice, we can also abstract different elements from the environment of Mr. Smith. The following can be specified as having significant meanings to nursing:

1. Mr. Smith is in a semiprivate room in which the roommate is suffering from acute pain. There are noises around him always.
2. His wife sits at his bedside, appearing very supportive to his needs.
3. His children live in the same town and are close to their parents.
4. The nurses on this unit are familiar with Mr. Smith, since he had been hospitalized on this unit on two previous occasions.

The above factors are some of the elements in the environment that are relevant in gaining answers to nursing questions. For example, do these factors influence or explain Mr. Smith's health in any way? Are there any crit-

ical aspects of his environment that influence the way Mr. Smith responds to his hospitalization and recovery? And do any of these factors have an influence on the way nursing care is provided to Mr. Smith?

These four sets of delineation indicate that it is possible to disentangle the situation of nursing care into four areas of focus: the client, the client-nurse, the nursing practice, and the environment. Furthermore, the questions posed in this nursing perspective are different from those raised in the other non-nursing perspectives. These are nursing questions, raised for the deeper understanding and explanation of the situation. The goal is to give nursing care to Mr. Smith that is scientifically appropriate and effective. The knowledge addressing these elements will be valuable to nurses in delivering nursing care to Mr. Smith. This analysis leads us to a typology that can be used systematically to analyze elements in nursing situations: a typology of four domains—client, client-nurse, practice, and environment.

### **THE TYPOLOGY—FOUR DOMAINS**

Four domains of client, client-nurse, practice, and environment are proposed at this point as components of a typology for conceptualization from the nursing perspective. This classification scheme is a way of disentangling realities, phenomena, and concepts within the nursing perspective. The four domains of this framework direct identification of concepts within specific phenomenal boundaries, and are suggested for use in properly “locating” phenomena of importance to nursing studies.

This suggested utility is quite different from the purposes linked to the frameworks of theory analysis advanced by Hardy (1978), Barnum (1994), and Fawcett (1994). These domains of the typology serve quite different purposes than those proposed by metaparadigm concepts such as those by Barnum (1994), Meleis (1997), Yura and Torres (1975), and Fawcett (1978, 1984). Barnum’s commonplaces of nursing theories are (a) nursing acts, (b) patient, (c) health, (d) relationship between nursing acts and patient, (e) relationship between nursing acts and health, and (f) relationship between patient and health. Barnum’s commonplaces are used as the basis for identifying major components of theories, especially in evaluating their comprehensiveness and focus, rather than as an aid to conceptualization of nursing phenomena.

Similarly, Yura and Torres (1975) identified four subconcepts—man, society, health, and nursing—as the most commonly identified components for theoretical formulations in nursing as articulated in baccalaureate curriculum. Also, Fawcett (1978, 1984) adopted person, environment, health, and nursing as the units specifying the phenomena of interest to nursing science and as the essential components of nursing theories. Meleis (1997)



adds “transitions” as an additional metaparadigm concept to the set proposed by Fawcett. Although the proposed typology of four domains is an attempt to refine such suggestions, the major purpose of the typology is different from the motivations expressed by Yura and Torres, and by Fawcett. Their main interests were to identify essential concepts in nursing theories. My idea is to use the typology to identify essential aspects of nursing as contained within the four domains. This typology is a conceptual tool by which nursing scientists can identify a locus of concepts and phenomena within specific domains. Although the domains may be used to test theoretical comprehensiveness, the main purpose for the typology is in its usefulness in conceptual delineation and theoretical thinking about the scientific field of nursing.

More importantly, this typology can be used to define the nursing angle of vision in viewing the world of health care. Any conceptual or theoretical development has to have a specific reference to nursing in order for it to have value to the scientific field of nursing. The primary concern regarding theoretical thinking in nursing is not that of comprehensiveness of nursing theories, but is in ensuring that what we develop theoretically has nursing significance. The four domains point to four spheres of the empirical world in which nursing-relevant phenomena could be located, while at the same time orienting scientists to possible relationships among concepts within and across domains. The typology is a conceptual map upon which the discipline can plot its phenomena of interest in a systematic, organized fashion in order to develop scientific knowledge. As shown in the following introductory discussions regarding each domain, and in more in-depth expositions offered in Chapters 4–7, the domains are used to make sense of concepts and phenomena we study in nursing.

### **The Domain of Client**

Clients present to us rich arrays of phenomena requiring various types of considerations, understandings, and interventions, as shown in the preceding discussions regarding Mr. Smith. The domain of client is concerned with those theoretical issues that pertain only to the client. The focus is on what is happening with, presents in, or refers directly to a client. In addition, when the client is the focus, we are also only concerned with those elements in the client relevant to nursing. The ultimate reason for nursing to examine “client” as the focus is that, by understanding happenings (phenomena) in the client, nursing can: (a) attain an understanding about the nature of phenomena present in the client; (b) gain knowledge regarding the client’s problems; (c) formulate generalized notions about why problems exist; and (d) deliver the most effective and needed nursing care to the client.

The elements of the scenario that pertain to the domain of client were identified earlier. Table 3.1 shows how such phenomenal elements are then made to have some meaning-relations with specific concepts in the domain of client. Concepts such as fatigue, discomfort, chronicity, etc., therefore, can be examined and analyzed as theoretical concepts for explanations. Some of the concepts are holistic concepts, while others are particularistic on several different levels of abstraction. Thus, concepts in the domain of client can be delineated in both the holistic and particularistic modes.

For example, on a holistic level, a patient who walks into an emergency unit with a swollen and injured face is considered and described in terms of general features that are sui generis to the human person and that describe the person as a whole, such as healthy, sick, happy, depressed, or dying. The description also involves a perception of the individual with respect to characteristics that depict the person as the basic unit of analysis. Thus, the following description of the person in this holistic mode of analysis might result.

Marjorie Johnson, a woman of middle years with a slight figure, who appears fearful and nervous in her posture, has gross injuries of old and fresh contusions and lacerations on her face. Her face appears

**Table 3.1** An Illustration of Relationships Between Selected Phenomena and Concepts in the Domain of Client

PHENOMENAL ELEMENTS	CONCEPTS
Tired; anorexic; underweight; general discomfort; depressed	<ul style="list-style-type: none"> <li>• Fatigue</li> <li>• Lassitude</li> <li>• Anorexia</li> <li>• Depression</li> </ul>
Chronic nonreversible lung disease; Lymphocytic leukemia	<ul style="list-style-type: none"> <li>• Chronic illness</li> <li>• Chronicity</li> </ul>
Intravenous infusion; Oxygen therapy	<ul style="list-style-type: none"> <li>• Invasion of body</li> <li>• Supplementation</li> <li>• Dependency</li> </ul>
Self-discontinuation of drug	<ul style="list-style-type: none"> <li>• Noncompliance</li> </ul>
Labored respiration; Productive cough	<ul style="list-style-type: none"> <li>• Respiratory distress</li> </ul>
Repeated respiratory infection	<ul style="list-style-type: none"> <li>• Chronicity</li> <li>• Recidivism</li> </ul>
Mr. Smith as a person	<ul style="list-style-type: none"> <li>• Man</li> </ul>

distorted and her posture is agitated. She looks as though in pain yet indicates that the injuries do not hurt.

On the contrary, on a particular level, this same patient is considered and described with a particular focus, the injury. A description with a particularistic focus on the injuries of Marjorie Johnson will result in the following:

Marjorie Johnson's facial injuries consist of a two-degree edema on the left side of the face, with a contusion of 2 cm diameter around the left cheekbone area, and a superficial cut in the mucosa of the upper lip that is bleeding intermittently. There are several small contusions near the forehead that are sensitive and painful to pressure.

The focus of the holistic description within the domain of client is the person as a whole, as a human person, while the focus of the particularistic description is the injury, in this instance. In the theoretical arena, both levels of description and analysis are necessary, so far as each level is selected for appropriate theoretical explanations.

Phenomena and concepts in the domain of client are viewed to belong to three types: *essentialistic*, *health-care experiential*, and *problematic*. A more comprehensive discussion of this subcategorization and a detailed exposition for concepts and phenomenal elements in the domain of clients are presented in Chapter 4. In addition, major descriptive and explanatory frameworks useful in studying this domain are also presented in that chapter.

### **The Client-Nurse Domain**

The client-nurse domain is defined as the area of study in nursing pertaining to phenomena arising out of encounters between the client and nurse. This domain points to many facets of the relation between the client and nurse in the process of providing nursing care. Phenomena in the client-nurse domain refer to the nurse in direct contact with the client. The domain encompasses various modes of contact, including spatial, physical, communicative, emotional, and interactive modes. Nurses and patients in nursing care situations converse, play specific roles, exchange feelings, and make connections. Contacts between the client and nurse are occasions in which transfer and/or interchange of information, energy, and affection/humanity occur. Such contacts are the medium for delivering nursing care and for helping clients from the nurse's perspective, and for gaining attention and receiving care from the client's perspective. Such concepts as touch, empathetic relationship, transaction, therapeutic communication, collaboration, and therapeutic alliance belong to this domain.

Table 3.2 shows the linkages between the phenomenal elements regarding Mr. Smith identified in the preceding section and relevant theoretical concepts pertaining to the client-nurse domain. As the examples show, some concepts are particularistic, such as “interpersonal spacing,” while others are holistic, such as “transaction.”

Phenomena and concepts in the client-nurse domain can be categorized into three different types according to the dominant features of client-nurse interchange: *contact*, *communication*, and *interaction* types. Of course, these types are oriented to particularistic conceptualization of the interchanges, and are perhaps most useful as analytical tools in studying the specific aspects of the client-nurse interchange with particular perspectives. This subcategorization does not preempt the usefulness of a holistic conceptualization of the client-nurse interchanges. A more in-depth exposition regarding the client-nurse domain is presented in Chapter 5.

### The Domain of Practice

This domain encompasses phenomena and concepts related to what nurses do in the “name of nursing.” It includes phenomena particular to the nurse who is engaged in nursing work. The concept of practice refers to the cognitive, behavioral, and social aspects of professional actions taken by a nurse in addressing clients’ needs and problems and in fulfilling the role of nurse in a given nursing care situation. It encompasses phenomena pertaining to the nurse formulating, thinking about, and contemplating nursing actions as well as those involved in nurse doing nursing, carrying out the work of nursing. The phenomena of concern are located in the nurse with respect to how she/he thinks, makes decisions, transfers knowledge into actions, uses available knowledge in actual practice, or enacts certain actions.

**Table 3.2** An Illustration of Relationships Between Selected Phenomena and Concepts in the Client-Nurse Domain

PHENOMENAL ELEMENTS	CONCEPTS
Nurse’s touch of Mr. Smith while giving care	<ul style="list-style-type: none"> <li>• Instrumental touch</li> </ul>
Talking between the nurse and patient; Caring occasion	<ul style="list-style-type: none"> <li>• Client-nurse transaction</li> <li>• Empathy</li> <li>• Caring</li> </ul>
The nurse’s presence and closeness with the patient	<ul style="list-style-type: none"> <li>• Distancing</li> <li>• Presence</li> </ul>

For the domain of practice, the main theoretical question involves the methods by which nurses make decisions regarding nursing care and what techniques and processes are adopted for enacting nursing actions. Thus, concepts such as critical nursing judgment, prioritization of nursing-care needs, clinical decision making, routinization of nursing care, personalization, and nursing rule-bending belong to this domain of practice.

Table 3.3 shows the linkages between the questions presented regarding the nursing care of Mr. Smith in the preceding section and relevant theoretical concepts. These are examples of concepts that require theoretical understanding if nursing actions are to make scientific sense. As the examples show, some concepts of nursing actions are particularistic, such as medicating skill and respiratory assessment, while others are holistic, such as nursing care planning. This, then, also suggests that phenomena and concepts in the domain of practice can also be analyzed in both modes, holistic and particularistic. Phenomena and concepts in the practice domain can be organized in two phases: *the phase of deliberation* and *the phase of enactment*. A more in-depth exposition regarding the domain of practice is presented in Chapter 6.

### The Domain of Environment

The domain of environment is an essential component in developing knowledge in nursing as it is the common source for understanding and explaining the phenomena in the client, client-nurse, and practice domains. The environment of the client is thought to be composed of physical, social, and symbolic components, varying in temporal and spatial contexts. Environment refers to the external world that surrounds the client as well as to that which forms the context in which the client-nurse interchanges and nursing practice take place. It is composed of both immediate

**Table 3.3** An Illustration of Relationships Between Selected Phenomena and Concepts in the Practice Domain

PHENOMENAL ELEMENTS	CONCEPTS
Observation of the patient's problems	• Nursing assessment
Organization of data regarding the patient	• Prioritization • Clinical reasoning
Formulation of alternatives in nursing care	• Nursing decision making
Administering medication; Adjusting oxygen mask; Observing the rate of IV infusion; Charting	• Nursing enactment • Nursing description

and remote elements.

Table 3.4 shows the linkages between the phenomenal elements that were identified in the preceding section regarding Mr. Smith and general concepts that are thought to encompass those phenomenal elements. These phenomenal elements and concepts identified for Mr. Smith’s situation have theoretical significance for nursing to the extent that (a) scientific scrutiny of such concepts will illuminate understandings and explanations regarding the client’s problems; and (b) theoretical understandings of concepts and their relationships to other phenomena will influence the nursing interventions.

Just as we examined phenomena and concepts in other domains in two analytic modes, so too the domain of environment also can be subjected to both modes of analysis. Environment in a holistic mode of analysis takes the form of global surroundings having multiple yet coherent influence as a totality to the client, client-nurse interchanges, and the practice. In contrast, environment can be analyzed in a particularistic mode as composed specifically of physical, social, and symbolic elements. A more comprehensive analysis of the domain of environment is presented in Chapter 7.

In a way, the typology of four domains proposed in this section is a way of reshaping the world to fit our purpose, to identify only those critical elements for scientific and theoretical scrutiny within the nursing perspective. The four domains are not separated in any formal way, except in their boundary specifications, that enable locus designations of phenomena and concepts. The ways in which the domains are conceptually divided for this purpose are summarized in Figure 3.2. The figure shows subcategories that

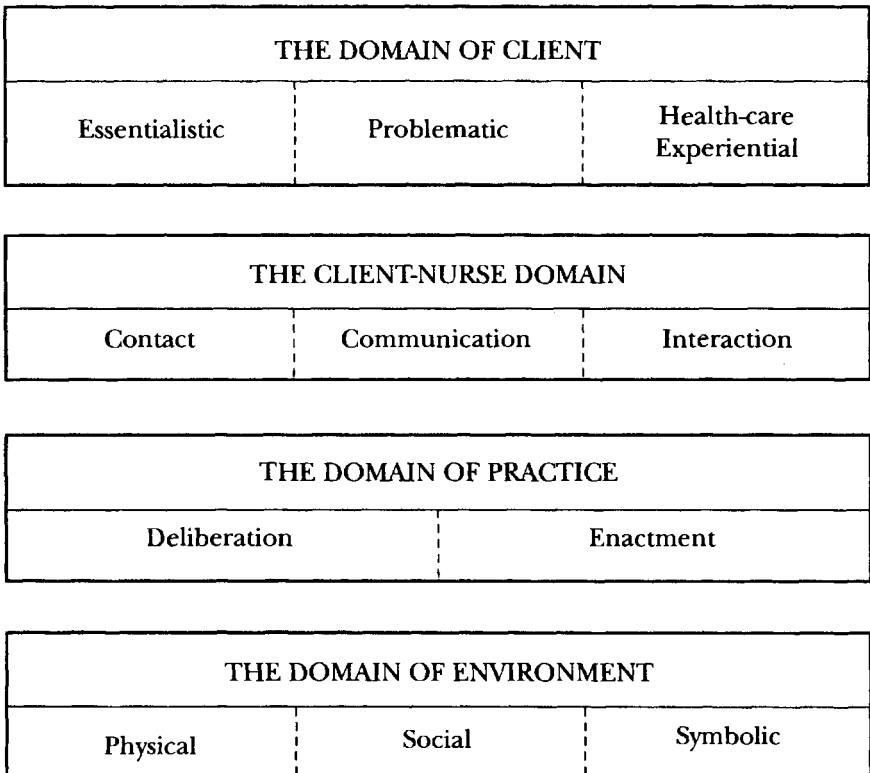
**Table 3.4** An Illustration of Relationships Between Selected Phenomena and Concepts in the Domain of Environment

PHENOMENAL ELEMENTS	CONCEPTS
Hospitalized in a semiprivate room; Has a roommate who is groaning and is in pain; Noisy background	<ul style="list-style-type: none"> <li>• Sensory overload</li> <li>• Territoriality</li> <li>• Social isolation</li> </ul>
Presence of wife	<ul style="list-style-type: none"> <li>• Affection</li> <li>• Significant other</li> <li>• Role expectations</li> </ul>
Wife and children; Friends and neighbors	<ul style="list-style-type: none"> <li>• Social support</li> <li>• Social network</li> </ul>
Being in a hospital	<ul style="list-style-type: none"> <li>• Health-care environment</li> <li>• Patient role expectations</li> <li>• Hospital rules</li> </ul>

make conceptually meaningful sense and analytical clarification in thinking about each domain, as discussed in this chapter and as also expanded in the later chapters. This typology can only serve as a way to see things more clearly and to understand the proper contexts of conceptual and theoretical development. It is a tool that can make the development of conceptual clarification less painful and less haphazard.

### UTILITY OF THE TYPOLOGY IN CONCEPT AND THEORY DEVELOPMENT

The question, then, is how this typology aids conceptual development in nursing. The examples of the scenario and the linkages shown between the observational elements (phenomenal elements) and the theoretical con-



**Figure 3.2** The four theoretical domains of nursing and their conceptual subboundaries.

cepts for the four domains as presented in Tables 3.1–3.4 refer, in fact, to the first-level, simplistic inductive conceptualization. We have defined the boundaries for understanding the phenomenal elements in reality as having specific locus of meaning with respect to client, client-nurse, practice, and environment. This process enables the inferences of realities to abstract concepts and makes for the understanding of aspects of reality in a general, theoretical sense, rather than as distinct, isolated, novel situations. This disentanglement of reality into many different observational concepts within the four domains also makes scientists view reality in a detached, analytic manner.

A reverse approach of deductive conceptualization for a scientist in approaching reality is also possible within the typology. For example, a scientist who is interested in the theoretical concept of fatigue will first define the concept to refer to phenomena in the domain of client. Following this definition, the scientist will formulate observational referents of the concept. The actual observation and analysis occur as the scientist selects particular situations of a client exhibiting the observational elements of fatigue. The scientist will thus focus on observing clients for the presence of fatigue since the domain of the concept is the client. The typology thus provides an easy, clear-cut way of designating units of analysis in conceptualization. For each domain, units of analysis for concepts always exist within that domain.

As the second step in theoretical thinking, concepts studied and abstracted for descriptive understanding need to be exposed for their significance in theoretical formulations. The typology is useful in theoretical formulations, for the domain identification of concepts allows scientists to define the level of comprehensiveness a given theoretical formulation will have. Theoretical development in nursing is a step beyond mere conceptualization. Theoretical development involves developing sets of interlinked propositional statements for selected concepts. Since a theoretical formulation in nursing can handle concepts within or across the domains, identification of concepts with respect to the domains can show the boundaries toward which the theoretical efforts are aimed.

The typology clarifies how encompassing a theoretical formulation is in its explanatory statements. For example, a theory of cognitive dissonance in nursing is limited to explaining the phenomena in the domain of the client, whereas a theory of social support in nursing links the phenomena in the client with those in the domain of the environment. In a more global way, a general systems theory of nursing such as that proposed by Rogers encompasses in its explanatory propositions many phenomena in all four domains.

Figure 3.3 shows many possible theoretical clusterings of concepts among and across the domains for different types of theoretical develop-



ment, albeit all theoretical linkages may be appropriate for nursing. Clusterings indicate possible propositions in theoretical systems. For example, with the selection of the following concepts for each domain, we can think of many different types of theoretical formulations among these concepts as shown in Figure 3.3.

*The Domain of Client*

- Pain experience
- Noncompliance
- Stress
- Overweight

*The Client-Nurse Domain*

- Collaboration
- Client-nurse distancing
- Empathy
- Therapeutic alliance

*The Domain of Practice*

- Priority setting
- Discharge planning
- Nursing assessment
- Personalization of care

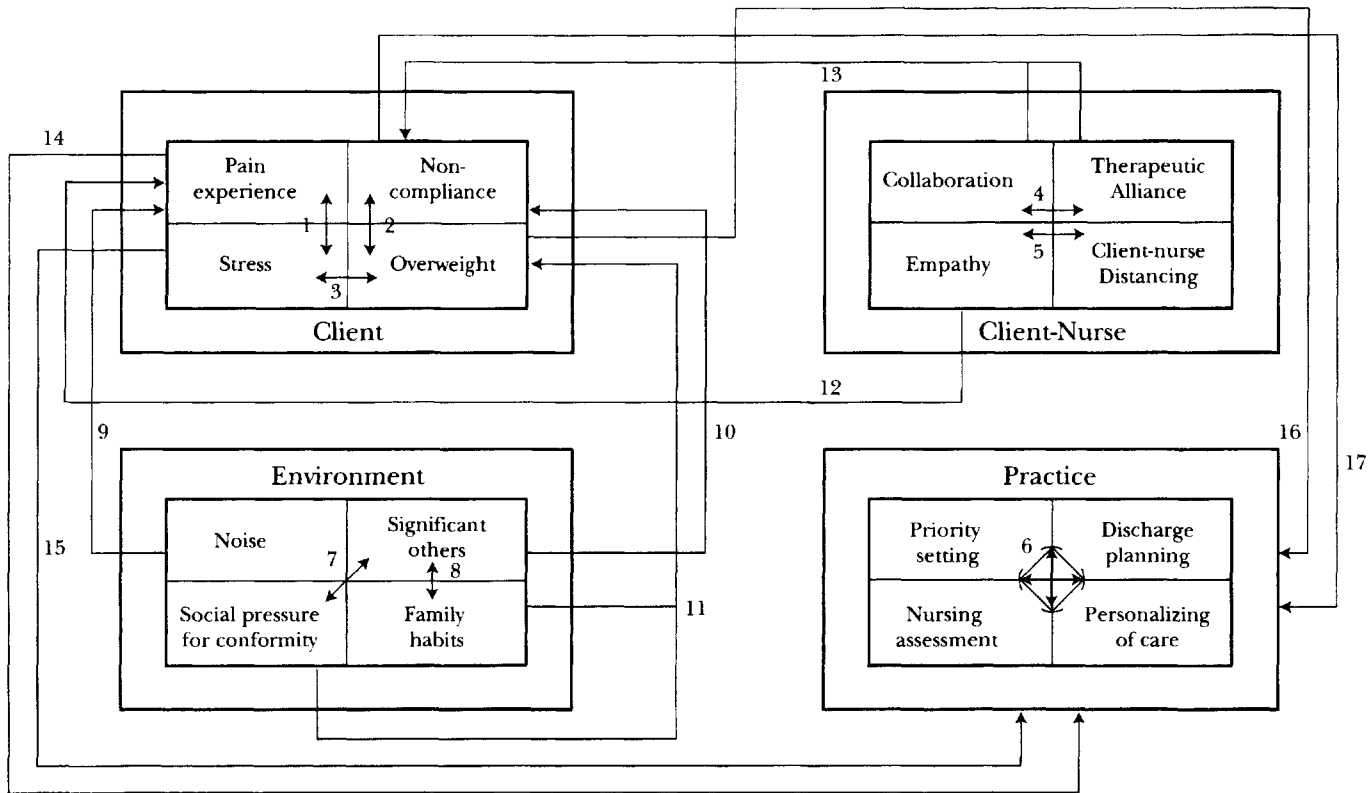
*The Domain of Environment*

- Noise
- Family's eating habits
- Social pressure for conformity
- Significant others

Thus, putting together these concepts can result in formulations of propositions. Possible relationships proposed in Table 3.5 serve as examples of theoretical developments linking concepts within and across the domains. These formulations implicitly show that when two or more concepts are clustered together as theoretical formulations and propositions, they tend to come together as broader concepts, such as adaptation, interaction, and influence. Hence, the typology is also useful in directing the delineation of broader theoretical concepts in the process of theoretical development. These eleven examples are only some of many possible numbers of theoretical formulations linking the twelve main concepts used in this example.

As we can see in Chapter 8, not all possible linkages and clusterings of concepts are theoretically meaningful in general, nor are for nursing in particular. Therefore, while it is not difficult to make propositional connections between concepts, it is difficult to put propositions together into a coherent system of theoretical formulations. The burden is on nursing scientists to make decisions about the nature of critical concepts and phenomena that are essential for theoretical explanations of nursing phenomena. Once essential concepts are selected, the complexity of theory evolves around the main attitudes regarding the comprehensiveness of the theoretical development.

The main question for theoretical development is to ask what needs to be explained and why such explanations might be important to nursing. The ultimate inference in any theoretical development in nursing needs to address phenomena in the domains of client and nursing action either directly or indirectly.



**Figure 3.3** Examples of relationships among concepts within the domains and across domains (numbers refer to the relationships specified in Table 3.5).

**Table 3.5** Examples of Theoretical Formulations Linking Concepts in Four Domains of Nursing

DOMAIN LEVEL	PROPOSED THEORETICAL RELATIONSHIPS
<i>Within-Domains</i>	
a. The Domain of Client	<ol style="list-style-type: none"> <li>1. Pain experience and level of stress (Theory of stress and coping)</li> <li>2. Overweight and noncompliance (Theory of balance or Theory of motivation)</li> <li>3. Level of stress and overweight (Theory of stress)</li> </ol>
b. The Client-Nurse Domain	<ol style="list-style-type: none"> <li>4. Collaboration and therapeutic alliance (Theory of collaboration)</li> <li>5. Empathy and distancing (Theory of empathy)</li> </ol>
c. The Practice Domain	<ol style="list-style-type: none"> <li>6. Nursing assessment, Priority-setting, Personalization of care, and Discharge planning (Theory of nursing practice)</li> </ol>
d. The Environment Domain	<ol style="list-style-type: none"> <li>7. Social pressure for conformity and significant others (Social integration theory)</li> <li>8. Family eating habits and significant others</li> </ol>
<i>Across-Domains</i>	
a. The domains of client and environment	<ol style="list-style-type: none"> <li>9. Pain and noise (Theory of stress)</li> <li>10. Noncompliance and significant others (Social support theory)</li> <li>11. Overweight, family eating habits, and social pressure for conformity (Reference group theory)</li> </ol>
b. The domains of client and client-nurse	<ol style="list-style-type: none"> <li>12. Pain experience and empathy (Theory of empathy)</li> <li>13. Noncompliance, collaboration, and therapeutic alliance (Theory of compliance)</li> </ol>
c. The domains of client and practice	<ol style="list-style-type: none"> <li>14. Pain experience and nursing practice</li> <li>15. Stress and nursing practice</li> <li>16. Overweight and nursing practice</li> <li>17. Noncompliance and nursing practice</li> </ol>

## **HOLISTIC AND PARTICULARISTIC MODES— CONCEPTUALIZATION WITHIN THE TYPOLOGY**

For theoretical formulations in nursing, five levels of holistic conceptualization are possible and relevant, based on the four domains of the typology. These five levels of holistic theoretical systems in nursing are: (a) client; (b) client-nurse; (c) practice; (d) the environment, and (e) the holistic level including the domains of client, client-nurse, practice, and environment. In addition, within each of these five levels of theoretical formulation, innumerable levels and types of a particularistic level of theoretical formulation are also possible. Table 3.6 lists selected concepts as “examples” of holistic and particularistic descriptions for the five levels. Scientists select and define proper levels of description for concepts chosen for specific studies within the theoretical contexts that are applied for the studies.

In many instances, the relationship between holistic and particularistic concepts for a given set of phenomena, as formulated into a proposition, takes the form of what Blalock (1969) calls “the element-class abstraction” in which a major difference in the conceptualization is in units of analysis. Such relationships and other similar relationships among different types of concepts, such as those alluded to in Figure 3.3, are discussed in greater detail in Chapter 8.

A word of caution is in order at this point: There is a difference between the two modes of analysis applied to description and the two modes of analysis applied to explanation. Description refers either to inductive or deductive conceptualization of phenomena for the purpose of defining the characteristics of concepts. In contrast, explanation focuses on relationships between at least two phenomena or concepts. Thus, the holistic explanation aims for comprehensive understanding of changes or characteristics of the whole, while particularistic explanation is oriented toward understanding particular elements of the whole. Propositions in a holistic explanatory system tend to be global, while propositions in a particularistic explanatory system are narrower in their conceptual focus. Holistic explanations, indeed, may be aimed at grand theories and meso-theories. Middle-range and micro-theories are aimed at particularistic explanations. This suggests that explanations within each domain are mainly particularistic explanations, whereas explanations across domains and in the system of all four domains tend to be holistic explanations.

### **SUMMARY**

The typology of four domains in this chapter and the analytic modes of holism and particularism are tools by which conceptual clarity is attained

**Table 3.6** Examples of Concepts in Nursing Study According to Level of Concept Description and the Domain

Domain Level	Level of Concept Description	
	Holistic	Particularistic
Client	<ul style="list-style-type: none"> <li>• Personhood</li> <li>• Health</li> <li>• Adaptation</li> <li>• Disability</li> <li>• Illness</li> <li>• Chronicity</li> <li>• Recidivism</li> </ul>	<ul style="list-style-type: none"> <li>• Pain</li> <li>• Injury</li> <li>• Anemia</li> <li>• Depression</li> <li>• Immobility</li> <li>• Infection</li> <li>• Edema</li> <li>• Respiratory distress</li> </ul>
Client-Nurse	<ul style="list-style-type: none"> <li>• Client-nurse transaction</li> <li>• Therapeutic relationship</li> <li>• Client-nurse interaction</li> <li>• Client-nurse exchange</li> </ul>	<ul style="list-style-type: none"> <li>• Client-nurse collaboration</li> <li>• Therapeutic alliance</li> <li>• Touch</li> <li>• Distancing</li> <li>• Gift-giving</li> </ul>
Practice	<ul style="list-style-type: none"> <li>• Clinical expertise</li> <li>• Nursing practice</li> <li>• Ethical practice</li> <li>• Nursing process</li> </ul>	<ul style="list-style-type: none"> <li>• Clinical diagnosing</li> <li>• Surveilling</li> <li>• Nursing assessment</li> <li>• Technical skill</li> <li>• Rule-bending</li> </ul>
Environment	<ul style="list-style-type: none"> <li>• Ecosystem</li> <li>• Biosphere</li> <li>• Field</li> <li>• Territory</li> </ul>	<ul style="list-style-type: none"> <li>• Noise</li> <li>• Pollution</li> <li>• Social support</li> <li>• Ethical standards</li> </ul>

in theoretical thinking. The domain typology aids nursing scientists in locating concepts. As presented in the following chapters, each domain poses somewhat distinct conceptual and theoretical problems and issues in nursing.

Holistic and particularistic modes of analysis as applied to the domain typology allow theoretical thinking in nursing to be confined to certain levels of abstraction, depending upon the need for scientific explanation and investigation. If we consider nursing as inclusive of all four domains, nursing as a general concept is at the most inclusive holistic level, while each domain is in a particularistic mode. Therefore, it is a matter of scope in analysis and observation. This methodology is important for theoretical

thinking. Conceptualization and related conceptual analysis require scientists to take “confined” views of the object world—the level of confinement depends upon whether one opts for a holistic mode or a particularistic one. These two frameworks are used repeatedly and consistently in analyzing concepts and examining theoretical statements throughout the book.

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# 4

## *The Domain of Client*

*. . . man, you see, is to be both the knower and the object of known; the difficulty is that of a knower having to objectify itself and having then to form a just concept of what the object is.*

—Cassius J. Keyser

### OVERVIEW

The primary aim of this chapter is to outline and discuss how nursing scientists might go about their search for theoretical concepts within the domain of client. The main focus is on concepts of interest to nursing that exist in this domain. This is done in three steps of discussion. Discussions in the first section attempt to clarify the essential characteristics of theoretical concepts that describe phenomena in the domain of client from the nursing perspective. The boundaries of the nursing perspective in theoretical thinking with respect to the client as the focus of attention are defined. The idea is to suggest that “the nature of the patterns and shapes one can recognize in the welter of human experience depends on one’s perspective,” as Blau puts it (1975, p. 3). In the second section, an attempt is made to show several different ways of abstracting the phenomena of human living and of health in the domain of client. The concepts of human living and health are treated here because these have been the main focal points of theoretical thinking for many nursing theorists. This section offers discussions on the approaches that are used and useful in delineating concepts based on a different intellectual scope. Approaches of delineation and abstraction are considered important in theoretical development, since it is neither necessary nor possible to observe and abstract all elements characterizing the real world in all instances. Different approaches permit abstracting selectively within proper frameworks of observation. Several non-nursing and nursing theorists’ approaches in conceptualizing human person and health are brought into discussion in this section to compare and contrast the postures that emerge from different directions.



The third section provides expositions on how to analyze theoretical concepts for phenomena in the domain of client through two examples: restlessness and compliance. The purpose is to illustrate important strategies of theoretical analysis of concepts. These analyses are offered as the preludes to the development of theoretical propositions in nursing that can be used in explanations and empirical analyses. What is not dealt with in this and in the following three chapters is the advancement of specific theoretical statements of relationships among concepts in a theoretical system. The central focus in these four chapters is in abstracting, delineating, and describing phenomena of significance in theoretical terms. This step is considered a prerequisite to thinking about relationships among two or more concepts and is a necessary step for developing a theory.

### **THE DOMAIN OF CLIENT IN THE NURSING PERSPECTIVE**

One of the essential skills that a nurse scientist needs in order to contribute to theoretical development in nursing is the capacity to conceptualize phenomena in the client from the nursing perspective. There are an almost infinite number of concepts that describe phenomena in the client that are not significant to nursing. The nursing perspective for this domain is specifically that of “health”—health not viewed in the context of two million streptococci invading the lung tissues or of a ruptured cerebral artery, but considered in terms of human living and behaviors of health. Concepts and relevant phenomena in the domain of client from the nursing perspective are important to the extent that the client, the human person, is the main focus of nursing. For nursing to demonstrate its credibility and relevancy in society, it is necessary to understand, explain, and predict certain happenings in clients. These “certain happenings” and definitions of them are central to this section’s theoretical thinking.

The main idea is to concentrate and direct our intellectual energy toward the study of more critical and essentially nursing-oriented concepts, selected from a vast array of possible ones. Defining a boundary is difficult because it involves a critical ability, a sense of relevance, and definite ideas about propriety for nursing. Current literature indicates that nursing scientists are approaching this boundary-definition issue in two different ways, i.e., from a holistic point of view that is global and all-encompassing, and from a particularistic point of view that is discrete and focused on selected aspects of human conditions.

The domain of client offers a vast array of human phenomena from which selections should be made for the study of appropriate and essential phenomena from the nursing perspective. As suggested in Chapter 3, the main difference between the holistic and particularistic conceptualizations

of phenomena in the domain of client is in units of analysis. Holistic conceptualization in this domain necessarily has to take in the whole person as the basic unit of analysis. Particularistic conceptualization, on the other hand, takes parts or certain elements of the human person as the basic units of analysis.

Since it is somewhat arbitrary and difficult to select concepts of importance within the domain of client from the nursing perspective, I propose a scheme for categorization by which certain characteristics of human phenomena are classified for theoretical analysis in nursing. This classification scheme for the domain of client includes:

1. Essentialistic concepts,
2. Problematic concepts,
3. Health-care experiential concepts.

Essentialistic concepts refer to those phenomena present in the client as essential characteristics and processes of human nature and living that are important to nursing and to human health in general. Examples of essentialistic concepts are negative feedback, homeostasis, structural integrity, coping, and self-image. Concepts referring to phenomena in human development and growth are also thought to be essentialistic. Maturation, bonding, socialization, ego-development, aging, etc., are a few examples representing developmental concepts. Essentialistic concepts refer to normal and usual characteristics and processes that human beings experience in ordinary states of living and growing. An understanding of these phenomena will certainly aid in understanding the human person and health from the nursing perspective.

Problematic concepts refer to phenomena that are present in human beings as pathological or abnormal deviations from normal patterns of healthy living. These concepts represent phenomena that require some type of nursing solution and intervention. Such concepts as pain, infection, anxiety, depression, and respiratory distress are of this type. Problematic concepts have been the major focus of study by nursing scientists, especially those who have put efforts into the development of nursing diagnosis terminologies. For this category, the term problematic is used to mean problematic to nursing. Thus, concepts such as appendicitis or bankruptcy, although these represent problematic human conditions, are not problematic concepts from the nursing perspective.

As the last group of concepts, health-care experiential concepts refer to phenomena that arise from people's experiences in the health-care system. This category includes such concepts as recidivism, compliance, health-belief, hospitalization, etc. This type of concept is relevant for nursing studies because it refers to specific human experiences that affect either the

process of health or the contents of nursing.

Table 4.1 lists examples of concepts categorized according to this classification scheme and in the holistic/particularistic modes. These examples have been drawn from the current nursing literature in a casual manner, and are listed here only as typical concepts in each category according to the definitions given earlier.

This way of classifying concepts in the domain of client focuses on general meanings of phenomena. Current development in the work for nursing diagnosis classification suggests that at present the discipline of nursing is interested more in the conceptualization of problematic and health-care experiential phenomena than in essentialistic concepts. My belief, though, is that the discipline needs to clarify conceptualization of essentialistic concepts that are necessary to understand many of the problematic and health-care experiential concepts.

**Table 4.1** Examples of Concepts in the Domain of Client for Study in the Nursing Perspective

Concept Type	Level of Concept Description	
	Holistic	Particularistic
Essentialistic	<ul style="list-style-type: none"> <li>• Personhood</li> <li>• Health</li> <li>• Normality</li> <li>• Hope</li> <li>• Independence</li> <li>• Maturation</li> <li>• Aging</li> <li>• Lifestyle behavior</li> </ul>	<ul style="list-style-type: none"> <li>• Respiratory compliance</li> <li>• Mobility</li> <li>• Dexterity</li> <li>• Ego</li> <li>• Intelligence</li> <li>• Self-image</li> <li>• Biologic rhythm</li> <li>• Hardiness</li> </ul>
Problematic	<ul style="list-style-type: none"> <li>• Stress</li> <li>• Suffering</li> <li>• Helplessness</li> <li>• Chronicity</li> <li>• Trauma</li> <li>• Illness</li> <li>• Maladaptation</li> </ul>	<ul style="list-style-type: none"> <li>• Infection</li> <li>• Pain</li> <li>• Respiratory distress</li> <li>• Obesity</li> <li>• Incontinence</li> <li>• Anorexia</li> <li>• Irritability</li> <li>• Chronic sorrow</li> </ul>
Health-Care Experiential	<ul style="list-style-type: none"> <li>• Noncompliance</li> <li>• Recidivism</li> <li>• Institutionalization</li> <li>• Isolation</li> </ul>	<ul style="list-style-type: none"> <li>• Nosocomial infection</li> <li>• Decubiti ulcers</li> <li>• Sensory overload</li> <li>• Technology dependence</li> </ul>

This classification scheme is one way of organizing human phenomena into appropriate categories for scientific examination from the nursing perspective. Nursing is concerned with clients' behaviors, responses, and characteristics in human living to the extent that these have some bearing on their health, health-maintaining behaviors, and nursing requirements. While this scheme is useful for categorical thinking, and has shown that commonly studied concepts in nursing can be classified accordingly, the discipline of nursing has long been preoccupied with the ideas of the human person and of health as important conceptual issues. Major nursing theorists have struggled to present some refined ideas about these two broad concepts in their presentation of nursing theories and conceptual models. Conceptualizations of humans and health are the foundations from which many other concepts in the domain of client are understood in special ways. Hence, conceptualizations of humans and health are ontological in nature. Accordingly, conceptual notions about humans and health are usually the first and basic ideas requiring identification in the development of nursing curriculum, nursing service philosophies, and professional standards. Of all concepts relevant for inclusion within the nursing framework, the concepts of humans and health are the most essential holistic ones for theoretical thinking.

### **CONCEPTUALIZATION OF HUMANS AND HEALTH**

In a holistic posture, phenomena in the domain of client are conceptualized as systems of interlinked elements, either with respect to the nature of human beings or to that of health. Although there are other concepts in the holistic mode that are important to nursing, concepts of humans and health stand out as the most important and essential ones for nursing. An understanding of what humans are all about and how things happen in humans is central to nursing, because the recipients of nursing actions as well as the performers of those actions are human beings. In addition, health, pertaining to life and death and states in between, is an essential property of humans. It is also the main purpose of nursing interventions.

Thus, the nursing perspective conceptualizes a person as biological yet much more than a biological being with an emphasis on health, and conceptualizes health as a variable state in which a person assumes certain characteristics of human living associated with biological, psychological, and social functioning and responses. Nursing is concerned with certain types of human affairs and human well-being, i.e., health and illness. Hence, it is natural for nursing scientists to struggle for clear conceptualizations of humans and human affairs of a particular kind—health. Concepts of humans and health take on proper meanings in the nursing

perspective insofar as conceptualization leads to effective and scientifically valid nursing strategies.

In nursing, there has been a long history of preoccupation with a grand understanding of the human person philosophically and theoretically. One obvious reason for this preoccupation is, in a way, rooted in the profession's insistence on having philosophical stands on life, humans, health, and nursing. This value has been most clearly expressed in the accreditation criteria for nursing curriculum throughout the years. Additionally, the profession has maintained a long-standing posture that views a human being as a whole rather than as discrete details within a maze of physio-psychosocial-spiritual components. Consequently, nearly all nursing theorists have supplied us with their specific visions of what a human being is and how one should understand human affairs. Likewise, we are also supplied with various conceptualizations of health by nursing theorists, motivated apparently by similar rationales.

A person is usually conceptualized in a global sense and is described in a synthesized fashion, indicating what a person is all about. Thus, nursing conceptualizations of people are generally founded on philosophical postures about human existence (i.e., ontological), and are directed toward unified views of people that provide useful approaches for nursing practice. This mode of aligning the conceptualization of humans with the basic tenets of the profession permits development of "models of humans" that are the foundations for a scientific growth of knowledge in the field. Such an approach has been used in psychology, sociology, economics, political science, and medicine. For example, Simon's model of man (1957) has been used in administrative science and social sciences as the basis for the fields' theoretical and empirical work. Likewise, Comte's positivistic conceptualization of a human being has influenced the early theoretical development in sociology in Europe. Models of human beings provide scientists with the basic attitudes and abstract tools to make detailed propositions in the development of specific theories of human beings.

In contrast to the ways models of humans are developed and used in scientific fields, conceptualization of health in nursing is a movement to a somewhat particularistic level of thinking. In this sense, models of health are less global than models of humans, and may develop from the main philosophical ideas of humanity but are specifically oriented to describing the nature of health, which is only one aspect of human affairs. Conceptualization of health is similar to that used for the development of conceptual models of "wealth," "knowledge," or "power," in the sense that the focus of conceptualization rests on certain characteristics of human life, not the human life itself.

These considerations point up analytical differences in the approaches for "models of humans" and "models of health," although both concepts

are holistic concepts for nursing. In general, models of humans are ontological and address the basic existential questions regarding body/mind and nature of human life, whereas models of health are conceptual and focus on identifying specific phenomenal elements that define health. Irrespective of the approaches adopted by theorists, the focus of attention for theoretical consideration remains on those phenomena in humans related to health insofar as a model is developed from the nursing perspective. While health as a concept is implicitly inferred more often in models of humans, it is explicitly defined and developed in models of health.

The difference in the approaches for developing models of humans and health seems to be the placement of focus: The first approach for a model of humans focuses on "human person" from philosophical orientation whereas the second approach for a model of health focuses specifically on "health" as the major phenomenon of interest. Thus, the two approaches pose different measurement problems in relation to health as well, in that the first approach requires measurement strategies that express the human position with respect to health, while the second approach needs to operationalize health with respect to its conceptual constituents. Regardless of the approaches adopted for explaining human phenomena in a holistic mode, models of humans and health developed from the nursing perspective ultimately must be brought to bear on nursing questions. In addition, models of humans and health are the basic frameworks for development of theories in nursing on various levels and within a wide range of scope. Theoretical development for nursing thus has to be viewed to have some connections to particular models of humans and health that provide the basic tenets and premises for specific delineations of theoretical statements and definitions within a theory.

These two approaches as conceptual models and theoretical systems in nursing are currently the main efforts that are being fervently pursued in nursing. The desire seems to be to develop a general nursing theory of a grand type through a model of humans or a model of health. However, models of humans and health are conceptual models that can be the baselines not only for theories of grand type but also for meso-level, middle range, and micro-theories.

Although several serious attempts to develop models of humans and health are currently being made in nursing, the next section examines several other models of humans and health that have been developed by theorists in other disciplines. This is done to provide a generalized baseline to compare and contrast how models of humans and health have been developed in the scientific community (including nursing), and to consider the relationships of nursing models of humans and health to other approaches. Thus nursing models of humans and health will be examined within the broader context of the idea-systems present in the scientific community in general.

## MODELS OF HUMANS

It is difficult to be comprehensive in discussing models of humans. Since our conceptualization of *homo sapiens* has been and will continue to be closely tied to prevailing philosophical attitudes about life, humans, and the universe, the history of dominant philosophies provides an important base for understanding how several different models of man have emerged in the recent past. For our discussion in this section, first I present only briefly several different models of humans which are being debated in the scientific world and that are considered relevant to nursing. This is mainly done to provide a background for the discussion of and comparison with nursing models of humans. A more comprehensive discussion follows regarding several models of humans developed within the conceptual models of nursing. Philosophical and conceptual linkages between models of humans developed in other relevant scientific disciplines and those developed in nursing indicate that scientific ideas in general do not arise out of a vacuum but have connections with the prevailing general paradigm of the scientific world.

Early scientific attempts at developing unified models of humans can be traced back to nineteenth-century positivism. Such scientific thinkers as Huxley, Darwin, Spencer, Moleschott, and Engels influenced the culmination of a concept of humanity in which a person is mainly thought of as a species having animalistic instincts and wants. Models of humans prior to the nineteenth century were so closely tied to the dominant religious beliefs and philosophies, especially those backed by little biological and physical understanding of human life, that the models' influence on the conduct of human practice was profound, yet arbitrary. The arrival of positivism encouraged many scientists to try to explain human behaviors in terms of animalistic patterns. Twentieth-century logical positivism also influenced the conceptualization of humanity in many fields such as psychology, biology, and sociology. In addition, Husserl's phenomenology and various philosophical ideals of existentialism complicated theoretical thinking concerning the concepts of humanity that emerged from many directions during the twentieth century.

### **Models of Humans in General**

As an archetype of empiricism and physicalism, the Skinnerian model of humans was developed with the main focus on human behaviors. Skinnerian conceptualization is based on behaviorism that has enlarged upon the basic ideas about the need-instinct proposition of human behaviors. Both psychological and social versions of the behavioral model of humans are based on the premise that human behavior is learned, main-

tained, extinguished, and modified by means of reward and punishment.<sup>1</sup> In a behavioral model, a person emits activities in a present situation based upon the experiences he or she attained either directly or vicariously as the consequences of previous activities; the consequences either reinforce or extinguish learning and repeating of activities. Behaviors are evaluated according to need/disposition or deprivation/satiation principles. Such behavioral models of humans resulted from the late nineteenth and early twentieth centuries' preoccupation with a value-free, positivistic approach to the generation of scientific knowledge.

In a somewhat different orientation, Bernard, Cannon, and Selye developed a physiological conceptualization of humans. A person is viewed as striving to adapt in the most efficient manner possible to demands or stresses that are put upon the person, either as a total organism or in parts, but always striving to maintain stability within the self. Theirs was an attempt to unify a person into a whole being, opposing the scientific advances and efforts that dissected a person into organs, cells, and different functional attributes. The method of studying humans through the use of autopsy and surgical techniques in the early 1900s influenced many scientists to view humans in a dissected form. Medical and pathological atomists' conceptions of humanity have their root in such a development. Although scientists whose work is based on the atomistic view of humanity still exist, the most dominant concepts of humanity in biomedical fields today are stress-adaptation models. Much of the current work in stress-adaptation models is based on the conceptual premises of the original ideas postulated by Cannon, Bernard, and Selye.<sup>2</sup>

René Dubos' model of humans (1965) is an extension of this view of adaptation and describes all aspects of the human environment as providing ephemeral conditions. A person is thought to exercise adaptive abilities by selecting among alternatives to achieve a self-directed end, given the external conditions that are encountered at a given moment. Dubos' human, furthermore, is a product of the lasting and universal characteristics of human nature, inscribed in being, and yet is capable of establishing a personal history; thus, the person possesses both phylogenetic and onto-

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1. See: Skinner, B. F. (1953). *Science and human behavior*. New York: Macmillan; Hull, C. L. (1951). *Essentials of behavior*. New Haven: Yale University Press; Bandura, A. (1969). *Principles of behavior modification*. New York: Holt, Rinehart, and Winston for psychological orientation; and Homans, G. C. (1961). *Social behavior: Its elementary forms*. New York: Harcourt and Brace; and Kunkel, J., & Nagasawa, R. H. (1973). A Behavioral model of man: Propositions and implications. *American Sociological Review*, 38, 530–543 for sociological orientation.

2. See: Cannon, W. B. (1931). *The wisdom of the body*. New York: W. W. Norton and Company; and Selye, H. O. (1956). *The stress of life*. New York: McGraw-Hill.



genic adaptability. A person is seen as an organism responding to stimuli of environmental challenge in a manner that is based on rationality, i.e., while some responses are based on the direct effects of the stimuli on the organism, most of a person's responses are usually determined not by such direct effects but rather by the symbolic interpretations he or she attaches to the stimuli.

Thus, Dubos' human treats and responds to actual environmental stimuli in a chained sequence of direct reactions, indirect reactions that occur as ripple effects of the direct reactions, and responses to personalized symbols that are generated by the impinging stimuli. This "human adapting," according to Dubos, makes the individual's responses to any environmental factors extremely personal.

Alfred Korzybski's theory of humans (1921), coming from the engineering and mathematical orientation that emerged in the wake of Russell's mathematical logic and Einstein's theory of relativity, is concerned with somewhat different aspects of human nature. This model views humans as having the characteristics of time-binding power beyond the space-binding capacity of animals and the matter-energy-binding property of plants. Although the language used in the description of a person in this model is highly oriented to the physical sciences, it describes a person as a life form different from animals and plants, having another dimension of orientation, that of time. It is a departure from the theological and biological conceptions of humans. A person and his or her capacity are conceptualized as: (a) bound to past achievements, (b) the user of ever-increasing, inherited wisdom, and (c) the trustee of posterity. This model of humans is rooted in Descartes' idea of viewing the universe in terms of space, matter, and time, and was developed with the backdrop of Einstein's proposition that links human movement in time and space to other objects in a relativistic fashion. It views humanity's basic *modus operandi* as "creative competition" by which new ideas and more goods are produced in a rational manner. By juxtaposing Korzybski's theory of humans to Einstein's theory of relativity, Polakov suggested that "man measures an event from the standpoint of his own system regarded as at rest" and that a person is a relativist having a unique personal system of reference in space-time contexts (1925). An illuminating aspect of this model having a physical perspective is its conceptual likeness to Dubos' model in which personally accumulated history is stressed.

In addition to the behavioral model discussed earlier, there are several different concepts of the psychological model of humans. Three views stand out distinctively, indicating different orientations. The psychoanalytic models of humans advanced by Freud and reformulated by many scientists<sup>3</sup>

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3. For the similarities and differences among the psychoanalytic human models, see the following: Brown, N. O. (1959). *Life against death: The psychoanalytical*

are based on the ideas of organizational and dominational relationships among different psychological elements in humanity. The id (or the instinct), the ego (the consciousness), and the superego are the main human elements that determine self-generated actions and a person's relation to the world outside. Ego as consciousness plays an important role in attaining, maintaining, and controlling human responses in the psychoanalytic model of man. A person's actions are the extensions of suppressions of the id's wants and the superego's controls by the consciousness, and yet expressed by the domination obtained by different aspects of the personality for pleasure and power.

On the other hand, Maslow (1967, 1973) attempts to generate an idea of humanity by interfacing human needs that are basically psychological in nature with the biological makeup of the human organism. Maslow's concept of a person as an organism that is oriented to self-regulation, self-government, and self-choice is akin to the rationalist view of humanity. However, it is based on the notion that human needs are fundamentally biological. He classifies human needs into two types: (a) the basic needs including safety and protection, belongingness, love, respect, self-esteem, identity, and self-actualization; and (b) the meta-needs including truth, goodness, beauty, justice, order, law, unity, etc. These needs are seen as tied to the structure of the human organism itself. He conceptualizes variations in human conditions according to satisfaction and deprivation of need, and views deprivation as the cause for disease or illness.

Gestalt psychologists' view of a person as a personalistic, holistic being is a more recent concept of humanity in psychology. This concept of a unitary human being suggests that human activities are produced by integrated efforts of a person to express what he or she knows and how he or she deals with this knowledge within the context of given biological conditions. The Gestalt person is understood not in his or her componental characteristics but as the whole depicted in his or her experience and behaviors.

Psychological models of humans also have limiting explanatory use for human phenomena in the nursing perspective. For nursing, only selected

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*meaning of history.* Wesleyan, Wesleyan University Press; Dobzhansky, T. (1967). *The biology of ultimate concern.* New York: The New American Library; Erikson, E. H. (1959). *Identity and the life cycle: Selected papers.* New York: International Universities Press; Erikson, E. H. (1964). *Insight and responsibility: Lectures on the ethical implications of psychoanalytic insight.* New York: W. W. Norton; Fromm, E. (1964). *The heart of man: Its genius for good and evil.* New York: Harper and Row; Fromm, E., & Xiran, R. (Eds.). (1968). *The nature of man: A reader.* New York: Macmillan; Hartman, H. (1958). *Ego psychology and the problems of adaptation* (Trans. by D. Rapoport). New York: International Universities Press; Rieff, P. (1966). *The triumph of the therapeutics: The uses of faith after Freud.* New York: Harper and Row; and Browning, D. S. (1973). *Generative man: Psychoanalytic perspectives.* Philadelphia: The Westminster Press.

phenomena in the client can be studied within theoretical systems that are based on psychological models of humans.

Another conceptualization of humans to emerge, rooted in Cartesian philosophy, Kantian rationalism, and Russell's system of mathematical logic, are economic models that view a person as being able to maximize preferences based on rational behaviors. The major premise of the economic model is global rationality, implying a perfect fit between a human choice and a preference, as in the game-theoretical model of vonNeuman-Morgenstern. However, Simon (1957) suggests a model that emphasizes "striving for rationality" rather than the "rationality" itself as the basis of human behavior. Simon's human strives for rationality and yet is basically oriented to a goal-satisfying rather than a goal-maximizing mode of decision-making behaviors. Simon's human makes decisions and selects choices among alternatives through a satisfying mode, a mode through which a person finds "a path that will permit satisfaction at some specified level of all of its needs" (Simon, 1957, p. 271). A satisfying mode is defined by an individual's aspirational level at the point of choice. Simon further advances his thinking on the concept of bounded rationality and its relationship to human behavior in his conceptualization of "thinking man." He recapitulates "satisficing" and "bounded rationality" as the basis of human behavior in the following way:

"... a picture of Thinking Man, a creature of bounded rationality who copes with the complexity that confronts him by highly selective serial search of the environment, guided and interrupted by the demands of his motivational system, and regulated, in particular, by dynamically adjusting, multidimensional levels of aspiration."<sup>4</sup>

What is projected as central to human existence and human affairs in economic and administrative models of humans is rationality. These models are conceptually concerned with circumscribed aspects of humans, decision making and choice behavior. These conceptualizations are not concerned with the total organismic person as physical-biological being. For them, such biological natures are only important to the extent that they influence preferences, needs, and evaluations of utilities. Therefore, human aspects other than rationality are only contextual to studying the processes through which a person handles himself and his external world. If we were to apply these models of humans directly to viewing the client in the nursing perspective, the theoretical explanations of human phenomena would be limited to choice-behaviors. Thus, such a model is useful only in studying particularistic phenomena in the domain of client. Of course,

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4. Simon, H. (1979). *Models of thoughts* (p. 4). New Haven: Yale University Press.

there are many more models of humans that have been proposed by scientists in different disciplinary orientations. For example, Parsons' model of social humanity is composed of personality and organism, acting and interacting with objects and other human beings in the social world. A person acts and interacts within given cognitive, cathectic, and evaluative motivations. The Parsonian individual is a product of integration of cultural values and social norms. Furthermore, human deviant behaviors are viewed in the context of functionality to the social system rather than to the individual's motivations or needs. A social person thus is a constrained being, acting within the limits of individual, social, and cultural standards and expectations.

From the perspective of social action, Hollis (1977) distinguishes two models of "man" as Plastic Man and Autonomous Man. Hollis' Plastic Man is a being constituted by adaptive responses stemming from the interplay between nature and nurture. On the other hand, Hollis' Autonomous Man is a being with a subjective self whose basic apparatus for social actions is rationality.

And there is also the biomedical model. In addition to the dissected view of the human system as a biological being, there has been a growing interest in medical fields for a development of conceptualization of humanity that encompasses bioethical issues that have raised many moral questions in the practice of health care in recent years. In an attempt to view humanity in the context of biomedical ethics, Fletcher (1979) proposes a composite human model. He specifies the necessary characteristics of a human person in terms of: (a) minimum intelligence, (b) self-awareness, (c) self-control, (d) a sense of time, (e) a sense of futurity, (f) a sense of the past, (g) the capacity to relate to others, (h) concern for others, (i) communicability, (j) control of existence and freedom, (k) curiosity, (l) change and changeability, (m) balance of rationality and feeling, (n) idiosyncrasy and individuality, (o) neocortical function, (p) not non- or antiartificial, (q) not essentially parental, (r) not essentially sexual, (s) not a bundle of rights, and (t) not a worshipper. This model raises several moral and ethical questions regarding the values of life and existence. Although such a model can create a great deal of controversy and discussion, it can enable scientists to view human life and human existence from quite different perspectives. More importantly, when such a model is applied to human services, there are many practice implications. In any event, such a model at least provides a framework upon which evaluation of human nature may begin and questions related to human interventions be addressed.

These are but some of the eclectic examples of models of humans in a variety of scientific fields that suggest varied viewpoints and different angles of vision. As this cursory review of such models suggests, our conceptions of humanity are closely related to philosophical ideas about meanings

attached to differentiating the subjective from the objective and about a person's relations to the world and herself or himself. Scientific advancement and technology, as well as the dominant modes of scientific investigation, also influence our ideas about human nature, capacities, and variabilities. Disclosures briefly discussed in these pages indicate that a person may appear differently when objectified with the tinted glasses of biologist, psychologist, sociologist, mathematician, or physician. Yet a person may also be perceived in the same manner even among scientists of different disciplinary orientations and of varying perspectives. It is also obvious that scientists use their conceptual models of humans for different purposes, i.e., for development of a theory of humans, an ethical basis of scientific inquiry, a framework for human intervention, or as a starting point for philosophical discourse.

These examples also indicate that models of humans conceptualized in other disciplines have limited theoretical utility for nursing if they are applied directly to nursing without expansion or modification. This enlightens our thinking and directs us toward developing nursing models of humans. For nursing explanations, it is necessary to have nursing models of humans, the contributions to the discipline of nursing of theoretical developments in other fields for models of humans notwithstanding. The specific nature of essential phenomena in nursing within the domain of client requires conceptualization of humanity that addresses such specific nature.

### **Nursing Models of Humans**

In nursing, then, what should a model of humans describe? Nursing models of humans tend to describe humanity with respect to placement in and operations related to health and well-being. Conceptual models proposed by several nursing theorists of the 1970s and 1980s such as Rogers, Roy, Orem, and Johnson have attempted to do this. I shall attempt at this point to summarize the mental images that these nursing theorists have projected in their models of humans. Of course, it needs to be made clear that these theorists describe their ideas in an implicit manner and do not call their conceptualizations of humanity, models. Health is usually the major theme handled in nursing models of humans as the essential descriptive characteristic of humanity. The current conceptualization of humanity in nursing models can be categorized into six major types according to their views of health as an essential human condition:

1. "Balance" as the essential human characteristic for human existence and health;
2. "Process" as the mode through which humans' existence, living, and health are actualized;

3. "Configuration" as an integrative basis of human existence and health;
4. "Aggregation" of parts as a way to express the human condition;
5. "Experiencing" as the basic characteristic of human existence and health; and
6. "Meaning-making" as the essential feature of human living.

This idea of differentiating conceptual approaches to formulating models of humans in terms of balance, process, configuration, aggregation, experiencing, and meaning-making is proposed here in order to attain a clear mental picture of human phenomena as proposed by different nursing thinkers. By introducing this classification, we are also able to compare nursing human models with those discussed earlier. The balance model is a conceptualization in which human phenomena are considered in terms of integration and stability. Selye's stress model of humans is a balance model in which human phenomena are mainly considered with respect to equilibrium.

The process model is a conceptualization in which human phenomena are explained as ever-changing, continuing activities. Dubos' adaptive model of humans is of this kind, in which a person is depicted as an ever-adapting, growing entity. The configuration model refers to a conceptualization of human phenomena in which integration among different elements and subsystems is taken to be the major characteristic. Gestalt human models are of this type.

The aggregation model is a conceptualization in which a person is viewed as an entity composed of different elements. Human phenomena are expressed as the additiveness of different elements that make up a person. Biological and medical models of humans tend to take this form of conceptualization of humanity. The experiencing model takes humans' experiencing at present in a given context as the primary focus for understanding human living and existence. Models based on existentialism and Husserlian phenomenology with their emphasis on the life world of individual, subjective persons are of this type. On the other hand, the meaning-making model emphasizes humans' reflexivity and hermeneuticity as the basis for human life and health. Taylor's human science model of "man" takes this form of conceptualization of humanity.

Johnson's behavioral system is an example of the balance model. Johnson (1980) refers to humanity as a behavioral system comprised of patterned, repetitive, and purposeful ways of behaving. Human behaviors are formed into an organized and integrated functional unit. Human health is implicitly expressed as the state of behavioral system balance and dynamic stability. According to Johnson, it is not the nature of properties or state of a person that is central to his or her health and existence, but rather it is the

system of behaviors as parts of an organized and integrated whole that is. Thus, although labeled as a behavioral model, its premises are quite variant from the classical behavioral models of reinforcement and extinction. This concept of balance as the expression of health is akin to the systems theorists' view of humanity that considers a person as striving to attain the maximum balance and homeostasis possible. From the latter's perspective, a system's adaptiveness with respect to stability is the central process for an explanation of variants in system-states, whether expressed in terms of behaviors or states.

Although Johnson identifies subsystems within the human behavioral system, it is ultimately the behavior as a whole that is the phenomenon of interest to her. Johnson states that this conceptualization is not intended to provide a framework for marking the boundary of what aspects of the behavioral system are appropriate for the perspective of nursing. An implicit inference in the model is that any possible or actual imbalance or deviation from the dynamic stability of the behavioral system is a potential target for nursing intervention. However, the specific types of behaviors or imbalances which would be the main targets for nursing intervention are neither clearly indicated nor implicitly stated.

The conceptual ideas projected in Rogers' model of unitary man are related to process. Rogers (1970, 1989, 1992) conceptualizes a person as continually renewing his or her patterns of life toward increasing complexity and negentropy. The patterns of life process are seen as manifested through a person's mutual, simultaneous interactions with the environment in the forms of integrality, helicy, and resonancy. Rogers' human, being an ever-expanding and contracting human field, is in the process of interchange with the environmental field in a reciprocal, interpenetrative fashion; such interchange is based on the homeodynamic principles of integrality, helicy, and resonancy. In his or her personal evolution in a given space and through time, a person adopts these forms of interactive and interpenetrative emergence of energy fields. These are basic forms of life processes for an increased organization and patterning in one's field-relations and interchanges with the environmental field.

Rogers depicts a person as not having specific goals in his or her evolutionary journey through life, except for the increasing complexity in organization and patterning, as the law of human developmental process. Furthermore, a person's goals in the life process are probabilistic rather than deterministic. This means that a person's goals in life process change with the progression of the process itself, and that goals are revised and formulated according to changes in personal evolution. What is most explicit in this model is the unity of a person as interacting being, having personal identity and existence defined by his or her relationships with the environment. Thus, it is not possible to understand Rogers' human evolution-

ary identity or process without having the knowledge of the characteristics of the environmental field or the person's relationships with it. Rogers also identifies seven qualities: wholeness, openness, unidirectionality, pattern, organization, sentience, and thought, as the basic properties of the life processes that determine the ways integrality, helicy, and resonancy in interchange are adopted in given situations. Thus, Rogers' human is an ever-changing entity whose characteristics are not determined by genetic givens, destiny, or predetermined patterns of growth, but are influenced in dynamic ways by the changing nature of his or her environment, the changing nature of self, and the evolving nature of interchange between them. Goals of life are never fixed, nor are the patterns of change that are possible for an individual's life.

Rogers implies that health is expressed as the process of life in its totality. She postulates that nursing seeks to (a) strengthen the human-environment symmetry; (b) promote synchronic interaction between a person and his or her environment; (c) strengthen the coherence and integrity of the human field; and (d) direct repatterning of the human and environmental fields for more effective fulfillment of life's capabilities and realization of maximum health potential (1970). The patterns of life process that an individual attains express whether or not he or she has realized his or her health potential. What is not specified in the model is an explicit definition of "health potential." Rogers' implicit notion of health stands for a person in a state of continuing, maturational complexities, not defined by any standardized expectations, but expressed only as evolutionary, sequential happenings. To Rogers, the human-environment field is an entity that generates organization and patterning; it is treated as though it has a consciousness or goal-directedness for an ever-increasing organization and patterning. The model gives the impression that the human-environment integrity is as critical for human existence as a person's integrity itself.

In the Roy Adaptation Model (Roy, 1976; Roy & Andrews, 1991; & Roy & Roberts, 1981), a person is perceived as an adaptive system receiving inputs identified as stimuli from the external environment and as generated by the self, processing them by internal and feedback processes inherent in an individual's ever-changing abilities, and producing outputs as either adaptive or ineffective responses. To Roy, adaptation has a positive connotation, a state of "all systems go," a "green light" in specific relation to what is happening to the person at a given moment. Roy's human responds to stimuli in four basic adaptive modes: (a) physiological needs, (b) self-concept, (c) role-function, and (d) interdependence. Adaptive or ineffective responses result from the functioning of two basic mechanisms of controlling and responding: regulator and cognator.

Because Roy conceptualizes a person as having four distinct modes for adapting to stimuli, the concept of humanity according to this model is that



of configuration, although there is an element of balance suggested in the model. A person is depicted as a configuration of responses in four adaptive modes. Thus, human responses are the major phenomena of interest in Roy's model and are analyzed in terms of their adaptiveness in relation to four subsectors in an individual. Health, then, is relative to the person's responses to stimuli that promote the person's general goals of survival, growth, reproduction, and mastery, manifested within each adaptive mode. A person who responds ineffectively to stimuli is seen as capturing and spending energy for the particular set of stimuli, exhibiting behaviors that are incongruent with the valued goals. Roy's human is a reactive entity whose basic mechanisms become activated in response to impinging stimuli. The characteristics of creativity and self-determination are not emphasized in the model.

These three nursing models of humans are contrasted here in order to provide concepts of humanity that are quite different from one another, yet have a shared, significant identification in the nursing perspective. These nursing theorists' ideas suggest that in the nursing perspective a person may be described in terms of the nature of his or her behaviors (Johnson), the level of complexity in organization and patterns exhibited in the person's relations with the environment (Rogers), or the characteristics of responses to stimuli impinging on the person depicted either as adaptive or ineffective (Roy). As shown here, the concepts of balance, process, configuration, aggregation, experiencing, and meaning-making as the distinguishing characteristics of human models can only be used to identify the dominant features of models rather than to label them as confined to specific types.

As indicated in these discussions, it is possible, then, to imagine a room with nursing scientists perceiving the client in many different ways, and analyzing health problems with different conceptual orientations. Rogers will wonder about the size, shape, and quality of the client's energy field and how the nurse's presence as an element in the environmental field affects the client's interchanges with the external world. Johnson's posture will be that of analyzing the client's behaviors in terms of the integration as a whole person-system. In contrast, Roy will evaluate the client's responses to the situation as adaptive or ineffective and identify the focal, contextual, and residual stimuli that cause deficits in the adaptive responses.

As Barrett (1978) suggested, a person becomes Janus, and each scientist or theorist or philosopher is imprisoned in his or her seat for a view of particular features. The question is whether a scientist should get up from his or her seat and walk around to obtain views of all the features from different angles, or should remain in one position in order to attain an in-depth understanding of features from that one particular perspective. It is certainly a paradox for scientists who wish to be comprehensive in the under-

standing of a phenomenon and at the same time desire to gain a detailed knowledge of a single aspect of that phenomenon.

The crux of the matter is in the complexities: A person eats, plays, and fights; laughs and cries; does good for others and commits sins; falls in love and falls out of love; makes friends and seeks solitude; is happy, sad, and plainly content; makes decisions and follows the decisions of others blindly; and is healthy, ill, disabled, and dying. All these aspects and more make the conceptualization of a person difficult. Nursing models of humans, therefore, can at least confine our theoretical interests to selected human features.

### **Conceptualization of Humans in the Nursing Perspective**

As the discussion in the preceding section shows and the literature reveals, there is no unified perspective within nursing as *the conceptualization of humans*. While some scholars may argue that it is both acceptable and necessary to have multiple conceptualizations of humans in the nursing perspective, we need to consider what the essential features of humans are that should be accounted for in conceptualization of humans in the nursing perspective. Nursing is a practice discipline that is concerned with providing services to humans directly regarding their health. Therefore, conceptualization of humans in the nursing perspective has significance in considering what the recipient of nursing care (i.e., the client) is like as well as what the practitioner of nursing is about.

Mrs. Dorothy Kingsley, a 73 year-old widow, has been discharged from the hospital after a hip replacement. She lives alone in an apartment housing complex for the elderly and manages to carry on, though most things need to be done for her. She sometimes uses a wheelchair to move around, although she is able to walk slowly and hesitantly with a walker, and has put on a nice housedress that hangs loosely when moving about. She is slight in her stature, and has a very slight stoop. She has lost some of her hearing ability, especially in her right ear, but is not keen on using the hearing aid although she has one. Her voice is round, and she speaks with large gestures with both hands. As she walks with her walker, her grips are tight and her closed mouth slants downward as though in some strain. Small lines around her eyes, however, reveal good-naturedness and readiness to a quick smile. She feels lucky for having had the surgery, and is confident that she will be able to go about in a few weeks to go to the malls for lunch or visit friends. She is on medication for hypertension, and feels well in general except for some pain and immobility at present associated with the surgery.

How do we see Mrs. Kingsley as a human being and as a patient? What should nursing's ontological gaze be in seeing this patient? With the focus on clients, the conceptualization of humans in the nursing perspective needs to refer to the human body as well as the self as a person. It needs to refer also to how humans feel and live with that body and self as well as with others and in various situations, insofar as nursing is concerned with health.

This ontological position suggests that humans are bodies and selves intertwined to carry on "living" through sensing, realizing, thinking, knowing, and responding to occurrences and changes that are internal and external to them. Although historically nursing has been concerned with the human body and care of the body, there has been a gradual silence about the human body in the nursing discourse (Harder, 1992) as nursing began to separate itself from medicine and align with human sciences in the recent decades. This moving away from the focus on humans' physical entity to the emphasis on experiences, feelings, and meanings has created some confusion in viewing humans in the nursing perspective. Nursing continues to be engaged in "body work" that involves caring for and treating parts of the body or the body as a whole, but at the same time is also concerned with helping people with their emotional, existential, and spiritual aspects of life. In order to overcome this paradoxical contradiction apparent in the nursing views of humans, three human features need to be captured in an integrated fashion in conceptualizing humans in the nursing perspective: *human body, personhood and self, and human living.*

The human body, entrusted with its appearance, make-up, concreteness, and boundedness, is to begin with biological but is existential in that it exists as an entity as it is experienced in time and space. Benoist and Cathebras (1993) suggest that the Cartesian conception of human body as an object led to the modern biomedical concept of human body as an entity separate or devoid of spirit or soul. However, the representation of the human body in terms of its biological and physical features has been objected to by many as delimiting the humanness and not expressing the "true" qualities of humans. Bio-psycho-social models both in medicine (Engel, 1977) and nursing are examples of attempts to overcome biological reductionism. Phenomenological and existential ways of thinking have led us to the notion of personhood and self in connection to embodiment. Lawler (1991) states that "our understanding of the body is firmly interwoven with the nature of personhood and with the meaning of being human, and our notion of human existence requires a bodily form that is recognisable as human" (p. 56). Gadow (1980) also suggests that humanness and human experiences may be conceptualized as phenomenological relations between the self and the body. Personhood and self signify the subjectivity that is possible only through reflexivity, consciousness, and meaning-making. Ontologically, how the body and self are connected to reveal humanness and human existence is problematic as evidenced in var-

ious theories of human nature. The notions of “mindful body” and “bodily mind” suggest the continuing debate and confusion regarding the nature of integration between the body and mind (either as consciousness or spirit). The mind as constituted in personhood and self transcends the conceptualization of it in the psychological or neuropsychological sense, and refers to the ability to construct one’s being as an existential idea.

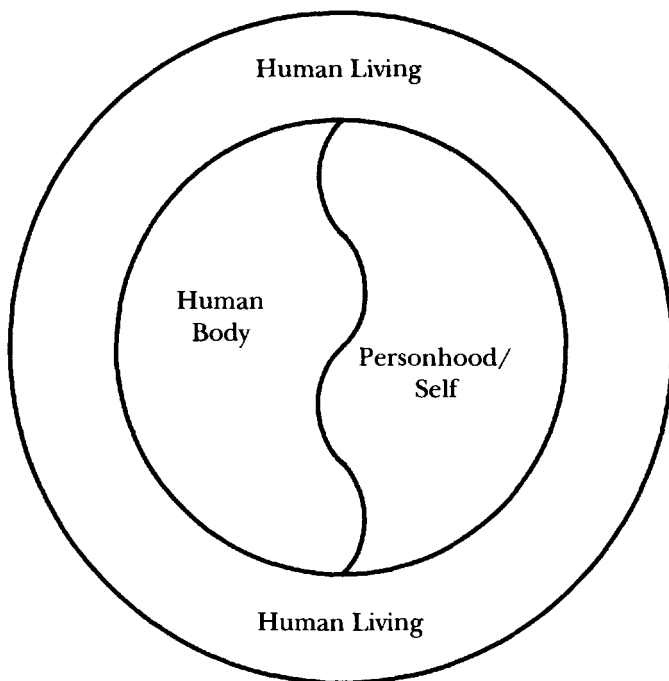
The human body also is a vehicle through which we are social beings, capable of symbolizing and interacting as well as being controlled and controlling. The human body is no longer a simple configuration of physical, materialistic elements, but constitutes both the physical/material and the symbolic and cultural. The human body exists and has meaning for its capacity to have relations with space and time, and to perform both mechanistic and expressive activities and also for its ability to project messages and identity in a cultural context (Benoist & Cathebras, 1993). Human existence and living are concretized through the body, and the body mediates living in its many particular forms such as eating, talking with friends, or loving and in its entirety in a holistic sense such as being a mother, a nurse, a worshiper, etc.

However, human living is carried on meaningfully in a form that is more than the composition of biological and mechanistic responses and activities only through the mediation of personhood/self. Hence, human living includes both (a) animalistic, biological activities and behaviors which come to have specifically human meanings, such as eating which is not simply an act of getting food but is an act having meanings in personal, social, and cultural contexts, and (b) those purely human, beyond-animalistic activities such as worshiping, creating poetry, or simply reading a newspaper. As illustrated in Figure 4.1, human body, personhood/self, and living may be seen as connected in an embedded, interpenetrating fashion to project humanness.

Nursing’s ontological concern with humanity lies in these three features as they impact on health individually and in concert. Specific conceptualizations of humans in the nursing perspective thus need to be developed with philosophical assumptions regarding human body, personhood/self, and human living as well as the relations among them with respect to health. Any version of biological, phenomenological, or behavioral reductionism is inadequate to address the theoretical and practical issues confronting nursing, as nursing is work for human health that is grounded in the human body, personhood/self, and human living.

## **MODELS OF HEALTH**

Another holistic approach to conceptualizing phenomena in the domain of client has been specified earlier as models of health. The theoretical



**Figure 4.1** Connections among human body, personhood/self, and human living.

focus of this approach in nursing is to view health as having particular meanings for nursing actions. Thus, in this approach, health would be defined in terms of nursing care needs and nursing interventions. Although health as a concept is rather global, compared to the concept of a person, it encompasses rather selected sorts of phenomena in humans. Because of this, many models of man contain basic notions about the phenomena of health, as indicated in the discussions presented in the preceding section. Health represents a circumscribed aspect of human phenomena and can be conceptualized in more particularistic modes. The literature indicates that the traditional models of health may be differentiated into two distinct types: structural models and functional models.

Structural models of health are oriented to looking at human structures and properties as the major indicators of the phenomena of health. In contrast, functional models of health view health as intrinsically tied to human functioning. In this section, models are examined according to these two types. Models of health proposed by scientists of other disciplines as well as by nursing theorists are examined together according to the types into which the models are classified.

## **Structural Models of Health**

The structural property-oriented approaches are rooted in the long history of considering "health" as opposite to sickness, disease, and illness, beginning with the ancient ideas (i.e., Egyptian and Greek) about the relationships between the way one feels and the nature of bodily constituents. Structural models of health are oriented to distinguishing the "normal" nature and constitution of elements in a human person, especially in the body—the physical being—and the deviations that exist that influence the way a person feels, performs duties, and behaves. In general, these models are clinically and/or medically oriented models, in which causes for change and deviations are the main epistemological interests.

Thus, for the conceptualization of health in such approaches, it is essential to know what causes deviations; hence the development of a string of theories of pathophysiological explanations, starting with early demonic theories of disease. Historically, many of the medically oriented theories of disease belong to this type of approach. Examples included Galen's theory of humoral balance as the basis of diseased states; the miasmatic theory of illness of the eighteenth century by which the production of disease is attributed to invasion of the body by earthly, noxious miasma; the germ theory of the nineteenth and early twentieth centuries; the general adaptation syndrome as the basis of stress/adaptation; and the current biochemical theories of pathology.

Health in a structural model is indicated by the signs and symptoms a person experiences or exhibits. These are considered changes and deviations in the human elements and structures. Currently, there are two general structural models of health: the clinical model and the adaptation model.

Clinical models, generally having a historical linkage to earlier conceptualizations of "disease" in medicine, are oriented to explaining health in pathological terms. Clinical models view health as a state in which there is an absence of abnormal signs and symptoms and as an opposite state of "diseased." In a diseased state, a person is in acquisition of an undesirable, abnormal, or deviant entity or property in human structures with specific known or unknown etiologies.

The terms, signs and symptoms in this context have negative, undesirable connotations. While current clinical models in general have reconciled with the unified view of a human as a free-flowing integration of mind and body, there is a tendency in clinical models to have a deterministic view of what might go wrong with human nature in given situations. The earlier conceptualizations of health in clinical models were implicitly based on the dualism of the "psyche" (the mind) and the "soma" (the body). Incorporation of the ideas on psychosomatic interdependence is a more recent development in clinical models. Yet the recent interest in psy-

chopharmacological research indicates persisting adherence of clinical models to physicalism as the major philosophical orientation.

The deterministic view in clinical models is evident in the continuing search for causal factors for diseases. Clinical models usually assume the scientific posture that seeks to identify and understand characteristics of diseased states as primary for correcting the diseased states.

Adaptation models are of more recent development. The concept of general adaptation syndrome (Selye, 1956, 1976) popularized the view of health in relation to an individual's responses and behaviors to stresses and noxious stimuli. Health in these models is conceptualized as a state of coping and adapting within a continuously changing environment. Health indicates that a person maintains his or her integrity of structures and yet changes his or her nature and behaviors to respond effectively to situational demands. Engel (1970) suggests that health and disease are phases that result as the human organism strives to master and handle stresses that are continually posed by environments on multiple levels, i.e., cellular, chemical, physiological, and behavioral levels. He views a state of health as when an organism functions effectively as a whole, fulfilling needs, successfully responding to the requirements of the environment, and pursuing its biological destiny, including growth and reproduction (Engel, 1975). This state of health is specifically tied to the adaptation that occurs in the human organism.

Myers' and his colleagues' work (1972) on stressful life events, the framework of Howard and Scott (1965), and the work of Hinkle (1961) and Wolff (1962) propose ecologically oriented adaptation models of health in which health is viewed as adjustments to one's social environment and occurrences in life situations. Such ecologically oriented adaptation models consider the ecological influences as structurally demanding and causing changes in the structures of adaptation.

Fabrega (1974) proposes a somewhat different adaptation model, which he calls a "phenomenologic" view of health and disease. The basic assumption is that disease needs to be understood in the context of an individual's subjective experiences. Such subjective experiences are thought to be shaped by social and cultural patterns. Characteristics of disease in the phenomenologic model encompass changes in the state of being, such as in the state of feeling, thought, self-definition, impulses, etc. These changes are seen as discontinuous with everyday affairs and are believed to be caused by socioculturally defined agents and circumstances. The main "change" of structure of interest to Fabrega is an altered concept of self-identity. In a phenomenologic sense, an altered self-identity is defined as disturbed feelings, bodily sensations, beliefs about how the body functions, self-derogatory convictions, imputations of moral guilt, etc. As the major form of disease state, it is inclusive of discomfort, disability, discreditation, and danger according to Fabrega (1974).

Among nursing models in which health is considered as a concept, Roy's adaptation model treats health as a state of structural characteristics in adaptive processes (Roy & Andrews, 1991; Roy & Roberts, 1981). Roy suggests that a state of health is possible for a person who is adaptive. A person is healthy when he or she is able to direct energies to respond to multiple stimuli of life rather than expanding and concentrating on one set of stimuli. In essence, Roy's model views health as having certain property and structural characteristics in an individual organism. A state of health is attained when an individual receives an appropriate type and amount of stimuli and has structural integrity in its adaptive modes and mechanisms.

Health in structural models is operationalized and measured most appropriately in terms of feeling-states, perceptions, and sign/symptom complexes. State characteristics that are considered the indicators of health in these models are: (a) measured objectively and compared to the established norms as the expression of "healthy" state, as in the clinical measurements of blood pressure, body weight, level of hemoglobin, size of liver; (b) expressed as experiences and perceptions, as in feelings of pain, headache, depression, fatigue, discomfort, respiratory distress; or (c) assessed as behaviors of adaptation, as in adaptive versus maladaptive behaviors, negative versus positive responses, enhancing versus destroying behaviors.

Instruments developed currently with this approach in the conceptualization of health are found in the works by Given, Simoni, and Gallin (1977); Kennedy, Northcott, and Kinzel (1978); and Wan (1976), among many others. In the same tradition, Turnbull (1976) treats health for nursing in a strictly structural perspective. A measurement of wellness and health is expressed in terms of intactness, symmetry, nourishment, and productivity. Structural models of health are thus oriented to describing health in terms of changes that are present in human structures producing variations in feeling states, behaviors, and appearances of the structures.

### **Functional Models of Health**

Functional models begin with the premise that health is a state of variability in human functioning. The functionalists' approach views dimensions of health and variations in the state of health in terms of a human ability to perform required functions. Optimum health refers to the normative reference point of desired capacity and functioning.

Naegel (1970) perceives health as "a condition necessary for the realization of two of our regnant values: mastery of the world and fun." Health as a state allows one to do what one wants to do and to be what one wants to be. As an opposite state, illness is seen to impede activity and limit one's autonomy, and to be a state of frustration and deprivation. In addition, Naegel sees health as a moral good that is desired by all but vaguely



defined: health is part of the condition of participation in social life as a valued state. In this view, health is globally described in social, functional terms. Health is a state in which a person is able to participate in the affairs of the world and the affairs of self with the freedom of the individual. To Naegel, autonomy is the basic functional requirement for an individual's freedom of pursuit, and health is the end-state in which the individual's autonomy can be enjoyed.

If we are to designate Naegel's concept of health as a functionalist's orientation in an individualistic sense, then Parsons' concept of health is a functionalist's approach in a social sense. Parsons (1951, 1958) conceptualizes health as a socially desirable and normative state that is functionally important to the social system. To Parsons, health is a functional requirement for maintaining integration in the social system in an aggregated form. From this assumption, an individual's health is defined in terms of his or her capacities to assume roles and perform essential social tasks satisfactorily. Twaddle (1974) consolidates both the biological and sociological meanings of functioning into a more inclusive conceptualization of health. In addition, health is a state labeled by self and others according to Twaddle.

Twaddle proposes the following postulates as the essential ideas about health and illness:

- Health and illness are defined normatively and refer to "standards of adequacy relative to capacities, feeling states, and biological functioning needed for the performance of those activities expected of members of a society," and yet deviations from the norms are rather ambiguously defined by the society.
- Health and illness are designated according to the norms of functioning in the biological context, in that parameters of biological functioning are used as the criteria designating the health status.
- The norms for differential labeling and designation of health status are not consistently applied to social groups, in that the norms tend to be differentially interpreted among different social groups, social situations and times, and differently applied by different individuals.<sup>5</sup>

Correspondingly, health is a designated state in which adequacy in one's capacities for role and task performance is judged by self and others against normative and socially held standards. What is most essential for these functional approaches, then, is the definition of "normal" or "expected" human functioning and capacity for functioning. Insofar as a person is capable of

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5. Twaddle, A. C. (1974). The concept of health status. *Social Science and Medicine*, 8, 83.

functioning as expected and adequately, an enlarged heart, an absence of a kidney, or the presence of discomfort and pain is not essential to this conceptualization of health. Engelhardt (1976) also notes that the conceptions of health and illness are tied to our ideologies and expectations concerning the world, in that we identify and judge certain states as illnesses according to what we consider as dysfunctional, deformed, or violating the norms of a reasonable expectation with regard to freedom of action on our part as humans. He considers it an instance of "hubris." Many recent studies indicating different evaluative standards of health applied to the general adult population and those applied to the aged suggest that differential criteria for evaluation of health status do exist for subpopulation categories.

The functional approaches have been used quite frequently in health services research. Efforts to develop indicators of health that depart from the classical, clinical measurements of abnormalities have evolved into several indices of health that are based on functioning. For example, as a most comprehensive approach, the Rand Health Insurance Study (Brook et al., 1979) has used physical, social, and psychological functioning as the basis for the development of health status indicators. Kaplan, Bush, and Berry (1976) also carried out a survey study in which normative designations of functioning capacities were assessed in order to use them as a reference guide for health-status designations. The long-standing use of activities of daily living scales in rehabilitation and gerontology is an example of application of the functional approaches for health assessment.

In nursing, Orem's self-care model is a version of a functional model of health. Orem (1991) conceptualizes health in relation to self-care deficits, which are expressed as deficiencies in any one of the self-care foci identified in three categories of universal, developmental, and health-deviation self-care types. Orem views that "health includes that which makes a person human (form of mental life), operating in conjunction with physiological and psychophysiological mechanisms, and a material structure (a biologic life), and in relation to and interaction with other human beings (interpersonal and social life)."<sup>6</sup>

Health is a state of wholeness or integrity of the person in terms of his or her capacity to provide self-care. Since Orem views a human being as a unity functioning biologically, symbolically, and socially, one has to be able to perform deliberate actions to be functional and healthy. Health is thus attained by sufficient and satisfactory self-care actions responding to varying demands for attention to self. Effectively performed self-care action contributes to human integrity, human functioning, and human develop-

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6. Orem, D. E. (1980). *Nursing concepts of practice* (2nd ed., p. 119). New York: McGraw-Hill.

ment. Orem further proposes that the client's health in the nursing perspective should be considered according to three types of self-care requisites (1980, 1991). Universal self-care requisites are considered to have six foci: (a) air, water, and food; (b) excrement; (c) activity and rest; (d) solitude and interaction; (e) hazards to life and well-being; and (f) normalcy. Developmental self-care requisites encompass two categories: (a) conditions that support life processes and promote the process of development; and (b) provisions for preventing exposure to deleterious conditions or for developing strategies to deal with harmful conditions. Health-care deviation self-care requisites are related to six categories: (a) preventive and proactive health-seeking; (b) therapeutic; (c) compliant to medical measures; (d) awareness of adverse effects of health-care; (e) self-concept generating; and (f) accepting and adjusting to health deviation consequences. Thus, self-care is the functional capacity to handle such requirements and is considered as deliberate action, either routine or programmed. Usually, self-care actions performed in daily living become routine, while new self-care actions have to be learned in response to given, specific demands.

Although Orem's attempt is to conceptualize health in a nursing frame of reference, moving away from medical, psychological, and sociological orientations, the self-care model suffers from its implicit assumptions of "unbounded rationality" as the basis for choice of actions and of "deliberateness" in choices as well as in actions. What is not handled adequately in the conceptualization of the model is the role of unconscious, reflexive, and autonomic human responses that define a person's functional capacities and which are responsible for many types of self-care activities.

As shown in these discussions of various models of health, a purely structural or functional conceptualization of health appears to be inadequate and incomplete in abstracting the complex phenomena of health. Recent interests in applying the general systems approaches to conceptualization of health are attempts to overcome such inadequacies.

Departing from the conventional perspectives and approaches presented in the preceding section, Newman (1979, 1994) proposes a theory of health based on Rogers' model of unitary man. Newman's basic assumptions regarding health, which is viewed as the synthesis of disease at one end and nondisease on the other, are six-fold:

- Health encompasses conditions of illness or pathology that are accompanied by varying degrees of incapacitation.
- Conditions of illness or pathology are manifestations of the total pattern of the individual.
- The manifested patterns of the individual precede structural or functional changes.
- The manifested patterns of the individual are not pathology itself,

and thus removal of pathology in itself will not change the patterns of the individual.

- Being ill is healthful when it is the only way an individual's patterns can manifest in a given life process situation.
- Health is the expansion of consciousness and is the totality of the life process.

To Newman, the phenomena of health constitute the concepts of movement, time, space, and consciousness. Newman poses five general propositions, considering the expansion of consciousness as the expression of health. Hence, the processes that specify how an individual expands consciousness will explain how an individual progresses in life with respect to health.

Newman considers time and space as the basis of life processes, having a complementary relationship. Time and space are postulated to be in a complementary elasticity by which an individual moves about in relation to space and time. This suggests that an individual compensates for a loss in space with a gain in time and vice versa. Therefore, the patterns of an individual are manifested through this complementary process. Yet space and time as objective world elements are meaningless to an individual until one's position in it is expressed by movement.

To Newman, personal reality comes into existence via patterns of movement. The meanings of space and time are relative to movements of self and perceived others. In addition, the patterns of movement are expressed within the conscious recognition of body and self. Thus, expressions of self are manifested in movements, and time is "possessed" by an individual through the patterns of movement one develops. Furthermore, since consciousness means awareness of the life context in space-time dimensions, time measures the level of expanded consciousness.

This conceptualization departs in several ways from the conventional views of health in nursing. To begin with, health is neither viewed in relation to structural integrity nor to functional competency. It is not a property concept, but a process concept. Health is an expression of the level to which an individual's consciousness has expanded and is expanding, influencing the awareness of self, which in turn determines the ways the individual moves within subjective time and space. Time and space are media within which an individual expands self through movement and consciousness. Thus, health is a process in which one finds individualized yet evolving patterns of movement and consciousness, defining and claiming "possessed" and "private" space and time from those that are present in the object world. Indeed, this conceptualization is revolutionary and requires a set of different world views. In this view, health is holistic, transcending the notions of illness, disease, or even body and mind. It nearly means life

itself; therefore, the conceptualization suffers from a lack of specificity. If health is the processes of life, it is conceived interchangeably with the concept of life. According to this conceptualization of health, a state of health cannot be differentiated from a state of life. In addition, this concept equates health with a state of consciousness, yet the meaning of consciousness is not explicitly defined in the theory. If consciousness is "knowing," this conceptualization also disregards that aspect of human life controlled, regulated, and promoted by the reflexive, autonomic, and unconscious responses. Consciousness equated with the concept of life also raises a philosophical question regarding the intrinsic value of human existence. Certainly, Newman's theory of health opens the way for many other possible revolutionary conceptualizations of health that may be more particularly fitting to theoretical thinking in nursing.

In addition to holistic conceptualizations of health expressed in Rogers's models of unitary humans and Newman's theory of health, there are two more recent ideas that should be noted: existential and phenomenological conceptualizations, and ideological and constructionistic conceptualizations. From the existential and phenomenological perspectives, health is what subjective selves experience that gives specific meanings of wellness. On the other hand, ideological and constructionistic conceptualizations of health consider health as a state that is constructed by the mind and an idea that exists in one's definitional world.

However, these discussions indicate that what is most critical in studying the phenomena of health rests not on the development of a unified concept of health, but on the understanding that different approaches to the conceptualization of health, e.g., structuralism, functionalism, general systems approach, essentialism, or relativism, will lead to different sets of theoretical ideas and explanations. Accordingly, health may be understood and explained in relation to such concepts as attitude, value, quality of life, experience, stressful life events, attribution, help-seeking behavior, energy expansion, sensory deprivation, self-image, etc.

This section has presented diverse conceptual thinking about humanity and health. As indicated earlier, the nursing perspective needs to steer our conceptual development and theoretical analysis to those areas of human affairs and human nature related to health. For nursing to make theoretical sense as a field, it is necessary to develop conceptual and theoretical approaches that can be used for nursing's understanding of human health. At the same time, truly fruitful theoretical advancements may not result directly from such holistic conceptualizations of humanity and health, but from more focused approaches that are developed to understand more particularistic aspects of humanity and health. This idea is in line with the assertion that nursing may benefit more at the present time by developing middle range theories of nursing rather than by trying to muddle through

grand conceptualizations of humanity and health. What is needed in developing middle range theories of nursing is a fundamental philosophy about human life and health rather than a well-developed conceptual model.

## SELECTED CONCEPTUAL ANALYSES

In the first section of this chapter, a list of concepts in the domain of client as examples for the nursing perspective was presented. In this section, conceptual analysis of two selected concepts in the domain of client are presented. The main purpose of this section is to show how a first-level analytical approach is used to gain conceptual and empirical understanding of phenomena. Two concepts, restlessness and compliance, are treated as examples for clarifying conceptual ideas about them and their relevance in the framework of nursing. Restlessness is selected as an example of a “problematic” concept, and compliance is selected as an example of a “health-care experiential” concept. Each concept is analyzed with respect to (a) definitional clarification and conceptual meanings as reflected in the literature; (b) measurement and operationalization of concepts as a step toward an empirical analysis; and (c) the concept’s relationships with other concepts that are important in nursing. The strategy and rationale for the conceptual analysis were discussed in detail in Chapter 2, and that rationale is adopted in this section for the analyses of restlessness and compliance. The specific reasons for selecting these two concepts are meaningless for actual presentations and have no significance to our exercises in theoretical thinking. However, there is a contrast in the level and richness of conceptual development for these two concepts: Restlessness as a concept has received very little scientific attention, while compliance has been studied not only by nursing scientists but also by scientists in other behavioral and social sciences during the past decade.

### Restlessness

#### Scenario

Ellen Austin, R.N., who is a team leader for this unit of ten semi-critically ill patients reports about the experiences during the night of two patients: Mrs. Jane Turcotte is a 32-year-old woman who was admitted to the hospital with abdominal and chest injuries resulting from an automobile accident three days ago; Mr. Thomas Taylor is a 68-year-old patient who is diabetic and has chronic obstructive lung disease, and has been on this unit for the past four days. Ms. Austin reports:

"Mrs. Turcotte had a very restless night. I do not think she slept even ten minutes. She thrashed about the bed all night long, was agitated and restless. She received the pain medication and the sedative, but these didn't induce her to rest. She took off her TEDS several times, almost pulled off her dressing, and attempted to get out of the bed. I stayed with her for a while, which seemed to calm her down a little. Mr. Taylor was out of his bed and walked up and down the corridor more than ten times during the night. He would get into the bed, then get up and sit in the chair, and then walk. This was repeated many times. He took a dose of sleeping medication early in the evening and did not want it repeated. He must be exhausted this morning. I asked him why he was so restless. He couldn't tell me the reason."

### *Definition*

Restlessness is most commonly used in the adjectival form to describe people's behaviors of agitation. Although the phenomenon of restlessness seems to be a frequent occurrence, it has not been studied extensively as a distinct concept in the literature. Yet the phenomenon of restlessness is found in ordinary life situations and in patients' experiences. We have seen many patients in hospitals, nursing homes, and clinics in a state of restlessness and agitation. We also have experienced restless moments and hours ourselves when we found ourselves wandering about the house without aim, and with a feeling of uneasiness and agitation. Norris (1975) found in her literature review that restless behaviors are found in animals in preparation for migration or hibernation. As described in the above scenario, there are many forms of behaviors that are associated with restlessness.

Agitation is the most commonly used term in combination with restlessness to describe a behavioral state that includes aimless, roving, or wandering movements of the body or extremities. English and English (1958) define restlessness as "a tendency to aimless and constantly changing movements," and define agitation as "a condition of tense and irrepressible activity, usually rather 'fussy' and anxious." Barnes and Murray (1980) define agitation as "a broad behavioral term connoting excessive motor activity, often nonpurposeful in nature, and commonly associated with feelings of internal tension, irritability, hostility and belligerency." A person in a state of restlessness tends to move about without purpose, with an unspecified feeling of uneasiness and tension. It is a behavioral state of motor activity accompanied with specific kinds of emotional experiences, and thus is a property concept. Norris (1975) suggests that restlessness may be specified by behavioral indicators: (a) increased, repetitive, aimless skeletomuscular activities; (b) urgency in repeating the activities; and (c) increased muscle tones of body, face, or both. These definitions suggest that restlessness is a state of behavioral movements of muscles, combined with an uneasy feeling state.

Restlessness is a "problematic" concept because it represents a state that requires our questioning of its causes, and because it is an undesirable, troublesome state requiring some form of solution, especially when it lasts for a long duration. Although restlessness of a short duration, the passing restlessness we experience in everyday life, is in the normal repertoire of human behavioral experiences, when it exists in a person for a prolonged duration or is exaggerated in its intensity as apparent in the two patients in the scenario, the phenomenon acquires a pathologic meaning.

As many psychomotor phenomena are treated in the recent literature, restlessness, conceptualized interchangeably with "psychomotor agitation,"<sup>7</sup> is also considered by many scientists in the context of neuropsychophysiological explanations. Olds (1976) postulates the effects of catecholamines on agitation, especially psychotic agitation, and many recent studies of amines' effects on behaviors have attributed restlessness to the effects of cimetidine or amphetamines. In addition, nocturnal restlessness of cardiac patients has been explained as the hypoxic response in several recent studies; such explanations might suggest relationships among cerebral hypoxia, catecholamine release, motor activities, and apprehension.

While it is not too difficult to recognize a person in a state of restlessness, restlessness is difficult to define explicitly for several reasons. First, it is often used to indicate a state of mind, as in "I am restless. The spring air must be affecting me!" even though the person may not exhibit behaviors of restlessness. Second, it is also often used to describe behaviors objectively observed, as in "He is restless today; he acts like a tiger in a cage." Third, it can be a fleeting or long-lasting experiential phenomenon in which many different kinds of body and motor movements are possible. And fourth, historically it has been described as one aspect of more complex phenomena, such as schizophrenia, depression, anxiety, fear, hyperthyroidism, hypoglycemia, and dysphoria.

Furthermore, it has seldom been treated in scientific fields as a distinct phenomenon. The phenomenon of restlessness, it seems, should be conceptualized with respect to the nature of motor activity and the associated feeling state. Therefore, restlessness may be tentatively defined as a state in which a person exhibits purposeless and irrepressible body movements and activities accompanied by a feeling of tension and uneasiness.

### *Differentiation of the Concept From Anxiety and Fear*

The major aspect that differentiates restlessness from anxiety and fear is the emphasis on motor activities and the specificity of the feeling state.

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7. Index Medicus classifies restlessness as psychomotor agitation, and both terms seem to refer to the same kind of phenomena.



While all three concepts deal with phenomena that occur in persons in stressful, emotional states, accompanied with neurophysiological and motor behaviors, restlessness as a concept is confined to phenomena in which specific kinds of motor activities are exhibited with a feeling state of uneasiness. In contrast, anxiety refers primarily to a state of an emotion that is subjectively felt and consciously perceived as tension, apprehension, and nervousness. It is usually accompanied by or associated with activation of the autonomic nervous system (Spielberger, 1975). Anxiety may be expressed in many behavioral forms, including restless motor activities. Thus, restlessness as a concept may be considered an element in a more general class of phenomena called "anxiety."

The concept of fear is less similar to the concept of restlessness, but it is possible to imagine the presence of restless behaviors when a person is in a state of mild fear. In general, fear refers to an emotional state in which a person feels the possible, pending imposition of an undesirable, noxious, dangerous, or threatening condition. It is expressed in various behavioral forms through the activation of the autonomic nervous system, ranging from a total frozen state to a frantic flight. The emotional state of fear is focused and usually has a specific object by which fearful emotions are elicited. In these respects, the phenomenon of restlessness differs from fear more definitely than it differs from anxiety.

### *Operationalization*

Very little work is available in the literature on the operationalization of the concept of restlessness. Nurses in clinical situations have used many descriptions of restlessness; many are subjectively derived understandings of restless behaviors. Norris describes restlessness as the following:

Restlessness seems to be expressed in many ways; by tossing, turning, or twisting in bed, by pacing, tapping with fingers or feet, picking with the fingers, scratching, or other motor activity of a repetitive, seemingly urgent, and not purposeful controlled or directed manner. Facial expressions may be tense, watchful, or fearful. The rate or amount of speech may increase.<sup>8</sup>

Clinical manifestations of restlessness appear to be irregular and are subject to personal interpretations. The common procedure used in studies is usually descriptive in nature and is indicated by a gross measure of judgment for the degree or presence of agitated motor movements.

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8. Norris, C. M. (1975). Restlessness: A nursing phenomena in search of meaning. *Nursing Outlook*, 23, 104.

Since an operationalization of a concept depends on the explicit definition of the concept adopted or developed, we assume that this operationalization, given the definition advanced above, requires at least two dimensional measurements: (a) the nature of motor activity, and (b) feeling state. There are several characteristics inherent in the restless motor activity—aimlessness of movements, irrepressibility of movements, and fussiness of movements. In addition, an accompanying feeling state of generalized tension, uneasiness, nonspecific distress, irritability, or belligerence needs to be included in the measurement strategies to express the phenomenon of restlessness.

Duration is also suggestive of an important aspect of restlessness, manifested clinically in patient-care situations. Intensity of restlessness is another aspect of clinical manifestation requiring nursing attention, yet there seems to be no objective way of differentiating degrees of intensity. At best, the measure of restlessness has to be descriptive with respect to motor activities and movements. Measurement of restlessness for the dimension of the feeling state is problematic, since it has to depend upon the client's expressions of feelings.

### *Relationships with Other Concepts*

There is a paucity of research that deals specifically with restlessness in patients. Few studies in the literature deal with the hypoxia hypothesis, which suggests that restless behaviors may be the response to hypoxia. Restlessness also has been considered the response to cerebral anoxia, usually resulting from injury. Norris (1975) alludes to several possible causes of restlessness, such as changes in the rhythmicity of life, anticipation of change, fatigue and boredom, role-deprivation, as well as many pathophysiological conditions.

Conceptualization of restlessness in a global, experiential sense is not found in the literature. Clinical observations and experiences suggest that restlessness is related to such experiences of hospitalized patients as unfamiliarity of surroundings, stress of illness or surgery, symbolic and physical meanings of isolation, and altered perceptions. A better understanding of restlessness-inducing factors within the person, the environment, and in experience can help develop nursing interventions that can be applied to clients who become restless. There may be many experiential and symbolic factors as well as physical ones in hospitalization and illness experiences that tend to arouse restlessness in certain clients. In addition, studies differentiating psychotic/schizophrenic agitation and simple restlessness should be of interest for a better understanding of neuropsychophysiological propositions, especially those related to catecholamine physiology.

## **Compliance**

These are a few examples of noncompliance in health care.

- A bottle full of antihypertensive drug on the night stand having the prescription filling date six months old.
- Four plus sugar of a diabetic client's urine test for the past four consecutive visits to the nurse practitioner at a clinic.
- Missed clinic visits by a patient on cardiac medication.
- Two packs of cigarettes smoked daily by a client who has an advanced chronic obstructive lung disease and bronchial asthma.
- A 3,000 calorie diet consumed repeatedly by a client on a 1,000 calorie reducing-diet regime.

### *Definition*

At the conclusion of the Workshop/Symposium on Compliance with Therapeutic Regimens at McMaster University held in May 1974, the group accepted a general definition of compliance as the extent to which the patient's behavior coincides with the clinical prescription (Sackett, 1976). In contrast to this definition of compliance, which is suggestive of the neutrality of the concept, there have been many definitions of compliance suggested by health-care practitioners and scholars that encompass the notion of power influence on the behaviors of conformity. Barofsky (1978) attaches coercion to the phenomenon of compliance, maintaining the negative meaning of the concept. Compliance thus raises an ethical issue dealing with client autonomy. The negative connotation of the term has been the focus of many debates among physicians, nurses, behavioral and social scientists, and social workers.

The primary difference between the definitions proposed by the Sackett group and by Barofsky can be found in the perspectives from which the phenomena are conceptualized. The first approach in which alignment of client's behaviors with prescriptions as a definition of compliance views the phenomena as a property concept. Here, the notion of how compliant behaviors may result is removed from the definition, and it only refers to the client's behaviors judged against the clinical prescriptions for adherence and conformity. Thus, in the health-care field, compliance as a property concept has an accepted meaning that refers to the adherence and coincidence of a client's behaviors to professional prescriptions.

In contrast, compliance as a process concept refers to the client's behaviors that vary according to the degree with which others influence the behaviors (Barofsky, 1978). This form of definition depicts the process of influence in which power to influence is exercised to produce certain

behaviors in the client. Thus, characteristically, the same client behaviors (i.e., by an objective judgment, such as taking medication at certain hours of the day, or making return clinic visits faithfully) may be classified as compliance, adherence, or therapeutic alliance, depending upon whether the behavior is produced by (a) coercion that is thought to produce compliance; (b) conformity that is thought to result in adherence; or (c) negotiation that is considered to bring about therapeutic alliance. For this definition of the concept, what is central to the phenomenon is not the nature of behaviors exhibited by the client but the way the behaviors are induced from the client. That is, it is important to differentiate whether the behaviors are produced by coercive pressure, self-propelled conformity, or negotiation between the client and the professional in which some type of transaction occurs. It is theoretically important because an understanding of such processes is necessary for predicting future behaviors.

In conceptualizing the phenomenon of compliance, there also has been some debate about what should constitute "clinical prescriptions." Medication orders, return visits, dietary modifications, exercise programs, curtailment of smoking, abstinence of alcohol consumption, and other changes in personal habits have been included as examples of clinical prescriptions in the field. Since the phenomenon of compliance refers to self-administered regimens without the constant surveillance by professional staff that exists in institutionalized care settings, clinical prescriptions generally refer to the kinds of activities and modifications of behaviors related to daily habits. The object is development of new behavioral patterns or modifications of existing ones. These behaviors are usually in the core of the client's private life.

Sackett (1976) introduces the intended goal, in terms of prevention, management, and rehabilitation, as an additional dimension of the clinical prescriptions. He shows that the studies reviewed suggest different levels of compliance, not only according to the types of regimen but also according to the intended goals of regimen.

This diversity in conceptualization of compliance suggests the complexity of the behavioral patterns linked to compliance, and begs for a unified theory of compliance.

### *Operationalization*

Expression of compliance in measurable terms has been the major difficulty for the researchers in the field. Although there have been many studies using various types of direct or indirect measures of compliance, there is no consensus as to what would explicitly and accurately reflect the degree of compliance. Gordis (1976) surveyed many studies of compliance and found that there is neither a general agreement on the definition that dis-

tinguishes compliance from noncompliance, nor a measurement system that expresses the true meaning of compliance in terms of outcome. Direct measures, such as the rate of drug excretion and blood levels of drugs, to test the compliance to medication-taking, has been found to be more reliable than pill-counting or self-reporting. However, it has been suspected that explanations of compliance may be masked by measurement errors in both types of methods.

Many of the indirect measures that use outcomes of regimens as the criteria for compliance, such as blood pressure level, weight-reduction rate, or respiratory capacity, have been found to be influenced by many other physiological and transient variables as well as regimen-compliance. In many instances, such measurements tend to yield minimal information about compliance.

Another major operationalization problem is in the comparability of compliance to one regimen with that to another. For example, there is no conceptual or operational clarity in handling the similarities and differences between compliance to a hypertensive medication and compliance to a low-salt diet. Obviously, the motivational and behavioral constraints that influence compliance to these two regimens are quite different. The complex nature of clinical prescriptions and the requirements these pose on individuals remain the most critical aspect of the phenomenon of compliance both theoretically and operationally.

Measurement of compliance relying on self-reporting has received a great deal of criticism for its reliability as well. Many studies found discrepancies between what clients report and their actual behaviors, although there continue to be reports of compliance studies using this form of operationalization, for the lack of a better or more convenient measure.

### *Relationships With Other Concepts*

Compliance literature abounds with research studies that link compliance with different concepts in the domain of client, such as motivation, amount of knowledge, cognitive dissonance, and the presence of serious symptoms. The health-belief model (Becker, 1974) has been used in many studies as the theoretical framework, trying to explain compliance on the basis of clients' internal states and definitions of situations. These explanations are mainly oriented to treating compliance as an essentially self-triggered phenomenon. Thus, compliance is viewed as a behavioral outcome of other personal traits and characteristics, such as (a) how motivated a person is to attain a healthy state; (b) how much a certain state of health is valued by the person; (c) what the extent is to which a person believes his or her conduct will result in a positive outcome; (d) what the extent is for a person to maintain a cognitively conflicting situation; and (e) how much a person knows about the nature of illness and the effectiveness of treatment.

In addition, several concepts in the domain of environment, such as social support, social pressure, and symbolic expectations, also have been found to influence a client's compliance. In the domain of nursing action, characteristics of client-nurse interaction, contracting, and collaborative decision making have also been studied to explain compliance in the client. The degree to which a client receives reinforcement, positive feedback, frequent support or supportive knowledge generated by the client's interactions with significant others and professionals, as well as the degree to which a client receives pressure for conformity, have been shown to influence compliance with various types of clinical prescriptions.

Hence, it appears that compliance is related to influences of internal and external types as seen from the perspective of the client. The exact nature of the processes by which both internal and external factors mediate compliance has not been studied extensively and needs to be investigated.

### SUMMARY

Since this chapter contains a great deal of new terminology and several new ideas in conceptualization, it is perhaps worthwhile to point out the main ideas that have been discussed. The domain of client as the focus of conceptualization is shown to contain diverse types of concepts and phenomena essential for theoretical thinking in nursing.

It appears that rethinking of the models of humans and health is central to clarifying both philosophical and theoretical stances that are necessary for theoretical thinkers to assume in nursing. It might be useful to examine many and varied models of humans and health that are currently used as the basis for theoretical developments in other scientific fields in order to attain a greater clarity in the theoretical requirements for nursing models of humans and health. It also seems fruitful to reexamine nursing models of humans and health that are being used in research and practice for their theoretical breadth and limitations.

While there are many different ways of categorizing concepts in the domain of client for studies from the nursing perspective, the suggested typology of essentialistic, problematic, and health-care experiential types provides a beginning for examining the conceptual properties in a systematic way. By way of examples, attempts are made to show how to ask important questions in definitional clarification of concept, operationalization of concept, and in considering relationships of concept with other related phenomena. Restlessness and compliance were discussed to show the use of these strategies in conceptual analysis.

The main thrust in conceptualization for the domain of client is in developing, ultimately, a nursing theory of humanity or a nursing theory of

health that can be the basis for understanding a diverse array of problems presented by the client whom we encounter in nursing. In addition, the need for development of middle-range theories aimed at understanding boundary-specific phenomena in clients has been implicitly stressed in the discussions of restlessness and compliance. Middle range theories in nursing that deal with broad, particularistic phenomena in the domain of client will help us accumulate the many layers of theoretical knowledge necessary for a development of grand nursing theories.

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# 5

## *The Client-Nurse Domain*

*Firstly, there is the unity in things whereby each thing is at one with itself, consists of itself, and coheres with itself. Secondly, there is the unity whereby one creature is united with the others and all parts of the world constitute one world.*

—della Mirandola

### OVERVIEW

This chapter presents a conceptualization of the client-nurse domain and theoretical ideas about phenomena in that domain. As presented in Chapter 3, the client-nurse domain is defined as the area of study in nursing related to phenomena arising out of encounters between client and nurse. The client-nurse domain encompasses client-nurse dyad phenomena that exist or are possible when a client is with a nurse or nurses in a health-care situation. In specifying this as constituting a specific domain of interest for nursing's theoretical development, I have proposed that "contacts between the client and nurse are occasions in which transfer and/or interchange of information, energy, and affection/humanity occur" (Kim, 1987).

The following section is devoted to discussion of conceptual issues in studying phenomena in the client-nurse domain. Delineation of the phenomenal world for the client-nurse domain is specified with respect to three different ontological foci for the study of human to human relations. The rationale and significance for specifying client-nurse relations in terms of three types of phenomena, i.e., *contact*, *communication*, and *interaction* are discussed as well. This is followed by an examination of selected nursing models in dealing with client-nurse phenomena with respect to their focus of attention and perspectives. The last section offers conceptual analyses of the phenomena of negotiation as an example of client-nurse domain phenomena.

## THE CLIENT-NURSE DOMAIN

Phenomena in the client-nurse domain occur in direct encounters between the client and the nurse. Phenomena that occur between two individuals (sometimes more than two, especially when the client constitutes a group of people as a unit) who have come together into situations because one party is the client and the other the nurse are nursing phenomena. They are nursing phenomena because they require understanding and explanation from the nursing perspective. Here it is necessary to differentiate nursing phenomena in the client-nurse domain from those that are objects of explanation in other scientific fields. For example, a sociologist might consider the patterns of interaction between the client and the nurse as subject matter, properly so, for explanation within a theory of social exchange. The sociologist's focus is necessarily "sociological," and insofar as it remains to be conceived as sociological, it is a proper subject matter for a sociological explanation. The sociologist is interested in explaining interaction in terms of how social norms, attitudes, and values influence interactional patterning; how interactions begin, develop, and terminate in such social situations; or how one party's use of social symbols affects others' reactions to them. These are valid and essential questions that sociology tries to answer in its proper relevance structure.

On the other hand, a nursing scientist may take the pattern of interaction between the nurse and the client as subject matter for explanation within a nursing theory or from a nursing perspective that is based on the philosophy of care. The nursing scientist focuses on understanding the phenomena, for example, with respect to (a) how the patterns of association between the client and the nurse influence the client's reactions to his or her health, problems, and health-care situations; (b) what kinds of relations and behaviors between the client and the nurse foster focus on the client's needs and goals; or (c) what kinds of communicative patterns foster the client's learning of new health-care requirements. The nursing focus is apparent in such questions. The same world, then, is examined on two different planes, that is, from two entirely different perspectives, allowing postulations of scientific problems that are oriented to two different objectives: Sociology, in this case, is interested in furthering an understanding of human interaction as social phenomena, while nursing is interested in understanding nurse-client interaction as nursing intervention or as a part of nursing actions, and is directed toward a knowledge base that can enable prescriptions of the most effective patterns of nursing behaviors in client-nurse exchanges or that provide understanding about the nature of client-nurse dyads as they impact on the client's health-related experiences.

What then are the valid criteria that can be used to point out as appropriate those aspects of reality in the client-nurse domain for study from the

nursing perspective? The valid criteria appear to rest with the kinds of questions that are posed in conceptualization. The main question is this: *Would a variation of "this occurrence" (that is, any occurrence of a type) that is taking place between the client and the nurse in any way alter or influence (or should alter) the way the client feels, perceives the world relevant to health, and proceeds to make actions regarding his or her health state?* If the answer is yes, then we have successfully conceptualized a nursing phenomenon in the client-nurse domain. In this way, phenomena in the client-nurse domain have two common characteristics:

- They are phenomena "existentially" occurring in situations where a client and a nurse are present in respective roles.
- They are phenomena whose meanings have implications for the client's health and health-related experiences.

Conceptualization of what is happening in such encounters mainly depends on the scope with which specific phenomena are abstracted. Let us return to the last section of the scenario of Mr. Harold Smith that was presented in Chapter 3.

Ms. Dumas, the nurse, enters the patient's room with the IV dose of cefamandole to be put through the IV line, and notices the uneaten dinner, signs of a quiet, depressed mood, and coughing. Mr. Smith's roommate is in a great deal of pain, having had abdominal surgery on the preceding day. He moans and groans aloud at times. Ms. Dumas administers the medication through the IV line and talks to Mr. Smith about his discomfort and coughing.

Each discrete act that occurs between Ms. Dumas and Mr. Smith can be conceived in a different phenomenal term in a particularistic mode of analysis. Thus, exchange of mood, energy transfer, attentiveness, etc., may be considered as particularistic concepts referring to some of the phenomena apparent in this situation. On the other hand, the occurrences in the situation may be conceptualized in a holistic posture, as transaction, nurse-patient interaction, or therapeutic relationship. Such differences in conceptualization of the phenomena apparently present in a nursing situation allow several levels of theoretical questioning, yet the locus of occurrence here remains within the context of client-nurse dyad.

One way of particularizing phenomena in the client-nurse domain is by focusing on specific ontological aspects of humans: *contact phenomena* with the focus on humans as embodied, "materialized" entities, *communication phenomena* with the focus on humans as symbol users both of language and other nonlinguistic forms, and *interaction phenomena* with the focus on

humans as social agents. As dyadic relations occur in a holistic manner engaging all aspects of participants, this differentiation is only an analytical tool to delineate focused features of relations. This means that in all dyadic relations, including those of clients and nurses, we are engaged with each other more or less all at once as embodied selves, using language, gestures, or feeling tones, and being social agents of roles. Some aspects of such dyadic engagements may be conceptualized as *contact*, *communication*, or *interaction* only for analytic purposes and in order to develop theoretical understanding.

### **Contact Phenomena**

Contact phenomena as a type in the client-nurse dyad refer to those phenomena that involve the participants' embodiment, physicalness, and space-occupying character. The ontological focus in considering dyadic relations as *contact* is in viewing humans in an entitative living form. When we are together with one another, we are close or distant, we touch with hands or with other parts of our bodies, we are present with our beings (that is, with our essences, with energy, prahna, spirit, etc.), and we assume positions relative to each other. In so doing, we exchange energy, make contact with each other's spirit, are cognizant of each other's presence, and feel each other's humanity. A nurse who enters into a patient's room may stand by the foot of the bed to give certain instructions to the patient, turn the patient over to give medication, massage the patient's feet, or carry out centering and the laying on of hands to relieve the patient's pain. In such instances, it is possible to delineate certain phenomena as *contact* between the nurse and the client as embodied human beings consisting of certain entities that come in contact with each other. It is possible to conceptualize such phenomena as distancing, instrumental touch, energy transfer, and therapeutic touch. This way of conceptualizing certain aspects of client-nurse dyad is important for nursing, because nursing unlike much other human services work, entails a great deal of body work that involves both patients' and nurses' bodies.

### **Communication Phenomena**

Communication phenomena have received a great deal of attention in nursing as communication has been considered a critical aspect of nursing practice. Many aspects of nursing practice involve communicating with patients and their families, for example in gaining information from clients, providing information to clients, and exchanging information and sentiments between clients and nurses. Communication phenomena involve the use of language and other symbols.

The ontological focus in considering dyadic relations as *communication* is in viewing humans as acculturated, linguistic, symbol users. Humans as symbol users are grounded in cultures and socialization through which shared meanings get established as the basis for understanding and exchanges. Studying communication phenomena is important in nursing, as a large portion of client-nurse relations involves exchange of information and use of symbols. Such concepts as tailoring, negotiation, therapeutic communication, communicative conflict, and client-nurse communication styles have been identified and studied in the nursing literature for their influence on clients' health, compliance, satisfaction, and learning.

### **Interaction Phenomena**

Interaction phenomena in the client-nurse dyad refer to those interactions that are analyzable by considering clients and nurses as social agents assuming their respective roles in the situation of nursing care. The ontological focus for conceptualizing certain aspects of client-nurse relations as *interaction* is in viewing humans as social agents who are engaged in forms of social life which vary according to the social situations in which interpersonal engagements occur. Clients and nurses in assuming their respective roles within health-care situations establish social relations that are unique to such situations.

The interaction phenomena of interest to nursing are "social" in nature and probably qualify justifiably as an appropriate subject matter for sociological attention. However, it is important for nursing to delineate and study interaction phenomena in the client-nurse domain with specific attention to their implications for clients, not necessarily on the social patterning perspective often adopted in sociology. Insofar as interactive features of client-nurse dyad have implications for client outcomes, it is important to develop theoretical knowledge about them from the nursing perspective. Table 5.1 lists examples of concepts that are appropriate for scientific attention in this client-nurse domain.

### **CLIENT-NURSE PHENOMENA IN THREE MEANING-ORIENTATIONS**

As presented above, client-nurse phenomena exist when two human beings, a client and a nurse, with all of the realities of being human, are together in the context of nursing care. Such togetherness has three distinct meanings:



**Table 5.1** Examples of Concepts in the Client-Nurse Domain for Study in the Nursing Perspective

CONCEPTS	LEVEL OF CONCEPT DESCRIPTION	
	HOLISTIC	PARTICULARISTIC
Contact Concepts	<ul style="list-style-type: none"> <li>• Comforting touch</li> <li>• Therapeutic touch</li> <li>• Distancing</li> <li>• Interpersonal energy transfer</li> <li>• Interpersonal presence</li> </ul>	<ul style="list-style-type: none"> <li>• Instrumental touch</li> <li>• Massaging</li> <li>• Eye-contact</li> </ul>
Communication Concepts	<ul style="list-style-type: none"> <li>• Communicative conflict</li> <li>• Communication styles</li> <li>• Therapeutic communication</li> </ul>	<ul style="list-style-type: none"> <li>• Tailoring</li> <li>• Client-nurse Negotiation</li> </ul>
Interaction Concepts	<ul style="list-style-type: none"> <li>• Mutuality</li> <li>• Empathetic relationship</li> <li>• Transaction</li> <li>• Therapeutic alliance</li> </ul>	<ul style="list-style-type: none"> <li>• Client-nurse collaboration</li> <li>• Role-conflict</li> <li>• Gift-giving</li> </ul>

1. It is itself a form of nursing therapeutics by which a specific client outcome is expected, such as relief of pain, alleviation of anxiety, feeling of comfort, or learning of a new self-care technique. This orientation of client-nurse encounters is based on the aspect of nursing under the auspices of the philosophy of therapy.
2. It is a medium through which nurses deliver various nursing therapeutics and strategies to clients, such as giving medication, doing a wound care, or providing self-care material.
3. It is a process that occurs within the philosophy of care in which a client and a nurse are connected with the nurse's human service orientation and the care-focus.

While it is possible that an encounter between a client and a nurse has all three of these meanings, a certain aspect of the encounter may be considered to have specific meaning orientation as a nursing therapeutic, a

medium, or a philosophy of care. Considering client-nurse phenomena in terms of their meaning-orientations is important because of their connections to client outcomes or client-related goals. For instance, client-nurse phenomena with the meaning-orientation of nursing therapeutics have direct implications for client-outcomes, while client-nurse phenomena with the meaning-orientation as medium is only contextually and indirectly related to client-outcomes. On the other hand, client-nurse phenomena with a meaning orientation in the philosophy of care have implications for client-outcomes only in terms of the general care process. Hence, it is essential to differentiate client-nurse phenomena in terms of their meaning-orientations in developing theoretical formulations.

### **Client-Nurse Phenomena as Nursing Therapeutics**

All three types of client-nurse phenomena, i.e., *contact*, *communication*, and *interaction*, may be therapeutic in the sense that nurses' relational behaviors have as their objectives a goal (or goals) of intervention for clients' health-oriented problems. Nursing is in the business of "improving" clients' health, that is, the bulk of what nurses do has to have the therapeutic orientation in the spirit of the philosophy of therapy. Most commonly, nursing therapeutics are physiological, behavioral, or psychological interventions aimed at solving patients' problems. For example, the nursing therapeutic for a patient in dehydration would be an administration of fluid and electrolytes on a hydration schedule based on a physiological theory, whereas the nursing therapeutic for a patient who is noncompliant of diabetic self-care may be a use of patient-contracting based on a behavioral theory. However, some of clients' problems require nursing interventions that are based on theories of relations. Hence, nursing therapeutics using specific forms of client-nurse encounters aim to solve clients' problems through relational processes.

Nurses can use relational processes such as touch, communication, or interaction to address specific patient problems. Therapeutic touch has been developed as a modality of nursing intervention used to relieve the patient's pain or anxiety. A specific form of communication has also been developed as "therapeutic communication" to deal with patients having difficulties with self-concept, social relations, or the process of adjustment to physical limitations. Role modeling as a form of client-nurse interaction has also been used to teach patients about new styles of behaviors. Such processes, that is, therapeutic touch, therapeutic communication, and role modeling for example, are nursing therapeutics, which use client-nurse relations as the basic forms for interventions. For this meaning orientation, then, specific forms of client-nurse relational processes target certain nursing problems of patients and are used to solve those problems. Hence, this

meaning-orientation is aligned with the philosophy of therapy in nursing, and points to the need for knowledge development for nursing therapeutics via human-to-human relational theories.

### **Client-Nurse Phenomena as Medium for Nursing Actions**

Nursing actions, that is, what nurses do in nursing practice, include activities which are carried out either in the presence of patients or away from patients. Although there are many actions which are carried out away from patients, what the majority of patient care nurses are involved in is carried out in actual encounters with patients. In such instances, the encounters themselves do not have specific therapeutic meanings. They are the media through which certain nursing actions are actualized. For instance, when a nurse carries out a complete nursing assessment in a patient, she or he asks the patient certain questions in order to get information about the patient's history, complaints and habits, listens to the patient's lung sounds or measures the vital signs, and inspects the patient's wound or physical appearance. In this case, the essential aspect of nursing action is a complete nursing assessment. However, this action of assessing the patient involves client-nurse phenomena such as information exchange and physical touch.

Hence, from this context, client-nurse encounters have a meaning orientation as a medium through which nursing actions are instituted and delivered. As a medium, what occurs in the client-nurse encounter has consequences on the way nursing action is accomplished. Communication patterns used in client-nurse encounters may influence the character of information obtained by the nurse in assessment. Or the way a client and a nurse interacted while the nurse was carrying out colostomy care may influence the way a patient establishes a perception about the nature of colostomy self-care. A subtle difference in a nurse's physical touch of the patient during dressing change, in giving an injection, while doing an endotracheal suctioning, or in adjusting IV chemotherapy infusion can influence the effects of such activity directly or indirectly, immediately or in a delayed fashion.

Client-nurse phenomena from this meaning orientation, then, arise out of client-nurse encounters in which there are primary nursing actions to be performed by nurses and where the encounters function as media for the delivery of such primary nursing actions. The characteristics, processes, and features of client-nurse encounters from this meaning orientation are viewed to have impact on the processes and outcomes of primary nursing actions. This view is thus important for our consideration because the effectiveness of nursing actions can be greatly influenced not just by the nature of nursing actions but also by the nature of the medium through which nursing actions are accomplished.

### **Client-Nurse Phenomena in the Philosophy of Care Orientation**

Nursing by its social mandate and professional orientation has two philosophical orientations as discussed earlier: the philosophy of therapy and the philosophy of care. As a human practice discipline, nursing work is oriented to helping people in need of service not only by solving their specific health-related, health-experiential problems, but also by providing care to their beings as individuals as they go through a process of health care. Hence, the philosophy of care is bifocally central to nursing in conjunction with the philosophy of therapy. The philosophy of care focus is actualized in nursing through various forms, such as in nurses' interactions with clients, through upholding the ethical values of human dignity and autonomy in every nursing action, and in defending patients' rights. It is the nurses' interactions with clients in which the philosophy of care is played out in nursing most importantly.

Hence, all client-nurse encounters are overarchingly governed by how the philosophy of care is integrated by the nurse. There is embeddedness of the philosophy of care in client-nurse encounters, regardless of whether the encounter is therapy-oriented or medium-oriented. However, such embeddedness can be analytically separated from the previously discussed two orientations, because the philosophy of care orientation points to specific meaning features of client-nurse encounters. Such phenomena as mutuality, empathetic relation, tailoring, therapeutic alliance, collaborativeness, and presence in client-nurse encounters have meanings in terms of the philosophy of care and can be analyzed and understood in this context. Such phenomena in client-nurse encounters shape the governing character of relationships in nursing.

The philosophy of care orientation directs us to examine client-nurse encounters in terms of the degree with which encounters are client-oriented, empathy-based, and humane. Hence, the orientation points to the needs to develop theories of approaches in client-nurse encounters. Theories of approaches are relevant for understanding nurses' approaches which differentiate the incorporation of the philosophy of care in client-nurse encounters, and in developing different ways nurses can approach clients in their interactions with them.

Table 5.2 provides examples of phenomena in the client-nurse domain viewed from a matrix formed by three types and three meaning-orientations.

### **NURSING MODELS FOR THE CLIENT-NURSE DOMAIN**

Although all nursing theories and conceptual models address client-nurse domain phenomena as relevant aspects to be considered in understanding nursing, there are only a few models that focus on client-nurse phenomena

**Table 5.2** Examples of Client-Nurse Domain Phenomena According to the Classification by Types of Meaning-Orientations

TYPES OF PHENOMENA	TYPES OF MEANING-ORIENTATION		
	Therapy Orientation	Medium Orientation	Philosophy of Care Orientation
Contact Phenomena	<ul style="list-style-type: none"> <li>• Therapeutic touch</li> <li>• Massaging</li> </ul>	<ul style="list-style-type: none"> <li>• Instrumental physical touch</li> </ul>	<ul style="list-style-type: none"> <li>• Cradling</li> <li>• Distancing</li> </ul>
Communication Phenomena	<ul style="list-style-type: none"> <li>• Therapeutic communication</li> <li>• Teaching</li> </ul>	<ul style="list-style-type: none"> <li>• Client-nurse talk</li> <li>• Information exchange</li> </ul>	<ul style="list-style-type: none"> <li>• Tailoring</li> <li>• Empathetic communication</li> </ul>
Interaction Phenomena	<ul style="list-style-type: none"> <li>• Role-modeling</li> </ul>	<ul style="list-style-type: none"> <li>• Role conflict</li> </ul>	<ul style="list-style-type: none"> <li>• Mutuality</li> <li>• Presence</li> <li>• Client-nurse alliance</li> </ul>

as the central concepts in their theoretical expositions. Mostly, nursing theorists consider and include the presence of the nurse in the enactment of nursing action as actors in the delivery of nursing service, often without a specific conceptualization of client-nurse relations as a part of nursing actions. As the conceptual models by Roy and Neuman are oriented to the study of clients and client-domain phenomena, their models do not include specific concepts in the client-nurse domain. For example, to Neuman (1995), the purpose of nursing intervention is to reduce stress factors and adverse conditions that either affect or could affect optimal functioning of a client in a given situation. Similarly, Roy's adaptation model also considers nursing intervention as the management of stimuli, and nurses' role as the deliverer of interventions (Roy & Andrews, 1991). The inherent interactive features involved in carrying out nursing interventions are treated as givens in these models.

Orem within her self-care model, which is oriented to the study of clients from the perspective of functioning, delineates the nursing system as a separate concept with the understanding that this is a system of actions and interactions designed by nurses for the benefit of clients in nursing practice situations (Orem, 1991). Orem's nursing system thus refers to both the actions of nurses performed to help clients to meet their self-care requisites and nurses' interactions with clients in this helping process. Nurses' use of "social and interactive technologies" is viewed to be essential in producing the outcomes of the "professional-regulatory technologies" applied to

clients in order to meet their self-care requisites (Orem, 1991). Thus, Orem's as well as Roy's and Neuman's views of client-nurse interaction are based on the meaning-orientation of it as medium. King (1981, 1990) in her theory of goal attainment proposes the concept of interpersonal system as the basic system for attaining a state of health for clients that permits them to function in their roles. Hence she views interpersonal processes between the client and nurse as the media through which nursing goals can be attained.

Among other nursing scholars, L. Hall (1966) conceptualizes nursing action in terms of care and nurturing, not in an interactive sense but in an "active" sense on the part of the nurse. Orlando's conceptualization of nursing action is an interactional one in which the nurse's action is based on the client's reactions in situations of nursing care. The nursing action is thus viewed as a dynamic relationship (Orlando, 1961). Riehl's interaction model, based on the symbolic interactionist orientation, conceptualizes nursing action as that of the nurse taking the role of the other in her relationships with the client (1980). Watson (1979) proposes that nursing action be based on "carative" factors and views the practice of caring as central to nursing. These conceptualizations adhere to the notion that nursing action is not simply doing things for the client or performing actions for the client, but involves the nurse as an interactive agent in a rather total way. On the other hand, theorists like Rogers, Parse, and Newman discuss the inclusive nature of client-nurse relations in considering the client as they view the client's experiences or states to have intimate interactions with the environment of which the nurse is an important part. Thus, these authors view client-nurse phenomena from the philosophy of care orientation in which client-nurse relations are viewed to be human-to-human encounters with the involvement of the totality of humanity.

Peplau (1962) has a specific interactive orientation in her conceptualization of therapeutic interrelationships in nursing. Wiedenbach (1964) also views nursing action as that directed to the client for whom actions as a helping process provide necessary requirements that will help restore the client's ability to cope with the demands of a healthy life. Hence, these two authors view client-nurse interaction from the nursing therapeutics orientation. In the following section, the theoretical ideas of three nursing theorists, Rogers, Peplau, and King, are discussed in detail in terms of their views on client-nurse phenomena.

### **Rogers' Concept of Unitary Human Beings**

Rogers' conceptualization of nursing action is covertly done within the model of a unitary man. Rogers states that nursing practice is directed toward promoting symphonic interaction between a person and the envi-

ronment, strengthening the coherence and integrity of the human field, and directing and redirecting patterning of the human and environmental fields for realization of maximum health potential (Rogers, 1970). For Rogers, nursing action is composed of behaviors, operations, and procedures, ranging from the use of instruments to human relationships. They are used with intellectual care in "rhythmic correlates of practice" in order to help people to achieve positive health or maximum health potential. The basic premises for nursing actions are (a) the wholeness of a person and his or her integrality with his or her environment; (b) the dynamic, evolutionary, innovative wholeness of the individual life pattern; and (c) the energy field for any individual as "an irreducible, pandimensional energy field identified by pattern and integral with the human field" (Rogers, 1992, p. 29).

Health and illness are considered on a continuum, expressed according to the degree with which multiple events as a patterned influence affect the person's life processes at a given space-time. Because each human being is unique and whole, and since a person is conceived to have the capacity to reason and feel, and thus participates knowingly and probabilistically in the process of change, both the client and the nurse are integral participants in the nursing intervention process. The nurse, therefore, is an environmental component for the client, repatterning the energy field of the client's environment simply by being present. According to Rogers' model, nursing action, hence, is concerned with the following aspects:

1. Changing the client's values for probabilistic goal-setting that is responsive to the changing nature of the human and environmental fields. This involves the nurse realizing the client's individual potential and uniqueness for a future maturation relative to health.
2. Strengthening the person-environment resonancy by rearranging the rhythmic flow of energy waves between a person and his or her environment and by maintaining rhythmic consistency. This involves the nurse ordering or reordering the nature, amount, and speed of wave dispersion in the human and environmental fields for enhancement of the client's development relative to health.
3. Attaining the person-environment complementarity in an effort to acquire the best possible patterns of living coordinates for the client in coexistence with environmental changes. This requires the nurse to help the client come to terms with and realize individual differences and potentialities for directing change that are most beneficial to his or her evolution and the most effective fulfillment of life's capabilities.

These three categories of nursing action in Rogers' model suggest that nursing action is not discrete activity but a process of holistic, interactive

intervention. Thus, the variability of nursing action can be expressed in qualitative rather than in nominative terms. Nursing action is conceptualized from the interactive perspective to the extent that the nurse's presence in the environment changes the characteristics of the environmental energy field and has the potential for strong influences on repatterning. The phenomena of mutual, complementary influence between the client and nurse is not distinctively conceptualized as a special case, for Rogers believes not in the human-to-human interaction as an essential phenomenon but in the human-to-environment interaction in which other individuals are quality-changing aspects of the environment as is the nurse.

Because nursing action is not directed at "solving" a health problem, the conceptualization of nursing action is not prescriptive. For that matter, the goal of nursing action is never deterministic. It is viewed in terms of "correlates" and mutual simultaneity. Hence, the outcomes of nursing action in the client are directed toward the more complex repatterning and organization of the energy field that are expected to occur in a probabilistic and correlative fashion, not in a cause-effect way.

### **Peplau's Concept of Interpersonal Relation**

Peplau (1962) defines nursing as a therapeutic, interpersonal process that helps the client solve problems and likewise moves the client toward the direction of creative, constructive, productive, personal, and community living. To Peplau, nursing refers to relationships between the client and the nurse in which interactive processes become a maturing force and an educative instrument for both parties. Thus, although the principal aim of nursing is to guide the client toward new learning and a positive change for self-repair and self-renewal, the nurse also experiences growth and maturity through interpersonal involvement. Peplau conceptualizes the interpersonal process in four phases through which the client and the nurse attain therapeutic outcomes. Orientation, identification, exploitation, and resolution are the stages of interpersonal relations, of which nature, length, and effectiveness are determined not only by the nurse's ability to perform the roles of teacher, resource person, counselor, leader, technical expert, or surrogate, but also by the client's abilities and motivations for movement in the relationship. According to Peplau, the major variable characteristics that influence the outcome of the interpersonal process are (a) the sequentiality of the interpersonal relation and (b) the nature of efforts of both actors in their collaborativeness or independence.

Independent variables that prescribe the need for the interpersonal process are psychobiological conditions such as needs, frustration, conflict, or anxiety that are detrimental to an individual's maturing process. Outcomes of nursing action as interpersonal process are oriented to the



total person rather than to specific aspects of the individual. The most significant departure in Peplau's ideas of nursing action from those developed by others is in the recognition that experiential growth from the interaction takes place not only in the client but also in the nurse. A resulting postulation is that a nurse will become increasingly proficient and effective in interpersonal relations with clients as the nurse's experiences in nursing action increase. However, this conceptualization does not consider the applicability of interpersonal process as a holistic modality of nursing action for a variety of problems a client may present and is limited in that way.

### **King's Model of the Interpersonal System (Theory of Goal Attainment)**

King's idea of nursing is based on the conceptualization of the nursing system as comprised of dynamic interacting systems. Within the dynamic interacting personal, interpersonal, and social systems, nursing occurs as actions, reactions, and interactions through which information is shared, relationships are created between the nurse and the client, and goals and the means for attaining the goals for the client's health are mutually established (King, 1981, 1990).

According to King, interactional aspects of nursing action accordingly encompass actions of perceiving, thinking, relating, judging, and acting against the behavior of individuals who come to a nursing situation. The client-nurse-interaction, the dyad interaction, is one type of interpersonal system in which several processes of the system are used to attain a goal. The processes can be summarized as follows (King, 1981, 1990):

- Perception process used to attain information about each other and the situation.
- Communication process for exchange and interpretation of information that each imparts in the interaction.
- Transaction process of sharing values, needs, and wants through interaction.
- Role process by which the nature of the relationship and modes of communication to be used in the relationship are identified.
- Stressor process of becoming energy responsive to the other.

These are expressible in variable terms to indicate the quality of nursing. Dependent variables of nurse-client interaction are goal attainment for the client, satisfaction, and enhancement of growth and development. Relationships among the different processes of interaction are hierarchical in that the perceptual process precedes communication, and both perception and communication affect the transaction. At the same time, the

processes of role and stressor influence all other aspects of interaction. King's model considers interaction as a descriptive, yet normative process, oriented to the client in a holistic way. Interaction is the fundamental mode of nursing action from which all other subsequent actions and transactions evolve for the attainment of goals.

As shown in these summaries, conceptualizations of client-nurse relations vary in these models with respect to the level of goal specificity (i.e., discrete/global), and in terms of prescriptive versus experiential orientation. These also vary in terms of their meaning orientation: Rogers's unitary human model with the philosophy of care orientation, Peplau's model with the nursing therapeutic orientation, and King's theory of goal attainment with the medium orientation. Theoretical explanations of the phenomena of client-nurse relations may take on various analytical forms as well. Client-nurse relation may be a medium through which a discrete activity is performed in order to correct some deviation in the client. In contrast, it may be the immersion of two individuals, a client and a nurse, in a total experience of interaction. Even at such extremes, the goal is always directed toward the client, any unexpected as well as expected changes in the nurse notwithstanding.

## **SELECTED CONCEPTUAL ANALYSES**

As in the client domain chapter, two concepts are examined in this chapter as examples of phenomena in the client-nurse domain. The concepts of negotiation and client-nurse alliance are presented. As stated in the earlier chapters, the main purpose of this section is to show how a first-level analytical approach is used to gain conceptual and empirical understanding of phenomena within the client-nurse domain. Each concept is analyzed with respect to (a) definitional clarification and conceptual meanings as reflected in the literature; (b) measurement and operationalization of concepts as a step toward an empirical analysis; and (c) the concept's relationships with other concepts that are important in nursing. The strategy and rationale for the conceptual analysis were discussed in detail in Chapter 2, and that rationale is adopted in this section for the analyses of negotiation and client-nurse alliance.

### **Negotiation in Nursing**

Negotiation between the nurse and the client as a phenomenon of client-nurse relations has been most frequently discussed in relation to patient compliance. Yet, negotiations are found in various nursing situations for some kinds of outcomes occurring in informal, incidental ways as well as in

a formal fashion. An informal, incidental negotiation may be found in a nurse-client exchange. For example, a nurse prods and cajoles a client who is in surgical pain to ambulate while the client implores and pleads against it, and yet after awhile they find a solution together that is agreeable to both, a negotiation. A formal negotiation in nursing may be found in contingency contracting in which the nurse and the client come to terms regarding the desired or targeted new behavior in the client and the reward in exchange for performance of that behavior, as described by Swain and Steckel (1981).

Negotiation in nursing analyzed in this section only refers to negotiation between nurse and client, rather than between client and family, nurse and nurse, or nurse and physician. Although such negotiations occur in nursing, these are not central to the nursing action perspective of the client-nurse system.

### *Definitions*

As stated in Webster's dictionary, negotiation is a conferring, discussing, or bargaining to reach an agreement in a generic sense, and it requires two parties, individuals or groups, in order for the phenomenon to occur. Strauss (1978) accepts the concept of negotiation as one of the possible means of "getting things accomplished" when two or more parties need to deal with each other to get those things done. Negotiation occurs as individuals involved in an interaction attempt to attain certain consequences or outcomes that are realizable only through dealings with another party or parties.

Negotiation may be oriented to many different kinds of consequences, some tangible such as labor contracts, and others intangible such as general understanding of each other's position or rules of behavior. Since negotiations take on different characteristics according to specific structural conditions of interaction, i.e., parties (persons), context (time and situation), and subject, negotiations in nursing are special cases of a general type in this respect.

Several characteristics differentiate negotiations in nursing from a general type. First, negotiations in nursing are between two parties having specific social roles, those of nurse and client, and occur in interactions characterized by these role relationships. Second, negotiations in nursing occur in health-care situations, in which most clients are more or less "captive," in the sense that they are restricted from walking away freely from the situations. Third, negotiations in nursing are oriented to consequences that are aimed at the client's benefit. Therefore, motivation for negotiation on the part of the nurse is assumed to be inherently "selfless" and other-oriented (i.e., client-oriented).

Negotiation in nursing is a rather new concept. Traditionally, clients and professionals are considered to have a one-sided relationship in which the distribution of power and knowledge between the two parties is unequal. Freidson's classical analysis of professional dominance in medicine indicates the use of power and expertise in influencing the patient's vulnerability (1970b). In recent years, however, there has been a growth of popular discussions about the role of the client in influencing the nature of the health care that one receives. With the emerging realization among health-care professionals that clients possess resources that can be used to recover and maintain health, and that the client's passivity in health care probably is not conducive to optimal health-care outcomes, collaborative models of professional practice have been proposed in various forms. In nursing, involvement of clients in their care has been a longstanding value, and has been emphasized more strongly in recent years along with the concepts of primary nursing and self-care. However, the processes by which negotiations occur in nursing and the nature of negotiations in nursing have not been conceptualized formally, nor have they been formally incorporated into nursing practice protocols.

Negotiation is a reciprocal, dynamic exchange between the nurse and the client in an effort to arrive at a mutually acceptable solution through a balanced use of expert knowledge, power, human sensitivity, and understanding. As a process, it is interactional and follows a sequence. The sequence of negotiation starts with an initial approach of two parties (a nurse and a client), in which recognition of the need for reconciliation or bargaining occurs. Exchange encounters, in which an option in solutions is not available or permitted, preempt the possibility of them advancing to negotiations.

From the initial state, the process of negotiation becomes diversified in its form and content according to the following six attributes, as described by Zartman (1976) and Strauss (1979):

1. The parties' previous experiences and encounters;
2. Patterns and outcomes of previous negotiations between the parties;
3. Distribution of actual and perceived power between the parties;
4. The values and costs at stake to both parties;
5. Expertise in the use of negotiation techniques;
6. Personal attributes used for influencing each other.

The final stage of the process culminates in the nature of negotiation outcomes that may be differentiated according to (a) outcomes' temporal limits, i.e., how long the agreement resulting from a specific negotiation is binding to the parties; (b) manifest and latent (tacit) meanings of the agreement; and (c) applicability and transferability of the agreement to other situations or its generalizability.

In nursing, then, negotiations occur when the nurse and the client realize difference(s) in opinions, approaches, or solutions regarding the client's nursing care. Negotiations may involve the goal of nursing care, the type of nursing care or procedures in nursing, and self-care. Negotiations in nursing may be oriented to solving conflicts that are only inherent in one specific situation or that have long-range implications, especially when they are related to lifestyle behaviors or long-term goals.

### *Operationalization*

Negotiation as it refers to a process is difficult to operationalize. A descriptive operationalization, at best, indicates the nature of negotiation. Because the process of negotiation is viewed to be influenced by the six structural aspects identified above, the actual operationalization needs to be made outside of these factors. Negotiation has been operationalized in terms of the time it takes to arrive at an agreement, the qualitative change that exists in the final agreement from the original wishes of both parties, and forms of interactional exchange used during the process, especially in terms of communication patterns.

In most studies of negotiation the units of analysis are: (a) whether or not negotiation is present in a situation; (b) how long a negotiation session lasts; or (c) what results from a negotiation session. Qualitative operationalization, in terms of good/bad, effective/ineffective, or promotive/destructive, has not often been considered.

### *Relationships With Other Concepts*

Zartman (1976) summarizes seven different approaches used in the literature to explain outcomes of negotiation:

- Evolutionary explanation,
- Contextual explanation,
- Structural explanation,
- Strategic explanation,
- Personality explanation,
- Behavioral explanation,
- Process explanation.

These seven approaches of explanation identify variables that influence or determine outcomes of negotiation. In nursing, the following may be applicable variables for studying negotiations according to these seven approaches.

*Effects of formality of negotiation.* It appears that formalized negotiation in nursing forces both the nurse and the client to enter into the process, while parties involved in informal negotiation may escape from the process without coming to agreement when the process becomes uncomfortable or stressful. Effects of delay or interruption may be significant for the provision of nursing care. Since there are no formal sanctions that either force or prescribe negotiated order in the client-nurse interaction, the form of negotiation in nursing should be considered in terms of client-care outcomes.

*Influence of the context of nursing care.* Contexts in which the nurse and client come together for negotiation vary according to type of health-care organization (ambulatory, acute care, long-term care, or home), type of nursing service system (for example, primary nursing or team nursing), power distribution, organizational philosophy, etc. Physical and ecological contexts may have influence on certain types of negotiations in clinical settings.

*Effect of the structure of the relationship.* Although tied to the contents in many ways, structures of nurse-client relationships refer to the patterns of communication and influence. Such factors as role-orientations of the nurse and the client and their evaluations of the relationships will influence the outcomes of negotiations.

*Effect of strategic elements.* Contingency contracting is a form of negotiation used in nursing in which negotiations focus on the values of "goods" to be forgone and the values of "goods" to be rewarded. Negotiations in nursing involve many different outcomes, ranging from a one-time action of turning in bed to stopping cigarette smoking, or to other major lifestyle changes. In negotiations, tradeoffs are often made among valued objects by the participants in an effort to arrive at an agreement. A personal value-structure will influence the way tradeoffs are made in negotiations.

*Personality explanation.* Successful negotiations may be attained more often when compatible personalities are negotiating in nurse-client relationships. Other personal characteristics such as affective orientation, independence, and locus of control may also influence negotiations in nursing.

*Influence of behavioral skills used in negotiation.* Nurses who have a broad behavioral repertoire, effective in interaction and exchange, may be more successful in nurse-client negotiations.

*Process explanation.* Negotiations may be studied in terms of ongoing process in a phenomenological sense. The symbolic interactionists' approach in the

explanation as to what occurs in the nurse-client negotiation will force us to examine negotiation as a special case in social interaction.

### **Client-Nurse Alliance**

Hopefully, the relationship that develops between the client and the nurse is one that is characterized by mutuality, alliance, and partnership. The nature of client-nurse interaction has an important impact on the way nursing care is provided and the achievement of desired client outcomes (Garvin & Kennedy, 1990; Kim, 1983). Such concepts as collaborativeness, coalition, mutuality, therapeutic alliance, and partnership, have been discussed in the literature as desirable characteristics that depict client-nurse relations in which sharing of knowledge, power, understanding, purpose, and feelings exist. However, the concept of client-nurse alliance or those concepts which seem to refer to the same type of phenomena have been described as both a state of client-provider interaction and a specific process of client-provider interaction that is oriented toward a client goal.

#### *Definition*

The phenomena of being in concert with each other between a client and a health-care professional have been conceptualized in many different ways in the literature. For example, Madden (1990) reviews the use of the term "therapeutic alliance" in relation to patient compliance, and indicates that often this concept refers to the interactive process between the client and the professional which is oriented to producing behaviors in the client that align with the therapeutic goals. Through the application of the hybrid model for concept development proposed by Schwartz-Barcott and Kim (1986, 1993), Madden arrived at the definition of the concept of therapeutic alliance as:

. . . a process that emerges within a provider-client interaction in which both the client and the provider are (1) actively working toward the goal of developing client health behaviors chosen for consistency with the client's current health status and life style, (2) focusing on mutual negotiation to determine activities to be carried out toward that goal, and (3) using a supportive and equitable therapeutic relationship to facilitate that goal.<sup>1</sup> (Madden, 1990, p. 85)

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1. Madden, B. P. (1990). The hybrid model for concept development: Its values for the study of therapeutic alliance. *Advances in Nursing Science*, 12, p. 85.

On the other hand, Zigmond (1987) suggests that mutuality between the client and the professional is achieved through the development of empathy that is possible through a dialectic fusion and merger of framework of experiences and a construction of common language oriented to empowerment, dignity, and self-responsibility. Jordan (1986) also emphasizes mutual empathy and mutual intersubjectivity as the key aspects of developing mutuality between two individuals. Henson identifies mutuality as “a connection with or understanding of another that facilitates a dynamic process of joint exchange between people” (1997, p. 80). Mutuality is viewed as a form of relationship between nurses and clients, in which they can be actively involved to work together for the attainment of mutually identified goals. Sullivan (1998) views the phenomena as coalition, which develops a spirit of cooperation and partnership building. Interpersonal coalition is viewed as a power-sharing partnership characterized by collaborative empowerment, mutual respect, trust, and mutual goals.

The literature is rich in describing the concepts of mutuality, collaboration, participation, coalition, and therapeutic alliance as referring to the aspects of client and provider relationships that pertain to sharing of feelings and orientation (mutuality), joining efforts to achieve goals (collaboration and participation), establishing a common power base (coalition), and building a mutual understanding of therapeutic goals (therapeutic alliance). However, these concepts, especially the concepts of mutuality, coalition, and therapeutic alliance, are viewed here as sub-aspects of the concept of client-nurse alliance, which is considered to refer to a broad conceptualization of client-nurse relationship encompassing the conjoining of two partners in terms of understanding, knowledge, power, and goals.

The concept of client-nurse alliance is viewed here to be a property concept depicting a state of relationship that is oriented to having a conjoint front. As stated in Webster's dictionary, *alliance* is a state of being united of interest in which two parties establish relationships for mutual objectives. Empathy, mutuality and coalition in client-nurse relations are the basis for *alliance* and encompass not only an understanding of and commitment to the client's needs and goals but also building of concerted power-base and sharing of knowledge. However, the *alliance* in a health-care context must be considered as a state in which the major orientation of the alliance is for the client's benefit. Hence the alliance results from interactive processes which are oriented to helping clients to attain health-care goals.

### *Operationalization*

As there is no specific piece of work in the literature that specifies the concept of client-nurse alliance as defined above, operationalization of the concept must be considered by consolidating the conceptualizations of



mutuality, coalition, and therapeutic alliance. The key empirical aspects of client-nurse alliance then include the following:

- A feeling of mutual understanding;
- An mutual appreciation of possibilities and limitations that exist in the situation of nursing care;
- A culmination of mutual acknowledgement of the client's health and health-care goals;
- A sharing of power and knowledge for the client's health and health-care goals;
- An achievement of a joint "voice" for the client's health and health-care goals.

This is an empowered state both for the client and the nurse in relation to adversities that may arise in health-care situations, making it possible for the movement toward the attainment of goals for the client.

### *Relationships With Other Concepts*

Although the client-nurse alliance has not been studied specifically in relation to other concepts, the concepts of mutuality, coalition, and therapeutic alliance have been identified as having effects on attainment of a goal that is satisfactory to involved parties (Henson, 1997), patient satisfaction (J. A. Hall, Roter, & Katz, 1988), compliance with therapeutic regimes (Barofsky, 1979; and Deering, 1987, for example), and positive client outcomes (Frieswyk et al., 1986). In addition, these concepts have been viewed to be influenced both by interactional processes and the nature of commitment that exists among the participants of relationships.

Theoretically, then, the concept of client-nurse alliance must be examined in relation to (a) how such a state as the client-nurse alliance may develop; and (b) what impact the client-nurse alliance has on the client. Explanation of the client-nurse alliance can be posed by considering the participants' characteristics such as the willingness to share, openness, empathy, power dynamics, and comfort in self-disclosure (Jordan, 1986). In addition, it can also be posed by focusing on the nature of interactional processes that result in client-nurse alliance. These include such processes as empathic interaction (Jordan, 1986), dialectical fusioning in which shared meanings and common language get established (Zigmond, 1987), equalizing of power differentials (Henson, 1997), interaction of mutual support, negotiation, and active participation (Madden, 1990).

Possible consequences and impacts of the client-nurse alliance need to be thought of from the perspective of clients. Since implicitly the alliance is desired for the client's health goals and health-care outcomes, the theo-

retical significance of the client-nurse alliance resides in the concept's relationship to client outcomes. The client-nurse alliance may influence at the primary level the kinds of decisions made on behalf of patients not only by nurses but also by other health-care professionals by affecting negotiation and collaboration. Such an effect may in turn impact on the ultimate client outcomes of care. In addition, the client-nurse alliance may create a sense of empowerment in the client. The concept refers to an important aspect of client-nurse phenomena, and should be fully developed theoretically.

### SUMMARY

The ideas presented in this chapter focus on phenomena that exist in situations where a client and a nurse are together. It is difficult to conceptualize phenomena in the client-nurse domain, distinctively distinguishing them from belonging to the client (the client domain) and to the nurse (the practice domain). Phenomena in the client-nurse domain must be considered analytically distinct from the phenomena in the client and the practice domains, by viewing them to belong to both the client and the nurse in the context of a relationship. While what are felt, experienced, and acted belong empirically to the separate actors in an interaction, they are relational phenomena because their existence is not possible without the coexistence of the actors in the context of an interchange.

I have proposed an analytical schema to differentiate phenomena of the client-nurse domain as contact, communication, and interaction types. While this schema is useful to partition out different aspects of client-nurse relations analytically, there may be a strong opposition to such particularization from holistic scholars. This schema is proposed as a way to clearly delineate different aspects of client-nurse relations and to think theoretically from a pluralistic perspective. This schema points to the possibility of focusing on specific ontological aspects of human relations in developing theoretical ideas about client-nurse phenomena.

In addition, three meaning orientations of client-nurse phenomena have been identified as (a) the medium orientation, (b) the therapy orientation, and (c) the care orientation. Viewing client-nurse phenomena from these three orientations allows conceptual and theoretical examinations of them from different perspectives of impact.

The major thrust in conceptualization for the client-nurse domain is to view client-nurse relations as human-to-human engagements with a specific emphasis on the features of client and nurse as participants and with the consideration of nursing context as the locus of occurrence. This thrust makes the knowledge development from a nursing perspective for the client-nurse domain unique and essential.

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# 6

## *The Practice Domain of Nursing*

*. . . making and acting are different. . . ; so that the reasoned state of capacity to act is different from the reasoned state of capacity to make. . . . The origin of action—its efficient, not its final cause—is choice, and that of choice is desire and reasoning with a view to an end . . . and such an origin of action is a man.*

—Aristotle, Book VI

### OVERVIEW

This chapter presents theoretical ideas about phenomena of nursing work, particularly located in the nurse as she or he is engaged in delivering nursing care. I propose a view of nursing work to encompass what nurses do and experience in clinical situations in relation to clients and in addressing clients' problems that are subject to nursing attention. Nursing work refers to nurses' practice that includes the cognitive, behavioral, social, and ethical aspects of professional actions and activities performed and/or experienced by nurses in relation to patient care. This is a somewhat limited view of nursing work, disregarding those aspects of what nurses do as organizational role players such as making out unit assignments, working with the unit budget, or working on a committee. Discussions regarding the conceptualization of nursing practice focus on the need to develop systematic and theoretical ideas about the nature of phenomena in the nurse as she or he is practicing nursing. A framework to analytically delineate two aspects of nursing practice is presented as a way to examine the complex nature of practice. A separate section is devoted to discussion of issues related to the concept of nursing diagnosis. Recent developments in the area of nursing diagnosis make it necessary to give an exposition on theoretical considerations regarding the concept and referents of nursing diagnosis, as well as on the role of the concept in theory development in nursing.

The last section offers conceptual analyses of the phenomena of clinical expertise and aesthetics of nursing practice as examples of the phenomena in the practice domain.

## MEANINGS OF NURSING PRACTICE

This domain embraces what and how we, as nurses, carry out and perform those actions we call "nursing." Our interest lies in understanding and explaining nursing practice and in improving the way we practice nursing.

As discussed in Chapters 4 and 5, many phenomena within the client and client-nurse domains are of critical import to nursing; yet it is theoretical development for the domain of practice that is essential in order to make nursing practice scientific. It is with the knowledge of this domain that we can come to a full understanding of how nurses make the difference in clients through nursing practice. Obviously, theoretical concerns for this domain are determined by a definition of nursing adopted in the study. If we consider nursing as a "particular way" of managing human health affairs, it is precisely this "particular way" that requires definition and by which relevant phenomena are identified for scientific explanation. Through scientific explanations of what goes on in the world of "nursing practice," we are able to systematize our ways of acting and to prescribe specific actions to fit specific requirements. The ultimate objective of the science of nursing necessarily focuses on this ability to prescribe nursing actions.

In other words, our need to understand and explain scientific problems that reside in the domains of client and client-nurse are for this ultimate purpose as well. More specifically, only those theoretical postulates and empirical questions that have ultimate significance for the contents of nursing work can be considered to be within the nursing frame of reference, and require scientific answers from the nursing angle of vision. The starting point, then, for a scientific study of nursing is in thinking of nursing activities as "purposive."

In ordinary nursing terminology, nursing practice refers to many different things and is often used interchangeably with "nursing skills," "clinical practice," or simply "nursing." Most often it is used, in a comparative sense, on a par with nursing theory and nursing research. Nursing as a discipline is viewed as having three structural components in this usage: theory, practice, and research. In addition, by definition, nursing practice may refer to the phenomena of the nursing profession, the phenomena that exist with the individual nurse in everyday practice in general, or the phenomena of specific action performed by a nurse in a given specific situation. Nursing practice can also be specified according to the type of nursing action, such as in nursing practice of communication or nursing practice of preopera-

tive teaching. It also may be categorized according to client characteristics, such as nursing practice for children, nursing practice for healthy adults, etc. Departing somewhat from such common sense uses of the term, the conceptualization of nursing practice specified as nursing work here refers to phenomena related to what nurses as agents of nursing work do and experience.

In a generic sense, practice is considered as activities, both mental and behavioral, that are carried out by individuals in a specified situation. The term is used differently from that common usage of "practice," as in "You will improve with practice," in which it is synonymous with "drill." A theoretical conceptualization of practice as used in nursing practice or professional practice is closely linked with another common usage, as in "Your idea is a good one, but it won't work in practice."

In proposing situation-producing theory as the proper form of nursing theory, Dickoff and James (1978) implicitly equate practice with activities that "produce situation." To them, practice is the vehicle by which a desired situation in nursing is produced, and is theoretically influenced by goal content, prescription, and a survey list. Theoretically, a survey list infers situational variables relative to prescribed nursing activity. In turn, they also conceive that practice, the activity performed in reality, is the base for descriptive theories (factor-isolating theories) as well.

In a similar point of view, Wilson (1977) proposes that the grounded theory approach advanced by Glaser and Strauss (1967) may be adopted to develop theories that are applicable to explaining and predicting processes of nursing practice. Beckstrand (1978a, 1978b) also defines practice as a class of phenomena that includes all actions that bring about changes in an entity for realization of a greater good. Phenomenologists have considered practice as experiences in clinical situations, having subjective meanings and contextual significance (Benner, 1984). On the other hand, Agyris and Schön (1976b) define professional practice as a sequence of actions undertaken by a person to serve others who are considered clients. In this sense, the term "practice" consists of the following characteristics:

- Practice as a phenomenon is a broader term than action but encompasses action; its conceptualization is based on a set of assumptions.
- Practice presupposes the presence of a mental image of what will be or need to be enacted. It assumes that a mental picture, a cognitive understanding, or knowledge is antecedent to action.
- Practice is situation-specific.
- Practice is social in that it belongs to actions associated with being a social agent.
- Practice is ethically and morally entrenched as an aspect of a human agent's life in the Aristotelian sense that it refers to life forms of free agents in an ethical sense.



The concept of "practice" including something other than what the nurse does with the client has been proposed by several authors in a general perspective (Benne, Chin, & Bennis, 1976; Bourdieu, 1977, 1990; Freidson, 1970a). The concept of practice that refers to the cognitive aspects of professional actions, along with the behavioral and social aspects, appears to be a significant departure from earlier ideas about professional practice in which professionals are presumed to behave according to what they know. Variability in professional actions related to the professional's use of knowledge and cognitive processes that are used for translating "what one knows" to "what one does" is specifically at the core of questioning about the concept of practice. And it is precisely this notion that is vital to scientific study of nursing actions within the practice domain. This focus of theoretical questioning is not interested only in "what" the nurse does with or for the client but more importantly in "*how the nurse arrives at given action choices*" and "*how such action choices turn into human activities.*"

Nursing practice in general is accepted as a set of activities performed by a nurse (an agent) toward the good of the client in specific situations. The concept involves: (a) knowledge of how to arrive at "good" outcomes of nursing; (b) knowledge of what is "good" for the client; and (c) performance of prescribed nursing actions in reality. The goal of action is always referable to the nurse as the originator of "provisions" for the client. The actions in nursing practice are special types of human enactments performed in the context of the service requirements of a client. Practice exists in a given nursing situation as a discrete case apart from all other cases, and is primarily oriented to the values that define what is normatively good for the client.

Donaldson and Crowley (1978) indicate that nursing scholars generally are in agreement on what nursing should be concerned with, and Riehl and Roy (1980) found commonalities among five nursing models examined by them with respect to the characteristics of interventions prescribed as nursing. For example, they found that nursing interventions prescribed by these nursing models allow for the client's expression of feelings, are aimed at maintaining whatever independent behaviors are possible for the client, and provide new ways for increasing the client's independence (Riehl & Roy, 1980). Furthermore, there is a movement toward developing a common conceptual scheme for nursing, beginning with the works of the North American Nursing Diagnosis Association on nursing diagnosis and also with the work to systematize nursing interventions (Bulechek & McClosky, 1992). Nevertheless, fuzziness still exists in conceptualization, especially in terms of defining the boundary within which actions are classified as nursing. This fuzziness can be attributed to the fact that most of what nurses do is not significantly different from what ordinary people do in their everyday lives. What are different are not the acts themselves, but

when, how, and why they are carried out. In nursing, the same acts take on special meanings in their enactment.

A nurse sits with a dying patient as a wife sits with her dying husband. The “act” of attending the last hours of a dying person may appear the same in these two occasions. However, the meanings of that act to the “attendees” as well as to the client would be different, and the actual contents of the act of attending may be very different in behavioral, affective, informational, and technical senses. Theoretical efforts in nursing, then, need to focus on how such ordinary actions take on professional, nursing meaning and in what ways they become different from ordinary human actions. In a nondeliberate effort to make nursing actions “unordinary,” that is “technical,” the current nursing world has become preoccupied with bringing into the core of nursing those actions that require competent use of technological instruments. Though this preoccupation results from the current use of technology in health care, technology has to be considered as the tools for nursing, not the content itself. The core of nursing actions within nursing work resides in the human-to-human actions performed by a professional nurse for goals that are oriented to the client’s health-related affairs.

For theoretical thinking in this chapter, then, I propose a definition of nursing practice as acts of a person under the conscious aegis of “nursing.” Although this definition appears to be circular, the labeling of the act as “nursing” is necessary for both subjective and objective endorsement of the actions within nursing practice in a social sense. Because nursing is a social role, the content of the role, i.e., the performance of it, has to be designated formally as belonging to that role. Since acts enacted in a given role may be different in many ways, it is difficult to describe the acts without enumerating every kind. It is more of a conceptualization issue rather than a definitional one to be concerned with what kinds of acts are of a nursing type.

By this way of thinking, then, the nursing act takes on a specific meaning with respect to its locus of occurrence, that is, in the nurse agent. Hence, nursing acts include those performed in the presence of a client or by the nurse in solitude, away from clients but on behalf of them, such as consulting with physicians, conferring with family members, or negotiating with referring agencies in behalf of the client. These certainly are behaviors that need to be included as appropriate nursing actions. In addition, nursing practice has two philosophical orientations in its relationship to nursing clients. Nursing clients represents two aspects of attention for nurses: clients’ specific clinical problems and clients as human persons. Nurses must address “problems” the client experiences in the health-care situation with nursing therapeutics and at the same time deal with the client as a human person. Hence, nursing practice must coordinate two

separate philosophies of practice: *the philosophy of therapy* focusing on clients' problems and *the philosophy of care* focusing on clients as human persons in totality.

As shown in Figure 6.1, the philosophy of therapy aligns practice with goal-oriented and strategic actions that are aimed at solving or attending to the client's specific problem(s). Clients' problems such as fatigue, pain, dyspnea, cognitive deficit, immobility, or noncompliance are viewed as targets requiring certain sets of therapeutic actions, interventions, or strategies. This occurs as an aspect of nursing practice from the philosophy of therapy orientation with the major aim being remedy and treatment. On the other hand, the philosophy of care orients nursing practice involving the whole of clients' experiences as human persons. The focus of attention for nursing practice with this orientation is not the clinical problem(s), but is the human beings in specific situations. Nursing practice with this orientation involves approaches to clients as human persons situated in the service settings of nursing. The major aim with this orientation is in providing "care" to clients as human persons with specific and unique histories, personhood, and experiences. Nursing practice, then, must coordinate both of these philosophies.

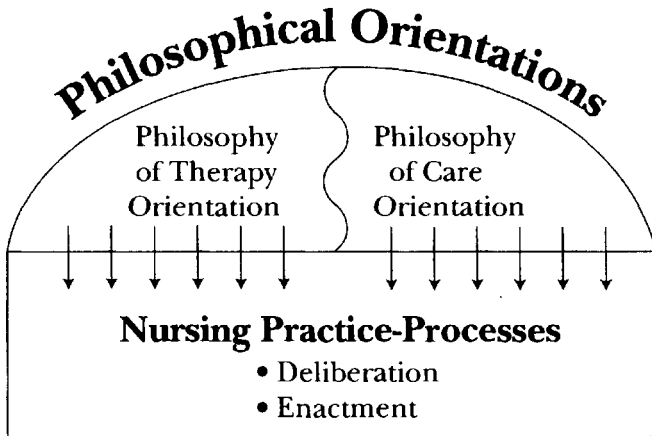
### **A FRAMEWORK FOR THE PRACTICE DOMAIN<sup>1</sup>**

As discussed in the preceding section, nursing practice conceptualized as such points to a rather complex picture. It involves both mental and behavioral aspects of actions which are interlinked with the agent of practice, the client situation, the context of practice, and the considerations of nursing perspectives.

Nursing practice encompasses actions that are performed by nurses alone without the physical presence of a client or with the physical presence of a client involving or not involving the client actively in the actions. Yet the goals of such actions are oriented to the client always. These actions refer to intellectual or cognitive as well as behavioral actions involved in providing nursing care to clients. The clearest example of such actions is what we call "nursing process." The concept of the nursing process refers to a set of intellectual and behavioral actions performed by a nurse in systematizing actual nursing-care actions. The purpose of the nursing process and relevant features of the nursing process are inherently tied to the client's problems; nevertheless, the actions of the nursing process belong

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1. This section is an expansion and elaboration of Kim, H. S. (1994). Practice theories in nursing and a science of nursing practice. *Scholarly Inquiry for Nursing Practice: An International Journal*, 8, 145-158.



**Figure 6.1** Philosophies of therapy and care as the frame for nursing practice.

to the nurse agent. As an agent, the nurse performs the following activities within the process:

1. Gathers information;
2. Makes judgments about the nature of information available;
3. Arrives at problem statements based on many information networks;
4. Examines available and possible kinds of strategies for the solution of problems;
5. Selects certain types of interventions as appropriate and effective;
6. Carries out those interventions, adopting scientifically selected operational procedures;
7. Evaluates outcomes of the intervention;
8. Modifies the existing information base on the client as well as the future *modus operandi* regarding the solution of the client's problems.

The nursing process is the most global way of conceptualizing nursing practice, for it includes nearly all aspects of nursing's intellectual and behavioral processes. However, this view of nursing practice within the frame of nursing process is linear and does not take into account the complex and comprehensive features inherent in the actions of nursing practice. The framework presented below is a way to elaborate on the complexity of nursing practice. This framework is an elaboration of the work presented earlier (Kim, 1994).

The complex nature of nursing practice indicates that the practitioner is involved in a set of actions—mental activities and enactment activities in

a specific situation of practice encompassing aspects that pertain to: (a) the client, (b) the context, (c) the agent-self, and (d) the nursing frames. Nursing practice is a complex series of actions that can be partitioned into two dimensions: the deliberation dimension and the enactment dimension as shown in Figure 6.2.

The deliberation dimension involves the practitioner engaging in mental activities to develop a program of action, manifestly or latently (that is, consciously or unconsciously), as analytically separated from the enactment of action. It focuses on the assessment the practitioner makes of the situation, the practitioner's judgement about the assessment, and the arriving at decisions as to what the nurse should do or needs to do in order to meet the demands of the situation. This may involve a situation with a specific, single problem to be addressed, or one that is entrenched with coexisting, multiple problems and issues requiring decisions not only for problem solutions, but also for coordination of judgments and choices. Deliberations are viewed to be analytically connected to a network of five structural units: (a) aspects of client, (b) aspects of nurse-agent, (c) nursing goals, (d) nursing means, and (e) context of nurse-agent.

The enactment dimension is *analytically* separated from the deliberation dimension, and involves acting and behaving in a specific practice situation involving the practitioner, the client as a recipient of service as well as a responding human-other, and the contextual frames within which the actions take place. In this phase, nursing action is analytically connected to three structural units: (a) the client, (b) the nurse-agent, and (c) the context of nursing action. Enactment is bound by time, space, and physical locality in relation to the acting agent, i.e., the practitioner. Although it is conceptualized to be analytically separated from the deliberation dimension, it does not mean that the enactment dimension does not have the mental elements, as human actions cannot be considered devoid of mental content. Separating this dimension from the deliberation dimension allows us to examine nursing practice for what is actually done and accomplished concretely in clinical situations. Although I conceptualize these two as analytically separate dimensions, the occurrence of these dimensions is not necessarily linear and connected sequentially in actual practice situations. This means that a nurse may be engaged in a sequence of activities in a given clinical situation, which are all deliberative as specific events, or that a nurse may be engaged in clinical events of enactment in sequence.

### **The Deliberation Dimension**

Deliberation in nursing practice refers to phenomena in the nurse-agent as she or he is mentally and intellectually addressing the clinical situation in anticipation of actual delivery of nursing services. Aristotle discusses the

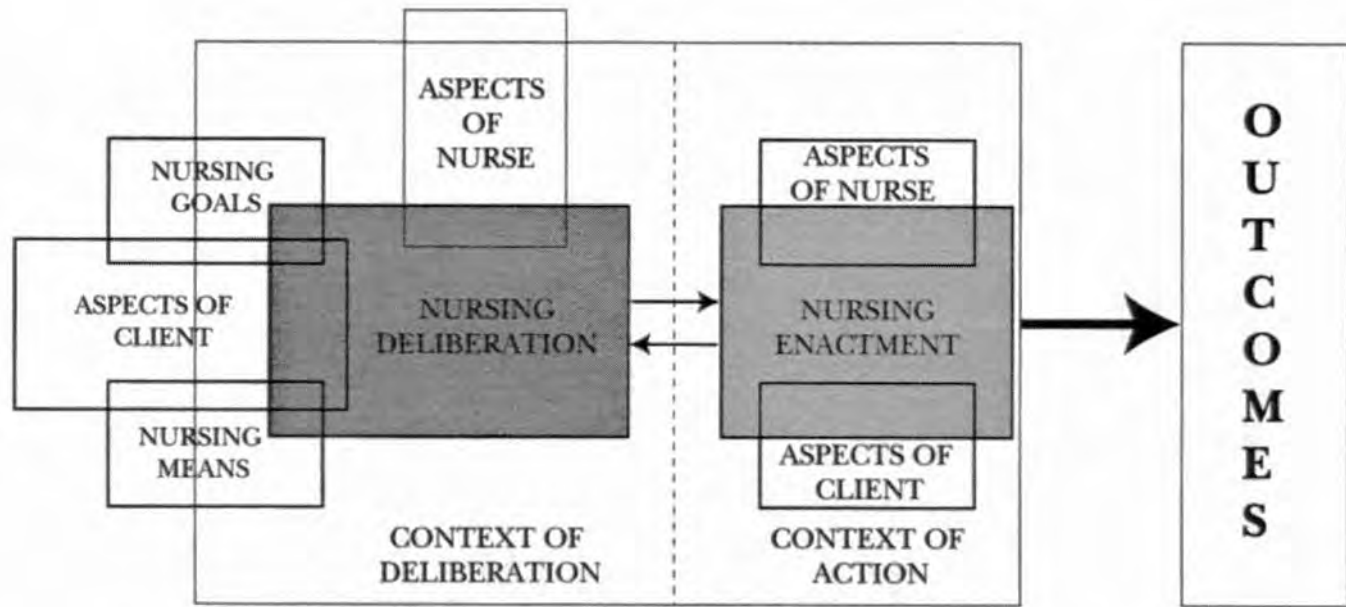


Figure 6.2 Analytic representation of the conceptualization of nursing practice.

meaning of deliberation in relation to practical wisdom (prudence or phronēsis) as:

Practical wisdom on the other hand is concerned with things human and things about which it is possible to deliberate; for we say this is above all the work of the man of practical wisdom, to deliberate well, but no one deliberates about things that cannot be otherwise, nor about things which have not an end, and that a good that can be brought about by action. The man who is without qualification good at deliberating is the man who is capable of aiming in accordance with calculation at the best for man of things attainable by action<sup>2</sup>

Hence, deliberation is connected to action and is oriented to a result. The nurse in the deliberation dimension (a) considers the meaning and nature of information; (b) processes a given set of information vis-à-vis existing relevant structures; (c) surveys and draws on both the public and personal knowledge arenas; (d) contemplates about future courses of action, establishes intentions; and (e) makes judgements and choices about conceptual and action decisions. The nurse in this dimension of practice may be involved in such mental activities knowingly or unknowingly, but regardless, she or he is engaged in deliberations by involving five sets of structures.

*The structure related to aspects of the client* is the focal framework upon which the significance of nursing for that client is established situationally, that is, for a given situation or an event, and holistically for that client's nursing care. This structure encompasses those elements that are related to the nature of specific problems confronting the client, that provide the client with meanings and perceptions about the problems and situations, and that are related to personal resources present and available in the client. As shown in Figure 6.3, these elements can be differentiated as general or specific, identified in terms of health problems and health-related experiences, personal history, motivation and commitment, attitudes, knowledge, and capacity. This structure thus defines the elements, which the nurse must bring into a varying focus in deliberating about a program of nursing service. It is the major frame that provides information to the nurse during this phase.

*The structure of nurse-agent* refers to the aspects of variability in the nurse which are possible for activation in the process of deliberation. As shown in Figure 6.3, it is organized into two aspects of the practitioner (i.e., the general and specific situation-bound) with respect to six categories:

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2. Barnes, J. (Ed). (1984). *The complete works of Aristotle: The revised Oxford translation*. Vol. 2. (pp. 1802). Princeton, NJ: Princeton University Press.

Structure of Client		Structure of Nurse	
General Aspects	Specific Aspects	General Aspects	Specific Aspects
Problems and Their Meanings		Personal Frames of Reference	
Motivation/Commitment		Motivation/Commitment	
Values and Value Standards		Values and Value Standards	
Knowledge and Experience		Knowledge and Experience	
Capacity/Abilities		Capacity/Competency	
History and Contextual Grounding		History and Contextual Grounding	

**Figure 6.3 Structures for deliberation: Aspects of client and nurse.**

1. The frame of reference the nurse is adopting in providing personal meanings regarding nursing practice in terms of standards, commitments, locus of interest, philosophy, and world views;
2. Motivation and feeling states;
3. Value commitments from the ethical and moral perspective that guide the nurse’s practice;
4. Personal knowledge existent in the nurse both as organized and unorganized entities;
5. Experiential history both as a nurse and a human being;
6. Personal capacity for practice as resources such as energy, skills, and modes of thinking.

The structure of nurse-agent is critical in the process of deliberation since the professional practice requires the agent’s primary focus on others (i.e., clients) and other-directed actions (i.e., actions for the benefit of clients). The practitioner has to negotiate with him- or herself regarding the paradox that ensues with the coexistence of this other-directedness in orientation and the fundamentally self-centered nature of human actions. It means that the practitioner in having the goals of practice embedded in the client engages in the phase of deliberation both with and without the conscious recognition of the extent to which the nurse’s own aspects are involved. The elements identified within this structure are what the nurse brings into the nursing practice setting, and are basically attained, accumulated, and culminated through professional socialization and experience. Their mobilization in and impact on the processes of this phase are selective and variable in different clinical situations.

*The structure of nursing goals*, as shown in Figure 6.4, encompasses the goals inherent in a clinical situation, both latent and manifest, and is dif-



ferentiated on two dimensions: scope and orientation. Goals in clinical situations may be general from the nursing perspective such as promotion of health or attainment of client autonomy, and specific to situation and problem on hand such as maintenance of airway patency or attainment of competence in diabetic self-care. In addition, goals may exist differently from the perspectives of the client, the nurse, and others such as family members and other health-care professionals. For any given clinical situation in which nursing actions must take place, there exists a set of goals identifiable as a varying combination of the generalized and specific goals for the client, the nurse, and others. There may be alignment or misalignment among these goals, as the client, the nurse, and others such as family members could be oriented to primarily different aspects of the client's well-being, different priorities, or different motivational structures. How the nurse becomes cognizant of and puts emphasis on different sets of goals in deliberation is one of the problematic aspects of the process of deliberation.

*The structure of nursing means*, in a similar manner to the structure of nursing goals (as shown in Figure 6.4), is differentiated into two aspects: the scope of application and availability. Nursing means include strategies of nursing applicable in clinical situations to bring about some ends that are relevant to nursing practice. Nursing means from the view of the scope of application can be general in that the target for the application is the client as a human person, or specific to a situation or problem. Nursing means can be available in the public arena mostly as validated forms of strategies, or privately to given nurses attained mostly through experience, or as conjectures existing only as tentative ideas. The nurse-agent thus also brings a varying combination of means emerging from this structure into the process of deliberation. The process therefore must involve juxtaposing the elements within this structure with the elements of the structure of nursing goals with

Structure of Nursing Goals		Structure of Nursing Means	
General Goals	Specific Goals (Situation or Problem Specific)	General Means and Approaches	Specific Means or Strategies
ORIENTATION:		AVAILABILITY:	
Goals defined by Client		Repertoire at Large	
Goals defined by Nurse		Personal Repertoire	
Goals defined by Others		Conjectured Means and Approaches	

**Figure 6.4 Structures for deliberation: Aspects of nursing goals and nursing means.**

a view toward establishing a program of actions that makes the practice coherent, meaningful, strategically effective, and sensible.

*The structure of the context of nurse-agent* is the background upon which the nurse's deliberation is processed and refers to elements in the physical, social, and symbolic spheres of the practice environment. Deliberation takes place in the context of practice situation that contains not only the environmental entities but also the meanings of such entities. Noise, conflicting demands existing in the situation, value structure or culture of the situation, an institutionalized form of practice, level of institutional integration of roles, a lack of staff, and being assigned to several complex clients are examples of the elements within this structure that impinge on the deliberation process.

Deliberations involving these five structures are not only oriented to making choices for actions to be pursued but in doing so the present situation of deliberation is contiguously linked to the future in association with the chosen actions. Normatively, it is expected that a practitioner be engaged in the deliberation phase with a commitment to achieving fidelity of strategy, competent delivery, timeliness and relevancy of program, and efficacy of outcomes. This view points to the idea that the processes in this phase necessarily need to be rational and prescriptive; however, the phenomena as they exist in actual practice may be more haphazardly or intuitively organized than programmatic or intentional.

Clinical decision making, clinical judgment and diagnosing, information processing, surveilling, priority setting, and nursing-care planning are examples of phenomena in this phase.

### **The Enactment Dimension**

The enactment dimension refers to the phase at which the nurse performs activities in nursing and the phenomena of enactment are conceptualized in terms of human action being carried out and performed behaviorally by a nurse-agent in the context of nursing care. If one believes that the reality of enactment has a direct and complete causal relation with intention, and intentions are a sufficient explanation of enactment, then it would not be necessary to consider this dimension separately from the dimension of deliberation. However, I believe this view is not tenable from the theoretical considerations, but also because the conceptualization of human action within the disciplines of human service practice requires us to consider human action in a much more complex way. Enactment in human service practice not only is realized by the nurse-agent, but also invariably involves another human being (the client) that is also an engaged, enacting agent. In addition, certain aspects of nursing practice require deliberation as separate activities of the nurse. Furthermore, the connections between delib-

eration and enactment are not uniform and linear, and can take various forms according to differences in the nature of the practice setting. For example, a critical care situation often requires on-the-spot, immediate action responses, while in a home-care setting enactment of nursing actions may be separated from deliberation by a prolonged time lag. Or, a nurse may do a deliberation while the enactment needs to be done by a third person through delegation of actions.

Facts of enactment are nonetheless time-bound, possibly have multiple meanings, and are fleeting, as depicted by Bourdieu (1990) in describing game playing as an example of practice.

A player who is involved and caught up in the game adjusts not to what he sees but to what he fore-sees, sees in advance in the directly perceived present. . . . He decides in terms of objective probabilities, that is, in response to an overall, instantaneous assessment of the whole set of his opponents and the whole set of his team-mates, seen not as they are but in their impending positions. And he does so "on the spot," "in the twinkling of an eye," "in the heat of the moment," that is, in conditions which exclude distance, perspective, detachment and reflection. He is launched into the impending future, present in the imminent moment, and abdicating the possibility of suspending at every moment the ecstasies that project him into the probable, he identifies himself with the imminent future of the world, postulating the continuity of time.<sup>3</sup>

Enactment is connected to deliberation but is accommodated by on-the-spot adjustments that connect what exists at the present of enactment to the immediate future. We feel the urgency of human enactment, as it is bound to the present and future at the same time but becomes the thing of the past instantaneously. We also feel the immediacy of human action in the human agent's engagement, as well as the finality of action once it is enacted. Action science proposed by Argyris, Putnam, and Smith (1985) and the notion of reflective practice advanced by Schön (1983) examine the reasons for practitioners' failure to achieve intended consequences in their practice and possible disparity that exists between what practitioners believe they are doing and what they actually do.

Enactment is conditioned by three structures: (a) aspects of nurse-agent, (b) the client, and (c) context of nursing action. As an enactor in this phase, the nurse brings into the situation of enactment the agent-self with all of its capabilities and limitations, desires and hesitations, sensibility and

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3. Bourdieu, P. (1990). *The logic of practice* (R. Nice, Trans.). (pp. 81–82). Stanford, CA: Stanford University Press.

hardiness, habits and quirks, history and background, and beliefs and knowledge. Such aspects of the nurse accommodate how actions become actualized, by making them good or bad, skillful or cumbersome, with passion or without, coordinated or disjointed, organized or disorganized, efficient or inefficient, ethical or unethical, and artful or mundane.

The client, often as one co-engaged in enactment of nursing actions, brings into the situation all aspects that make her or him a specific individual, engaged in the specific situation of his or her life that are ongoing. Through the client's responses, behaviors, and presence, enactment is also accommodated as nursing actions are being performed in clinical situations.

The contextual aspects of the situation of enactment are the physical, social, and symbolic aspects of the environment that are bound to the enactment in a spatiotemporal sense, both immediately and remotely but significantly. The context of enactment both confines and allows forms of nursing actions that are possible. Nurses, regardless of their deliberation, need to adapt to the situational contingencies in performing nursing actions. For example, a nurse may "end up" delegating a specific action to a health-care assistant even though her intention was to do it herself. A nurse may need to stop teaching a patient about diabetic self-care in mid-stream, as she is being paged for an immediate attention.

Technical competence, nursing aesthetics, delegation behavior, nursing documentation and nursing description, ritualized practice, caring, ethical practice, and tailoring nursing actions are examples of phenomena in the practice domain with a focus in the enactment phase.

### **Phenomena in the Practice Domain in a Holistic Sense**

This differentiation advanced in the preceding section allows us to view nursing practice analytically with a phase orientation, partitioning out phenomena that are particularly mentalistic from those that are action-oriented. This, for analytic purposes, enables us to look toward developing theories, which are oriented to characteristically different types of human processes. However, many human experiences and human practice phenomena are so totally, intricately, and pandimensionally interwoven with both mental and action aspects that it is impossible to partition them even analytically with a phase orientation. Such phenomena require more holistic conceptualizations. For example, the concept of innovation adoption refers to both mental and action-oriented phenomena of knowledge utilization. Similarly, the concept of clinical expertise as advanced by Benner (1984) has a holistic orientation. In addition, many of the professional role-related phenomena in the nurse relevant to clinical nursing practice are not amenable to the phase conceptualization. These include such phe-

nomena as role-overload. Table 6.1 shows examples of phenomena in the practice domain.

These are beginning conceptualizations of many aspects of phenomena in the practice domain. It appears that it is useful to adopt two distinct approaches to conceptualizing phenomena in the practice domain, as in other domains. The first approach is a holistic one by which the total process is perceived as nursing practice or nursing process. The second approach is a particularistic mode by which many phenomena are distinctly perceived as separate concepts.

Conceptualization of phenomena in the practice domain either in the holistic or the particularistic approach points up two distinct characteristics of the phenomena: quality of nursing action and methodological difference in nursing action. Hence, for example, the phenomena of the nursing process can be considered for scientific explanation with respect to the qualitative nature (e.g., good/bad; effective/ineffective; or effi-

**Table 6.1** Examples of Concepts in the Practice Domain

ANALYTIC FOCI	LEVEL OF CONCEPT DESCRIPTION	
	Holistic	Particularistic
Focus on Deliberation Phase	<ul style="list-style-type: none"> <li>• Nursing care planning</li> <li>• Information processing</li> <li>• Clinical decision making</li> </ul>	<ul style="list-style-type: none"> <li>• Clinical inferencing</li> <li>• Nursing diagnosis</li> <li>• Prioritization</li> <li>• Surveilling</li> </ul>
Focus on Enactment Phase	<ul style="list-style-type: none"> <li>• Nursing aesthetics</li> <li>• Caring</li> <li>• Ethical practice</li> </ul>	<ul style="list-style-type: none"> <li>• Technical competence</li> <li>• Delegation</li> <li>• Nursing documentation</li> <li>• Nursing description</li> <li>• Tailoring</li> <li>• Nursing assessment</li> <li>• Ritualization</li> </ul>
Holistic Focus	<ul style="list-style-type: none"> <li>• Nursing process</li> <li>• Knowledge utilization</li> <li>• Innovation adoption</li> <li>• Clinical competence</li> <li>• Clinical expertise</li> <li>• Role overload</li> </ul>	

cient/inefficient), and to the techniques of adoption (i.e., sequential application; frequency of use; time of use; independent/team approach). Nursing decision making can also be thought of in these two ways: (a) good/bad, appropriate/inappropriate, or adequate/inadequate, which are qualitative aspects of the decision making, regardless of actual techniques adopted in the process; and (b) adoption of specific techniques of decision-making such as optimization, "satisficing," or balance techniques.

### **Modes of Investigation for the Practice Domain**

Nursing scientists have to be in a somewhat different position from that of pure scientists for whom detachment and debunking are, of necessity, essential attitudes toward their subject matters, especially in studying phenomena in the practice domain. While maintaining scientific objectivity and detachment, nursing scientists have to work in balance with the attitude of advocacy for "good practice." Indeed, the challenge to the science of nursing is in finding ways to discard trivial and frivolous acts from the ordinary repertoires of what nurses perform in "doing nursing," and to replace these acts with interventions and therapies that have significant purpose and rationality.

In order to do this, it is necessary, first, to know (or find) ways of separating those nursing acts that are trivial or frivolous from those that are meaningful, in that they are "nursing" acts. Implied in this statement is an acceptance of the reality that all of what nurses do in ordinary nursing situations is not necessarily "nursing," and that nurses are neither scientific in all their acts nor able to make all their acts have nursing meanings. It is probably neither necessary nor possible to program (i.e., prescribe) every action of a nurse, that is, every act performed in a nursing situation. Nonetheless, the essential objective for the science of nursing is to strive for a system of knowledge that will increase the proportion of rational and explained acts in the total repertoire of what the nurse does in nursing.

One primary way of arriving at this understanding is through deciphering the meanings of acts performed by nurses. This points us toward an inductive method of study in which the description of the nursing world allows us to attach meanings to nursing acts and discover patterns of occurrence. For example, if we find that different nurses entering a terminally ill patient's room assume certain body postures and utter certain words to the patient, we would be in a position to question their meanings as well as effects on the patient. The inductive approach for the discovery of patterns and meanings of nursing acts is important for the science of nursing in its current developmental stage as a scientific field. This is not to say that the deductive approach is not useful for development in the science of nursing. Both approaches need to be applied appropriately in studying nursing.

## MODELS FOR THE PRACTICE DOMAIN

Conceptualization of phenomena in the practice domain is rarely done by nursing theorists in a systematic way. Most conceptual models of nursing treat phenomena in the practice domain as natural occurrences, neither requiring specific conceptualization nor theoretical explanations in a specific nursing perspective. Otherwise, it is considered to be encompassed within the idea of nursing process that the profession has come to accept as a universally correct *modus operandi* for providing nursing care. During the last three decades, nursing process has become well incorporated into the nursing knowledge system, and is considered the systematic way of giving care. The American Nurses Association's Standards for Practice are based on this form of problem-solving and action in nursing. Nursing process as an accepted "theory" or "principle" for provision of nursing care is treated by most nursing theorists in their writings as such. Application of the nursing model in the nursing process is discussed in great detail in many writings.

The attitude that nursing action follows naturally from nursing assessment is particularly prominent in models in which nursing action is viewed in a prescriptive manner. For example, according to the Roy Adaptation Model, the nurse knows what to do if the behavior of the client has been clearly specified, linking it to its predominant stimuli in the nurse's assessment, since the "intervention is based specifically on the nursing assessment" (Roy & Roberts, 1981, p. 47). Further on, they state that:

Based on this model [the Roy Adaptation Model], some nursing interventions will be traditional techniques such as comfort measures or health teaching. However, our theoretical work may allow us to discover entirely new activities that are the unique responsibility of the nurse when she is viewed as the promoter of patient adaptation.<sup>4</sup>

What they do not consider "problematic" in these statements is "how a nurse will discover a new activity," or "how a nurse makes a choice of a new activity over an old one," or even "why a nurse might want to seek new activities." In this model, the nurse is required to make "judgments" about ineffective processes influencing the client's adaptation level in order to come up with a diagnostic label for an ineffective behavior. It is exactly this phenomenon of nursing judgment that is problematic when a nurse scientist shifts the focus from the client to the nurse. The phenomenon of nursing judgment is an example of constructs that belong to the practice domain,

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4. Roy, C., & Roberts, S. L. (1981). *Theory construction in nursing: An adaptation model* (pp. 47-48). Englewood Cliffs, NJ: Prentice-Hall.

requiring scientific explanations. Nursing assessment also refers to a set of phenomena in the nurse that pertains to specific processes and features.

Similarly, Neuman (1995) considers the use of the assessment/intervention tool designed according to the Neuman Health Care System model to offer a prescriptive base for nursing action. Like Roy, Neuman views the selection of nursing action as deterministic based on the adoption and careful use of an assessment tool.

Rogers is somewhat more specific and states that professional nursing practice is creative and imaginative, and is considered to be rooted in "abstract knowledge, intellectual judgement, and human compassion" (Rogers, 1970, p. 122). She believes that nursing action is not determined by set formulas, and that the nurse's ability to select appropriate tools of practice is an intellectual skill. Rogers identifies three variables as those influencing the safe practice of nursing (i.e., how the nurse selects appropriate actions and how selected actions are put together): (a) the nature and amount of scientific knowledge; (b) the imaginative, intellectual judgment; and (c) human compassion.

Intellectual skill in selecting those tools and procedures best suited to a given situation and artistry in utilization of mechanical and personal resources are important dimensions of nursing practice. However, it must be thoroughly understood that tools and procedures are adjuncts to practice and are safe and meaningful only to the extent that *knowledgeable nursing judgements underwrite their selection and the ways in which they may be used.*<sup>5</sup>

She continues:

Nursing practice must be flexible and creative, individualized and socially oriented, compassionate and skillful. Professional practitioners in nursing must be continuously *translating theoretical knowledge into human service* and participating in the coordination of their knowledge and skills with those of professional personnel in other health disciplines.<sup>6</sup>

Although these are pointed out as essential elements for good nursing practice and refer to both the deliberation and enactment dimensions of nursing practice, Rogers does not follow through with this idea in her

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5. Rogers, M. E. (1970). *An introduction to the theoretical basis of nursing* (p. 126). Philadelphia: F. A. Davis. Italics are mine.

6. Rogers, M. E. (1970). *An introduction to the theoretical basis of nursing* (p. 128). Philadelphia: F. A. Davis. Italics are mine.



model, nor does she translate the meaning of this idea within her model of unitary human beings. Conceptualization in which an explanation of variable conditions of such phenomena as "translating knowledge" or "using the tools of practice" apparent in the practice domain is not offered in the model of unitary man. Theoretically, Rogers' statements are rhetorical and fall short of scientific explanation. While she identifies phenomena requiring scientific explanation, she neither offers exact definitions of elements critical for variations in the nurse's actions nor describes the way these elements are related to each other and related to the content of nursing action.

King's notion of nursing practice is incorporated into the concept of give-and-take, the interaction that is the basis for nursing decision making in the model (1981). Thus, the variables influencing nursing practice are what the nurse brings into the client-nurse interaction situation. These are the nurse's perceptions, skills in communication, values for transaction, role concepts, and stress. These same elements as variables in the client are also brought into the interaction. Nursing practice varies not because of what the nurse processes in isolation from the client, but only as a result of the nature of the interactional evolution that takes place with what the nurse and the client bring into the situation and how they work together. This suggests that King considers nursing practice only from the interactional orientation. Nursing action as a process does not exist in the nurse; the nurse is a variable for nursing action for what the nurse is and how she or he participates in interaction with the client.

In a more specific fashion, Orem (1980, 1991) proposes the concept of nursing agency, denoting the nurse's specialized abilities. Nursing agency includes (a) specialized education, (b) specialized knowledge of the nursing situation, (c) mastery of technology of nursing practice, and (d) motivation for practice. The characteristics of nursing practice are expressed in terms of the art of nursing and nursing prudence. The art of nursing means creating systems of nursing assistance and care, and depends upon the quality of the nurse for creative investigations and analyses and syntheses of information within the nursing situation. On the other hand, nursing prudence means rightly doing selected acts in a given situation based on one's knowledge of the situation. It depends on that quality of a nurse that is related to the ability to seek and take counsel in new or difficult nursing situations, to make correct judgment for action under changing conditions, to decide to act in a particular way, and to take action. The art of nursing and nursing prudence are influenced by experience primarily, but interactively also by such variables as a nurse's talent, personality, developed and preferred modes of thinking, stages of personal and moral development, ability to conceptualize complex situations of action and to analyze and synthesize information, and life experiences (Orem, 1980, 1991).

Thus, according to Orem's conceptualization of nursing practice, an activated nursing agency produces nursing operations and actions that vary in terms of the art of nursing and nursing prudence. The basic postulation is that nursing agency, in combination with other personal characteristics of the nurse, influences the nature and mastery of those nursing actions performed. This model, however, does not deal with the issue of how nursing actions are selected and performed in certain ways by the nurse. Orem conceptualizes the phenomena in the practice domain in a holistic manner.

This section surveyed the approaches used by selected theoretical works in conceptualizing nursing practice and treating phenomena in the practice domain within the proposed theoretical models. As shown, these theoretical frameworks treat phenomena in the practice domain tangentially, rather than as the primary foci for description and explanation.

### **ISSUES IN THE CONCEPT OF NURSING DIAGNOSIS**

The discussions offered in the preceding sections of this chapter bring us to conceptual issues regarding the concept of nursing diagnosis. The reasons for dealing with the concept in a separate section are twofold: In a definitional sense, nursing diagnosis is a label that is attached to a phenomenon (or a cluster of phenomena) present in a client, indicating that the phenomenon requires a nursing solution. Thus, the naming of client phenomena has to depend in the first place on the way "client" is conceptualized, and secondly, on the definition of a nursing solution *vis-a-vis* a medical solution, or pharmacological solution, or social service solution, etc. In addition, a nursing diagnosis as a phenomenon is a "created" phenomenon, that is, it is a concept constructed to fulfill specific needs of the profession. A nurse has to perform a labeling act in examining the reality that is present in the client and by selecting relevant facts. Nursing diagnosis is a way of translating "natural phenomena" to have specific, scientific "nursing" meanings. It is a systematic conceptualization of phenomena in the client system from a nursing perspective, not only for descriptive understanding, but necessarily for prescriptive purposes. Nursing diagnosis is necessary only because one is interested in also making decisions about a specific nursing solution (or what is also termed as nursing intervention, nursing approach, or nursing therapy).

In accepting the nursing process as the major scientific approach for delivering nursing service during the past two decades, the nursing profession has also basically accepted the concept of nursing diagnosis as a process through which a nurse arrives at a judgment regarding the client's problems requiring a nursing solution. However, there still is an inter-

change in the use of terms—nursing diagnosis, nursing problems, nursing needs. Whether or not a nurse comes up with an exact name for the client's problem in nursing terms, the diagnosing act for the nurse has been included firmly and formally in the nursing process. In general, nursing theorists, nursing researchers, and nursing practitioners agree that a nurse, in delivering a systematic, scientific nursing service to the client, should go through the step of identifying the client's problems and arriving at a list (i.e., nursing problem statement, list of nursing needs, or nursing diagnosis) that is then scrutinized for a nursing solution. Therefore, the controversies are not related to the basic concept of nursing diagnosis. The major issues are related to (a) varying views regarding "clinical" referents of nursing diagnosis, and (b) nursing diagnosis classification system.

### **Referents of Nursing Diagnosis**

It is generally accepted that nursing diagnosis refers to health problems or health states that are treated by means of nursing intervention (Gebbie and Lavin, 1975). Health problems that are the referents of nursing diagnosis have been conceptualized from nursing perspectives in a variety of ways. As an attempt to differentiate nursing diagnosis from medical diagnosis, Aspinall, Jambruno, and Phoenix (1977) view health problems in nursing diagnosis as impaired body functions, while others (for example, Roy, 1975) view health problems in terms of response to illness or pathological conditions. Jones (1979), on the other hand, states that a nursing diagnosis is the statement of a person's responses to a situation or illness that is actually or potentially unhealthful and that a nursing intervention can help to bring about change in the direction of health, a concept adopted from Mundinger and Jauron (1975). This diversity in the early conceptualizations of nursing diagnosis still persists, although the position taken by the North American Nursing Diagnosis Association (NANDA) has dominated the definition regarding nursing diagnosis.

The definition proposed by the theorists at the Third National Conference is more global: "Nursing diagnosis is a concise phrase or term summarizing a cluster of empirical indicators representing patterns of unitary man" (Kim & Moritz, 1982, p. 219). Although this definition has been developed by a group of nursing theorists and suggests general agreement in viewing problems of human health, the actual application of this definition in "creating" conceptual labels (or terminology) for nursing diagnostic states is at variance with the concept of wholeness. In addition, nursing theoretical models already developed have their own definitions of health problems: adaptation (Roy), self-care deficit (Orem), patterns of unitary man (Rogers), responses to stressors (Neuman), and behavior (Johnson). As indicated by Gordon and Sweeney (1979), there is a lack of consensus on the referents of nursing diagnosis.

There is general acceptance of the idea that nursing diagnosis does not (or should not) refer to pathological deviations or disease states. However, nursing diagnosis may refer to health problems and health states focusing on many different aspects of human experience. Stevens lists the following five examples (1979, p. 95):

1. Experiential states;
2. Physiologic deviations from the norm;
3. Problematic behaviors;
4. Altered relationships;
5. Reactions of others.

Stevens' observation was based on the list established by the National Conference Group's work. This group's continuing efforts as well as others' work oriented to establishing a "complete" list seem to bring forth more confusion in specifying the exact characteristics or criteria of referents of nursing diagnosis. For example, Avant (1979) developed a set of criteria for nursing diagnosis of maternal attachment. In proposing this as a nursing diagnosis, Avant submitted a vast array of nonproblematic phenomena as possible referents for nursing diagnosis. Indeed, this is philosophically correct, since nursing is concerned with enhancement of health and healthful behavior. However, making diagnosis about nonproblematic phenomena raises a question of suitability: Should the nursing diagnosis indicate the results of differentiation and abstraction of problems that require nursing attention? Or should the nursing diagnosis indicate concise statements descriptive of human conditions? The question also is how rigorously should we follow the criteria for rejection: "Any rejection [of a category from the list of nursing diagnoses established by NANDA] should be based on clinical evidence that the diagnosis provides no basis for nursing intervention" (Gebbie & Lavin, 1975, p. 57).

The general statement accepted by the theorists at the Third National Conference appears to reflect the second position, that nursing diagnosis is a term denoting a description of a human condition. However, the diagnostic nomenclature approved by the Group includes only problematic phenomena, denoted by such terms as alterations in, impairment of, abnormal, dysfunctional, inadequate, lack of, and disturbance in (Kim & Moritz, 1982). These refer to deviated and problematic states in structural (i.e., alteration, lack, disturbance, and inadequacy) and functional (impairment, abnormality, and dysfunction) aspects of human phenomena. In addition, the list also includes areas of diagnosis related to the process aspect of human phenomena, such as grieving, coping, or manipulation. This observation calls attention to the need to develop conceptual systems that may be used to point out referents of nursing diagnosis. Of course, as pointed out by Stevens (1979), it is related to the problem of defining the subject

matter for nursing and nursing practice. Therefore, specifying the referents of a nursing diagnosis is closely linked to the conceptualization of phenomena in the domain of client.

### **Nursing Diagnosis Classification System**

The impetus for development of a classification system of nursing diagnosis has culminated from the positions that "without such a system, nurses will continue to experience difficulty in educating beginning practitioners, designing and performing research, and communicating nursing care within the nursing profession or across the health system" (Gebbie & Lavin, 1975, p. 1), and that "the development of a diagnostic classification system for nursing is an essential next step in the development of the science of nursing" (Roy, 1975, p. 90). These positions are congruent with the ideals and hopes of the profession, and seem to suggest a diagnostic classification system as a way of defining the content of nursing's subject matter. This attempt is also thought of as a step in theory development in nursing (B. Henderson, 1978; Kritek, 1979; Roy, 1975). Kritek (1979) believes a nursing diagnosis classification system is a factor-isolating theory on which the next level of theory development is based.

The North American Nursing Diagnosis Association as the official body formed to advance the systematization of nursing diagnoses and the development of a nursing diagnosis classification system has adopted the inductive approach in what they termed a taxonomic classification of nursing diagnosis (Gebbie & Lavin, 1975). By adopting the inductive method, the Group bypassed the question of "theoretical orientation" of the classification system, their later adoption of the conceptual framework of unitary man notwithstanding. Their position is to arrive at an agreement on the problem-label, etiology, and signs and symptoms, i.e., defining characteristics for diagnostic categories by using language that is not theory-based. By being atheoretical in its approach, the classification system may be accepted, tested, and used by nurses with different theoretical orientations. However, a conceptual system that is composed of a definition, a causal statement as to why such a phenomenon occurs (etiology), and operationalization of the term (defining characteristics) cannot be derived without theoretical premises. It appears, then, that a classification system developed in a manner such as adopted by NANDA is multitheoretical rather than atheoretical. This posture by NANDA raises questions such as: To what extent would alternative classification systems of diagnostic terms that are based on specific nursing theories be accepted and used interchangeably with other systems; and could a unified nomenclature of nursing diagnosis classification incorporate alternate "explanations of etiology" that are based on other theoretical assumptions and postulations?

Another question is related to the implications of a nursing diagnosis classification system for nursing intervention. Would such a system result in nursing's own version of *Merck's Manual*? To what extent will the nursing diagnosis nomenclature dictate nursing intervention prescriptions? The work of Bulechek and McCloskey (1987, 1992) has a serious implication for linking nursing diagnosis to nursing intervention. An inventory and classification of nursing interventions must then be linked to clients' problems, if the dominant premise for nursing is based on the philosophy of therapy.

On the other hand, there are also voices criticizing the advancement of nursing diagnosis work, for example, as a possible ground for erroneous reification of phenomena or as a way to professional stereotyping and labeling of clients (Mitchell, 1991). These are questions nursing scientists and practitioners should deal with and debate if we are not to be stifled by "a need to have a system," and if we are to allow multiple approaches to theoretical development in nursing.

## SELECTED CONCEPTUAL ANALYSES

As have been presented in Chapters 4 and 5, two concepts are examined in this chapter as examples of phenomena in the Practice Domain. The concepts of *clinical expertise* and of *nursing aesthetics* are analyzed as examples of phenomena in this domain. As stated in the earlier chapters, the main purpose of this section is to show how a first-level analytical approach is used to gain conceptual and empirical understanding of phenomena within the practice domain. Each concept is analyzed with respect to (a) definitional clarification and conceptual meanings as reflected in the literature; (b) measurement and operationalization of concepts as a step toward an empirical analysis; and (c) the concept's relationships with other concepts that are important in nursing. The strategy and rationale for the conceptual analysis were discussed in detail in Chapter 2, and that rationale is adopted in this section for the analyses of clinical competence and nursing aesthetics.

### The Concept of Clinical Expertise

#### *Definition*

Since the publication of Benner's work in 1984, the term, clinical expertise, has been used quite extensively in the nursing literature. It often refers to a state that results from an extensive clinical experience that culminates into a special state of "know-how" in clinical situations. The term, clinical expertise, is often used interchangeably with clinical competence. Because nurses begin to practice as professional practitioners in clinical situations

upon graduation from educational programs, their practice is considered to move toward an increasing expertise and competence through experiences and acquisition of advanced knowledge. As any professionals, nurses learn and accumulate new knowledge through experience. Through each clinical case and each incidence of clinical experience, nurses are able to validate and/or refine existing knowledge, and have the opportunity to create new knowledge. In addition, through experience nurses become comfortable and skillful in executing clinical techniques, and develop shortcut ways of thinking and deliberating about clinical problems. Expertise and competence have been depicted in terms of intuition, skillfulness, and adaptability to new clinical situations.

Benner (1984), specifically drawing from Dreyfus and Dreyfus (1986), espouses the notion of expertise from the perspective that focuses on cognitive processing of clinical situations. Benner (1984) uses the concept of clinical expertise within the context of a conceptualization of levels of practice, adopted from the Dreyfus model of skill acquisition, that includes beginners, advanced beginners, competence, proficient practice, and expert practice. Within this model, expert practice is shaped through experiences, and is notable for the use of a mode of pattern recognition based on exemplars and intuitive knowledge developed from holistic grasping of situations and understanding. Benner's conceptualization of clinical expertise views nursing practice with a focus on initial grasping of the clinical situation as the foundation for a stream of both deliberation and enactment that become actualized as an integrated, nonseparable whole.<sup>7</sup>

In reviewing the nursing literature, Jasper (1994) notes that the expert nurse is understood to be a person who has acquired and exhibits advanced levels of knowledge and skills which have usually resulted from experience, and who has developed intuition that allows her or him to respond to clinical problems with holistic, noncompartmentalized "know-how." Intuition is a key to expertise to many scholars, as differentiated from analytical, structured knowledge, and is identified as "tacit knowledge" (Polanyi, 1964). Rolfe (1997) suggests that the expert nurse's reliance on intuition can be explained as the use of fuzzy logic.

From the cognitive perspective, expertise refers to the development of knowledge structures underlying professionals' practice. Schmidt, Norman, and Boshuizen (1990) suggest that expert physicians develop sequentially different sets of knowledge structures, which are used as the basis for their practice. Different knowledge structures are developed sequentially beginning with the elaborated causal networks, and continuing to a compilation of abridged causal networks, a network of illness scripts, and a network of instance scripts.

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7. Debates regarding Benner's conceptualization of expertise are found in English (1993), Darbyshire (1994), Cash (1995), Paley (1996), and Benner (1996).

In most of these conceptualizations, professional expertise focuses on the thinking aspect of practice, with a view that the way the clinical situation is initially grasped and recognized leads to different sets of nursing activities. Defining clinical expertise solely in terms of intuitive knowing was raised as problematic for its lack of truth value and validity claims (Cash, 1995). Furthermore, the concept of clinical expertise derived from experience also points to the problem of routinization as shown by Argyris and Schön (1976b) and by Argyris, Putnam, and Smith (1985).

Hence, although the concept of clinical expertise is used frequently in the literature to designate a specific form of practice, a definition of the exact nature of clinical expertise remains elusive. One area of agreement seems to be the difference in the nature of problem-solving between experts and novices.

### *Operationalization*

Identifying the exact features of clinical expertise has not been done well in the literature, indicating the difficulty embedded in its definition. The qualitative features identified for clinical expertise, such as intuitive knowing and holistic pattern recognition, are themselves difficult phenomena for exact identification. In addition, there is a controversy as to the emphasis given to skillfulness in technical execution of nursing activities, possession of advanced knowledge, ability to produce correct outcomes, and recognition by peers as the features of clinical expertise. Benner (1984) has used the recognition by peers and supervisors as one criterion for recognizing clinical expertise. In addition to pattern recognition, Benner, Tanner, and Chesla (1992) identified three other aspects of expert practice: (a) the sense of urgency and the grasp of what lies ahead; (b) the ability to manage multiple, complex demands of a situation with skillful maneuvering; and (c) a realistic sense of responsibility. On the other hand, Jasper (1994) identifies possession of a specialized body of knowledge or skill, extensive experience in that field of practice, highly developed levels of pattern recognition, and acknowledgement by others as the major defining attributes of expertise. From another perspective, Schvaneveldt and colleagues (1985) suggest that expertise can be specified by the use of cognitive processes that identify the important, critical information and associations, yielding a simpler network.

Clinical expertise in terms of attitudes toward clients and regarding nursing has not been addressed extensively, although nursing experts are described often not just as skillful, intuitive practitioners but also as compassionate, caring, and trustful professionals. The work by Benner and other scholars with the same epistemological tradition has dominated the conceptualization of clinical expertise to emphasize the "thinking" aspects of practice. It seems that to identify clinical expertise from the perspective



of problem-solving only is limiting and does not take into account the general features of nursing practice that encompass the scientific, ethical, and aesthetic aspects. It is critical to consider the conceptualization and operationalization of clinical expertise from the general perspective of a nursing perspective that encompasses all dimensions pertinent to determining "good," "skilled," and "exemplary" practice, especially if we believe that clinical expertise is something that epitomizes the highest level of nursing practice.

### *Relationships With Other Concepts*

Most of the studies dealing with clinical expertise in nursing have been descriptive, and specify the length of clinical experience as the major determining factor. Benner's model of clinical practice that distinguishes levels of practice is based on the length of experience, identifying expert practice as that having at least five years of experience (Benner, 1984; Benner, Tanner, & Chesla, 1992). This consideration of the length of experience as the major determining factor for clinical expertise poses a controversy in light of the literature on action science and reflective practice. The action science proponents (Argyris, Putnam, & Smith, 1985; Argyris & Schön, 1976b; Schön, 1983, 1991) suggest that there is a tendency in professional practitioners to adopt what they call the Model I theory of practice that tends to make their practices self-sealing and nonprogressive. This means that the length of experience alone may not lead to clinical expertise.

Another concept that has been discussed in relation to clinical expertise is experience as the basis for learning. Benner, Tanner, and Chesla (1992) suggest that expertise is developed through a progressive construction of clinical worlds. Experiential learning as the basis for developing such clinical worlds is closely tied to emotional responses to actual situations. From this hermeneutic phenomenological perspective, different emotional responses to experience are seen to guide the types of learning and construction of clinical worlds. On the contrary, Eraut (1994) suggests that professionals' case-specific learning may not contribute to the development of advanced professional knowledge unless each case is regarded as a special case and deliberation about its significance is consolidated into any general theory of practice.

More importantly, the relevance of clinical expertise must be considered in relation to client outcomes. Although it is understood in general that the notion of clinical expertise must make some claim to the effectiveness of nursing care and health-outcomes in clients, there is a very little work that specifically addresses the relationship between expert practice and client outcomes. It is imperative that we examine to what extent and in what ways clinical expertise influences client outcomes and the process of nursing care.

## **The Concept Of Aesthetic Nursing Practice**

The art or aesthetics of nursing has been claimed by many nursing scholars in talking about nursing as a necessary and rightful aspect and counterpart to the science of nursing. However, nursing has been preoccupied during the past three decades with the development of scientific knowledge in an effort to come of age as a legitimate scientific discipline. We are beginning to have voices raised calling our attention to the aspects of nursing that transcend prescriptions, therapies, and interventions. Among these voices are the ones that consider the aesthetic nature of nursing practice as its essential component. Carper (1978) raised this point by issuing an "esthetic pattern of knowing" as one of the four essential patterns of knowing in nursing. One voice comes from Katims (1993) who proposes nursing caregiving as aesthetic experience that needs to be founded upon the "felt" qualities of care and excellence. Holmes (1992) offers a view of nursing as a "form of aesthetic praxis" which refers to nursing action as performance expressive of a nurse's values and beliefs, and embracing a reflection upon theory and practice. Aesthetic nursing practice thus refers to the doing, performing, and engaging that are involved in nursing work.

### *Definitions*

Art or aesthetics is a very difficult concept to define. The uses of these terms are also varied. Here, the concepts of art and aesthetics are used as synonyms referring to the same phenomena, although some authors are very selective in the uses of these terms. Aesthetics is often considered in relation to creative work and expression.

Johnson (1994) delineates from the literature five separate senses used to describe nursing art as:

- The nurse's ability to grasp meaning in patient encounters;
- The nurse's ability to establish a meaningful connection with the patient;
- The nurse's ability to skillfully perform nursing activities;
- The nurse's ability to rationally determine an appropriate course of nursing action; and
- The nurse's ability to morally conduct his or her nursing practice.<sup>8</sup>

On the other hand, I had differentiated the conceptualizations of aesthetic nursing practice that appear in the literature from three different perspectives (Kim, 1993). These perspectives are based on different con-

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8. Johnson, J. L. (1994). A dialectical examination of nursing art. *Advances in Nursing Science*, 17, p. 3.

ceptualization of aesthetics and human action. The conceptualization of aesthetic nursing practice with an emphasis on creativity focusing on the "form" of practice as a product is based on the Kantian notion of aesthetics that is oriented to experiencing aesthetics or art (Crawford, 1974). From this perspective, the art of nursing is in the contents of nursing practice as it communicates aesthetic ideas to perceivers, especially to clients. From the Kantian perspective, nursing practice may be considered as the objects of aesthetic experiences as it satisfies judgments of taste regarding the beauty and felt-pleasures by both nurses as the creators, and clients as the observers. Here, creativity is an essential component that arouses aesthetic experiences.

The second perspective comes from the notion that views the totality of nursing practice as aesthetic experience (Katims, 1993). The lived experience of nursing is considered art to the extent that nurses are able to "keep experience through aesthetic practice in which self-reflection and creativity are emphasized in the presentation of self by the actor from falling toward meaningless ritual or yawning chaos" (Alexander, 1987, p. 204). This view aligns with the idea of creativity as "the fusion in an experience of the pressure upon the self of necessary conditions and the spontaneity and novelty of individuality" (Dewey, 1934, p. 286). Aesthetic nursing practice, hence, results from coordinated creativity and is involved with the totalizing process that unifies the knowledge, thoughts, feelings, meanings, connections, and performances connected with the nursing experience. From this sense, aesthetic experience is not in the judgments of actions as products but in the experience itself. Carper's (1978) notion of empathy as an essential aspect of the aesthetic pattern of knowing also belongs in this conceptualization. The nurse as an actor can make the experience aesthetically meaningful through the engagement that upholds care, empathy, and an integrated coordination of points of views of participants about the experience.

The third perspective emerges from critical philosophy and the emancipatory theory of aesthetics. Aesthetics is considered in alignment with the notion of human practice that emphasizes self-reflection and human freedom. Holmes (1992), from this perspective, proposes "art as a form of value-expression" and suggests aesthetic nursing praxis as "a performance in which the values and ideals of nursing practice are embodied" (p. 946). Nurses' actions as art are the vehicles through which nurses are able to express personal meanings and values in actions and secure personal identity and mutual understanding. Aesthetic nursing practice as presentation of self is represented by the emphasis on self-reflection and creativity through the rejection of meaninglessness and alienation.

A definition of aesthetic nursing practice may be possible that encompasses this diversity in the conceptualizations of aesthetic nursing practice. The following definition is given as a generic form.

Aesthetic nursing practice refers to the aspects of nursing practice that are involved in "careful" individuation of actions and the harmony with the acting on object (i.e. the client), the world in which the actions take place, and the acting self (i.e., the nurse). This harmony is produced through creative presentation of the self in consideration with what is desired, meaningful, and beautiful in practice.<sup>9</sup>

### *Operationalization*

While the literature is abundant with expositions on aesthetic nursing practice from descriptive points of view, there is a paucity of discussion regarding the exact features of aesthetic nursing practice. Carper (1978) suggests that empathy, "the capacity for participating in or vicariously experiencing another's feelings," is an important mode for aesthetic patterns of knowing that "enable the creation of a design for nursing care that eliminate or would minimize the fragmentation of means and ends." She also suggests that aesthetic nursing must be accompanied by the design of nursing care with a sense of form that is controlled by "the perception of the balance, rhythm, proportion and unity of what is done in relation to the dynamic integration and articulation of the whole" (Carper, 1978, p. 18).

Aesthetic nursing practice, on the other hand, has been considered in terms of creativity, emphasizing the description of creative process in nursing. This is in line with the work by Rothenberg (1992), in which the form and structure of creative process are thought to be critical features along with the contents of the process.

For Holmes (1992), aesthetic praxis is evident when the practitioner as a reflective practitioner shapes her or his practice by becoming aware of the interplay between self and performance, applying creativity and genuine value expressions. It is performance in which the practitioner aims to realize the optimal potentialities of one's being through the engagement in practice that is good in itself.

Johnson's survey of the literature (1994) illustrates the diverse, multiple, and complex nature of what constitutes aesthetic nursing practice. The elements of aesthetic nursing practice range from intuition, insight, and authenticity, to skillfulness, rational ability, and moral commitments, depending on the conceptualization of nursing art. This points not only to the multiple perspectives with which aesthetic nursing practice is conceptualized, but also to the diversity in designating the essential features that specify aesthetic nursing practice.

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9. Kim, H. S. (1993). Response to "Nursing as aesthetic experience and the notion of practice." *Scholarly Inquiry for Nursing Practice: An International Journal*, 7, p. 281.

*Relationships With Other Concepts*

The major questions pointing to further understanding and explanation regarding the phenomena of aesthetic nursing practice are: When is nursing practice aesthetic? How can we know that aesthetic nursing practice exists? What brings about aesthetic nursing practice? And, what is the impact of aesthetic nursing practice on clients and nurses, and on the culture of nursing practice? While these are important questions requiring systematic investigation, there is a fundamental question regarding the epistemology of aesthetics. Aesthetics or art refers to personal experiences which are situationally and often fleetingly experienced. They are accessible only through subjective reflections. Hence, the methodology for studying aesthetic nursing practice needs to be identified carefully in order to address such major questions, especially those inquiring into the descriptive nature of aesthetic nursing practice.

A nurse's personal qualities and experiences such as creativity, intuition and knowledge, a nurse's mode of practice oriented to reflection and emancipation, moral commitment to caring and authenticity, and relational abilities have been discussed as possible factors associated with aesthetic nursing practice. Caring and empathy are considered either as the intrinsic features of aesthetic nursing practice or as those aspects of practice that lead to the experience of aesthetic nursing practice (Appleton, 1993). However, understanding the nature of aesthetic nursing practice in its relationships with specific phenomena in the nurse, in experiences of the clients, and in the context in which nursing practice takes place is only at a beginning stage.

**SUMMARY**

The main idea for this chapter has been to bring about a closure to a circle for conceptualizing nursing phenomena. Knowledge about nursing practice is one of the central aspects of nursing knowledge. My contention throughout the chapter has been to offer a systematic framework for conceptualizing nursing practice phenomena. Once different phenomena are classified into like categories, it becomes clear to theoretical thinkers that discovering and developing theories for nursing phenomena can be pursued in a systematic fashion.

Nursing's theoretical development up until now has paid more attention to developing models to understand phenomena in the domain of client. As shown in this chapter, conceptualizations of phenomena in the practice domain are descriptive at best. Theoretical linkages explaining the nature of phenomena in the practice domain, in relation to both intrinsic and extrinsic forces, and normative theories for practice must be developed. We

also are still struggling with boundary-defining tasks. Subject matter for nursing study and definitions of nursing phenomena can only result from rigorous conceptual and theoretical specifications of the domains of nursing knowledge.

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# 7

## *The Domain of Environment*

*... the man of flesh, bone, and illusions will always experience unexpected difficulties as he tries to adapt to the real world, which is often hostile to him.*

—Renè Dubos

### OVERVIEW

In the preceding chapters, the theoretical nature of phenomena in humans, in the client-nurse encounters and in nursing practice, is examined within the nursing perspective. The purpose of this chapter is to shift the focus to the human environment, and examine the relevance of environmental factors in a consideration of human health and nursing practice. The fundamental question for the purpose of this chapter is: In what ways and to what extent is it useful to analyze environment from the nursing perspective? This chapter deals with this question in three steps. In the first section, delineation of the general characteristics of the domain of environment is carried out, paying attention to spatial, temporal, and qualitative meanings of environmental elements. Expositions also deal with essential aspects of environment with reference to client and nursing practice. In addition, the holistic approach to conceptualization of the human environment, especially that advocated by Rogers (1970, 1980, 1992), is examined for its theoretical and methodological adequacies.

In the second section, each qualitative component of environment, categorized as physical, social, and symbolic environment, is analyzed theoretically. Distinct bodies of knowledge and specific theoretical perspectives exist for each component, making separate expositions helpful.

Three concepts (sensory deprivation, social support, and sick-role expectation) selected from each component of the environment are analyzed in the next section as illustrations of conceptual analysis applied to the domain of environment. These analyses show different ways of conceptualizing selected aspects of the environment and how such conceptualiza-

tions are linked to different phenomena in nursing. Relationships between these selected concepts from the domain of environment and several important phenomena in the domain of client are examined in this section as well. The aim is to show the extent to which explanations of human phenomena may be attributed to environmental factors from the nursing perspective.

### THE DOMAIN OF ENVIRONMENT

Human living is carried on in a changing context that we call environment. Our feet rest on the ground that is a part of the planet Earth because we are unable to float about in the air; we breathe the air, which is of varying degrees of cleanliness; we sometimes are able to claim many acres of land as ours, but we are sometimes forced to occupy only several cubic feet of space for our body; we can see a setting sun and feel pleasantly affected by its beauty or depressed by the burden of a lost day; we pray to God for salvation, but we at other times participate in a dance to chase away demons; and we wake up in the morning next to a loving person, as we at other times run away from our parents, friends, or enemies in desperation. And such factors cause us to be malnourished or fat, to have goiter or scurvy, to be healthy or sick, to be lonely or content, and to feel secure or anxious. Environment is an essential part of human existence.

Environment is defined as the entity that exists external to a person or to humanity, conceived either as a whole or as that containing many distinct elements. Thus, this definition does not include what Bernard called *milieu interieur* as a part of environment (Robin, 1979). A person's functioning and development are partly constrained and determined by the nature of the environment in which the person finds or positions himself or herself. Many human health conditions have been found to be associated with environmental factors. For example, regional differences have been found in studies of the prevalence of dental caries (Ludwig, 1968). Effects of ecology on nutritional stress (M. T. Newman, 1968), black lung disease among miners, and neurosis in industrial societies highlight the affects of environment on people's health. Feibleman delineates the relationship between human nature and the environment, in a spirit similar to Dobzhansky's (1967) and Dubos' (1965) espousal of the environmental control of human conditions:

Where he [man] begins is determined by the equipment he brings with him to his birth, and it is considerable. He inherits the past of his ancestors, and thus acquires all sorts of capabilities and limitations; but he acquires during infancy the responses to artifactual [tool

and language] and social stimuli. He is in contact with tools from the cradle, and adults make signs to him in it.<sup>1</sup>

Yet, it does not suffice to say only that the environment affects human conditions and experiences such as health, illness, happiness, or growth. It is necessary to go one step further and consider that human nature also allows conscious and purposeful use of environmental conditions for the benefit of existence. Control of environment has been one of the many persisting human preoccupations, especially of Western humanity. Modern civilization and technology, specifically, suggest the advances people have made in controlling their environment. People have created changes in their environment over its history, and likewise have been affected by the changes.

Demonstrations by people in Europe and America against the proliferation of nuclear weapons and demonstrations in various sites in the United States against the construction of nuclear power plants, as well as the Chernobyl accident, suggest our concern regarding the influence and the potential influence of an "artifactual" environment on human life. At the same time, factors in a person's more immediate environment, such as crowding or pollution, can be attributed to having an influence on the person's state of health, growth, and feelings. In a strict sense, human existence cannot be considered out of the environmental context.

For our analysis, this context, i.e., environment, is considered in terms of three characteristics constituting the environment as a complex entity: (a) spatial, (b) temporal, and (c) qualitative. These three characteristics of environment provide different frameworks for conceptualizing environment. Environment in a spatial sense is conceptualized in concentric circles around the person in the center, indicating proximity of environmental elements to the person. Spatial aspects of the environment also circumscribe the size of its boundary. Thus, if we consider the universe as the total environment of a person, some of its elements are parts of the immediate milieu, located within the inner ring. Such elements in the immediate environment have a rather direct impact upon a person's life. On the other hand, many elements are remote, existing in the outer circles. Such elements influence the person only in marginal ways. Yet all elements in the environment in totality represent a context within which one lives.

Temporally defined environment, on the other hand, encompasses aspects of environment with respect to duration and manner of presence. Hence we may have environments of which elements exist (a) continuously,

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1. Feibleman, J. K. (1978). The artificial environment. In J. Lenihan, & W. Fletcher (Eds.), *The built environment: Environment and man*, Vol. 8 (p. 161). New York: Academic Press.

intermittently, or fleetingly, and (b) regularly or randomly. The first characteristic of the presence of elements in the environment is related to duration and is suggestive of permanence and temporariness. The second characteristic (regularly or randomly) is related to the manner of presence, that is, whether elements exist in the environment in a patterned, systematic way, or in a haphazard, irregular manner. Whether or not an environmental element is present in one's surroundings rather permanently will determine to a certain degree the amount of its influence on a person, although certainly the element's quality will affect the degree of its influence.

The third way of conceptualizing environment focuses on the qualitative aspect of the environmental elements, thought of in terms of physical, social, and symbolic qualities. Accordingly, environment can be classified into three subenvironments—physical environment, social environment, and symbolic environment—by dividing the environmental elements by their characteristics in these three respects. This differentiation is similar to the conceptualization offered by Murdock (1980) in which he distinguishes physical, social, and ideational environment. Parsons' notion (1951) of the object world of an individual, which is thought to be composed of physical, social, and cultural objects, is also akin to this categorization. Parsons defines the object world as a situation of social interaction in which physical objects are means and conditions of one's actions, social objects provide specific orientations of interaction, and cultural objects provide symbolic elements for definition of interaction (Parsons, 1951). For our conceptualization, the object world, i.e., environment, is considered not only for situations of social interaction but also for situations of human living of all sorts.

Physical environment consists of the energy-generating, matter-based aspects of milieu that are in various forms of biotic and abiotic elements. Social environment, on the other hand, refers to individuals and groups with whom a person interacts and communicates. Family members, friends, colleagues, neighbors, and other people who may be remotely placed constitute one's social environment. In contrast to these two categories of environment (physical and social), which are more concretely based in the empirical world and are in concrete forms, symbolic environment consists of (a) ideational elements such as ideas, values, beliefs, history, and knowledge; (b) normative elements such as rules, laws, expectations, and constraints; and (c) institutional elements such as roles, organizations, institutions, society, and culture. These are elements that have no physical or concrete forms and exist only in people's minds. The symbolic environment is the specific artifact of human history, in that contents of the symbolic environment are the products of life stories of anonymous successions of ancestors and contemporaries.

Figure 7.1 shows the relationships among the three aspects describing and defining the environment, and suggests variability in its compositions in three dimensions. Contracting and expanding natures of the three components, namely physical, social, and symbolic components, depicted in Time 1 and Time 2 sequences, are characterized by spatiality and by temporal effects that change the manner with which the qualitative constituents of the environment are present in it.

The concept of environment proposed here implies that environment can be perceived either as a whole, encompassing the totality in the three dimensions, or as separated spheres of milieu viewed according to size (spatiality), continuity (temporality), or constituents (qualitative components). Specifically, this three-dimensional differentiation points to possible qualitative variability in an environment. For example, an environment can be indicated as a specific physical territory containing physical elements that stay or disappear randomly, or as a vast symbolic and social field such as a scientific community.

Inherent in these ways of conceptualizing human environment is the idea that elements of the environment are perceived by the person through the senses and are evaluated according to the affective and cognitive structures developed within the person. Therefore, sensory perception is the basis of knowing what exists, while cognitive and affective evaluation allow the person to attach meanings to whatever is perceived to exist. Hence we like the setting sun, interpret a touch as caressing, etc. However, there are elements in the environment that are not perceived consciously, not evaluated to have a specific meaning. Such elements may nevertheless exert influences on one's life.

What then are useful ways of examining environment and phenomena of environment in the nursing perspective? The nursing perspective requires conceptualization of environment in two specific ways: (a) environment having the client as an individual at the core of the concentric field; and (b) environment as nursing-care environment in which the environment takes on one specific symbolic meaning, that of health and nursing.

For the first concern, environment of client is the external reality that is identifiable according to the three dimensions proposed in the preceding section. Analytically, the environment of the client needs to be considered with specific reference to his or her health. This orientation is basically related to examining Dubos' proposition that "the states of health or disease are the expressions of the success or failure experienced by the organism in its efforts to respond adaptively to environmental changes."<sup>2</sup> Theoretical interests, then, are in extracting those aspects of the client's environment (or human environment in general) that are more closely

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2. Dubos, R. (1965). *Man adapting* (p. xvii). New Haven, CT: Yale University Press.



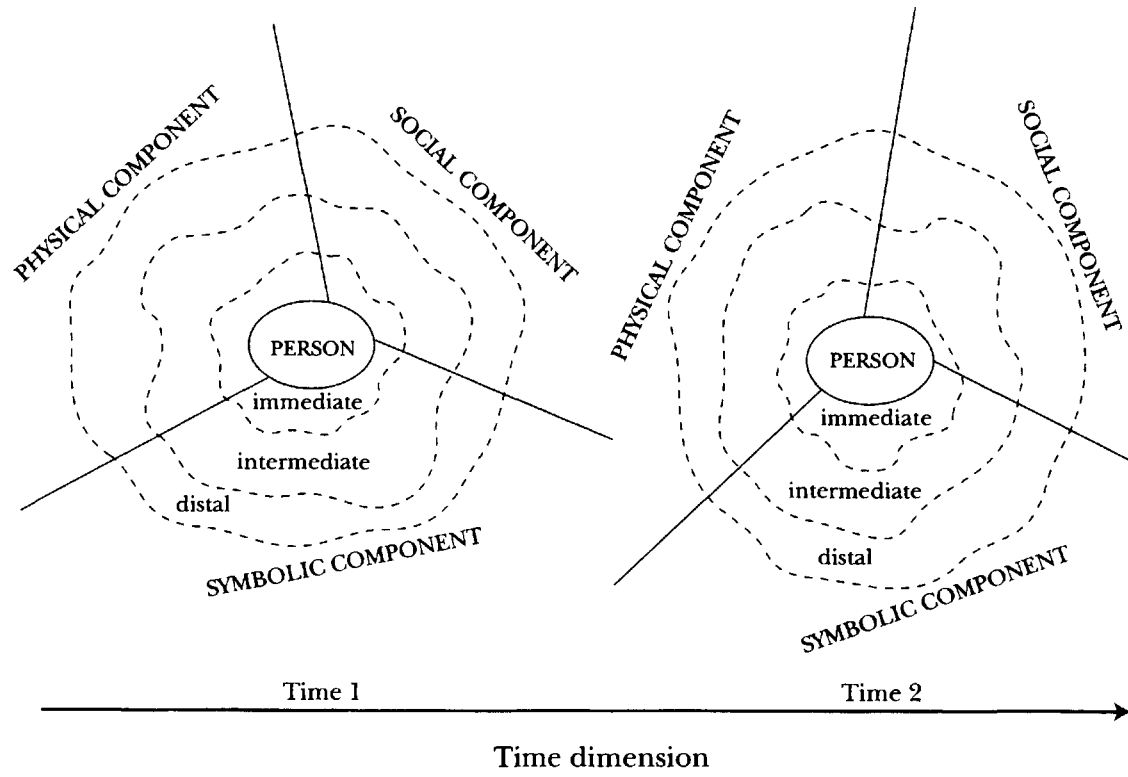


Figure 7.1 Aspects of client's environment—time, space, and components (physical, social, and symbolic).

tied to human conditions of health. Dubos (1965) views the environment as physical, biological, and of social forces and qualities, and defines health in terms of a person functioning in a given physical and social environment. Inherent in his notion of environment is the idea that environment not only provides the circumstances and forces for a person's adaptation that is expressed as health, but is also a context in which health as "functioning" is defined for the individual. The environment is seen as a whole in which a person acts, reacts, and interacts within the confines of genotypic and phenotypic givens and of the potentialities of self-determination, and through which one occupies changing states of health.

Rogers (1970, 1980, 1992) conceptualizes the environment in a holistic way, although her approach is more totally unitary than that postulated by Dubos. Dubos (1965) maintains the separateness of different components of the environment in his analysis of the specific effects of different environmental forces on human condition. Rogers views environment as one open system that should be considered in its totality as an energy field (1970). Rogers' conceptualization of environment may be best understood within the current physics' worldview, the theory of relativity. Einstein's general theory of relativity (1961) suggests that the universe as a construct of space, in a relativistic sense, is curved, and that the flow of time in that universe is "relative" to the timekeeper's state of motion. Since this assumption holds for the general case, that is, with a holistic worldview, and is tied to the notion of dematerialization of matter into energy (i.e., matter as concentrated patterns of energy), environment in this view is a spatial, temporal entity consisting of energy patterns.

Accordingly, Rogers proposes that the universe is an energy field within which the human field and its environmental field coexist only in a relativistic sense. Environment is conceptualized as "a four dimensional, negentropic energy field identified by pattern and organization, and encompassing all that are outside any given human field" (Rogers, 1980, p. 332). It is also considered to be unique to each human person. To Rogers, environment is that possessing a spatial and temporal boundary, and expressed as a patterned and organized field of energy. It is seen as a totality, an entity that is only expressible as a whole. Therefore, to Rogers, environment is a variable only in terms of energy of pattern and organization.

Operationalization of this conceptualization has been found wanting, because the energizing phenomena of an environmental field as the manifestations of the totality are empirically difficult to grasp for understanding as well as for measuring. However, Rogers' global posture of conceptualizing environment may be a fruitful way of looking at the world, especially if we are interested in considering human health in a holistic manner. According to Rogers' model, nurses and nursing actions as elements of the external world of a client are imperceptible, totally interfused

aspects of the environment. The environment as a totality is represented as an energy field, having certain kinds of patterns and organization. What is rather confusing in Rogers' conceptualization of environment is her conceptualization that both human and environmental systems are expressed as energy fields. Possible differences in the characteristics of energy fields have not been clearly conceptualized. For instance, the human energy field is alluded to be more complex because of human consciousness and creativity, yet the exact nature of that complexity and its difference from the environmental energy field, which is composed of both animate and inanimate elements, is not specified in the model. Specifying similarities and differences between the human field and the environmental field will give a greater explanatory credence to her view.

Other nursing theorists view environment in a rather casual manner. King (1981), for example, conceptualizes environment as the world that is perceived by a person, composed of people and things that are sources of stressors for the person. This view is useful insofar as it is adopted in the interactional contexts with which King is mainly concerned. In a similar fashion, theorists such as Neuman (1995), Roy (1980), Roy and Andrews (1991), and others having a theoretical orientation in systems models of stress/adaptation also view environment as that from which stresses and stimulations are generated to the individual and with which the individual tries to attain balance. The exact nature of environment and the mechanisms by which stresses originate in the environment are neither defined nor explored in these models. For such conceptualization, nurses and nursing actions are capable of generating stresses and stimulations to the client as parts of the environment.

Such observations make apparent the difficulty in viewing and analyzing environment in a holistic sense. For this reason, a particularistic approach, taking physical, social, and symbolic environments as separate phenomena, is adopted as an analytic posture in the following sections. While no environment may be conceptualized as having only one of these components completely separately, it appears useful to take different characteristics of environment as the point of departure for theoretical considerations in an analytical sense.

## **THE MAJOR COMPONENTS OF ENVIRONMENT**

### **Physical Environment**

Concepts of physical environment are most appropriately found within the domain of a field called human ecology. The main concept in the field of human ecology is ecosystem, which is defined as a system of interactions among the various human groups themselves and with the physical and

chemical components of the environment. The basic process of an ecosystem is usually considered in terms of energetics, having energy transfer between and among elements of the environment as the basis for changes that evolve. Inherent in this idea of environment is that elements in the environment are capable of generating and exchanging energy and that energy transfer is the elementary form of interaction between elements.

Physical environment has been categorized in various ways. Air, water, and places as used by Hippocrates are persistently used to describe the universalistic world of living. The concept of "place" can be all-encompassing with regard to the constituents that are connected with a spatially and/or geographically defined area. Therefore, a place may mean an urban location of congestion with polluted air, limited open space and vegetation, and crowded with heterogeneous sorts of people.

In general, physical environment is thought to be composed of biotic and abiotic elements. Biotic elements exist in various forms, ranging from viruses to human beings. Symbiosis as a process has been identified as producing peaceful, mutually advantageous coexistence and growth among many species. A human being as a physical entity in the physical environment takes on conceptually a quite different meaning from that of a social being in the social environment. As a physical entity, a person produces and uses heat; occupies space; generates, regenerates, and degenerates its chemical constituents; and has a contiguous surface. Territoriality and crowding are the most commonly studied phenomena in which human beings are taken as physical objects in the environment. Of course, the process by which a person handles the problems of territorial competition and crowding are far more sophisticated than those of other biotic organisms.

Abiotic elements may be distinguished as natural or as artifacts. Although our external world is composed of many and various types of natural physical elements, such as air, water, mountains, rivers, stars, sounds, etc., civilization has created and deposited many more abiotic artifactual elements in the environment of modern humanity. We are surrounded by artifacts, starting with clothing as the most proximal ones and extending to satellites orbiting the earth. In addition, we are continuously trying to change the nature and form of the natural physical elements in an attempt to control our surroundings.

Currently, in the field of genetic engineering research, biotic artifacts such as the variant DNA-spliced *E. coli* forms are beginning to be created, arousing suspicions and concerns about contaminating the biosphere with unknown living organisms whose potential affects on humans and the universe are not yet predictable. Genetic engineering poses problems, not only those related to changing the fundamental genetic makeup of organisms, but also those associated with the consequences of such manipulations on human existence. Yet, a fascination with control and understanding per-

sists. In a way, the diversity in the available forms of artifacts in modern societies suggests the high level of control humanity has made of its physical environment, and also suggests more possibilities for the future.

Physical environment affects the individual's health in a variety of ways. Nutritional disturbances produced by an under-supply of foodstuffs in different regions of the world are the most obvious. Environmental diseases, such as lead poisoning, asbestosis, or high altitude headache, as well as infectious diseases, are also well-recognized by-products of the harmful elements in the physical world. In addition, many physical elements of an environment are also responsible for patterning specific lifestyles, activities, and habits of people, indirectly influencing individuals' statures, physiques, longevity, and health. Furthermore, artifacts produce stimulations such as noise, heat, radiation, and crowding as well as convenience, efficiency, and effectiveness in living conditions. These, in turn, influence an individual's health in both positive and negative ways.

To date, Dubos (1965) has made the most impressive arguments regarding a person's relationship to the environment and his or her capacity to adapt to various environmental elements.

At a higher level of integration, the organism responds adaptively to many kinds of stimuli by behavior patterns designed to abolish or neutralize the stressor stimuli, or to withdraw from it. Organisms with a highly developed nervous system have several alternative mechanisms of behavioral responses and, furthermore, they possess the ability to ignore some of the stimuli that impinge upon them. The higher the organism is in the evolutionary scale, the more numerous and varied are the types of responses at its disposal and the greater its ability for selecting limited aspects of the environment to which it responds. The most evolved types of responses are the processes of social adaptation, through which the individual organism and the group modify either their environment or their habits, or both, in order to achieve a way of life better suited to their needs and tastes.<sup>3</sup>

In addition, Dubos postulates that a person's ability to adapt to the environment is influenced by the kinds of symbolic meaning the person attaches to elements in the environment and by the manner with which he or she responds emotionally, that is symbolically, to other human beings. A person's capacity for adaptation is seen as boundless, yet this potentiality can become stifled if a state of adaptedness to environmental conditions is attained and maintained for a prolonged period. A person's adaptive

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3. Dubos, R. (1965). *Man adapting* (p. 261). New Haven, CT: Yale University Press.

potentiality is stimulated by challenges of unforeseeable threats and changes in the environment, although sudden and profound changes in the environment always pose adaptive difficulties, however transitory they may be. In this perspective, Dubos (1965) indicates that health as a state free of pain and disease is a mirage, but when viewed as a state in which environmental challenges are met adaptively for human functioning, it conveys a dynamic meaning.

These ideas suggest that physical environment may be conceptualized in a variety of ways:

1. Milieu for functioning,
2. Source of stress and stimulation,
3. Source for adaptive challenge,
4. Symbiotic-interdependent system,
5. Spatial construct,
6. Object of human control.

In this way, environmental influences on health are thus perceived differently according to the perspectives used to view the environment. Furthermore, the nursing-care environment as a temporary physical environment for a client may be also considered in different terms such as: (a) a milieu for the client's functioning that possesses many restrictive objects; (b) that containing objects and people providing stimulation to the client (e.g., beeping sound of the cardiac monitor); (c) that providing unexpected as well as expected difficulties to the client, such as a new diet; (d) a system of interdependence in which material, energy, and information are exchanged between the elements in the environment and the client; (e) a confinement where there is a limited freedom of movement; or (f) that containing objects for control by the client. Thus, the environmental forces in a nursing care environment are additions to a person's ordinary environment, posing temporary threats to and amenities for a client's life and health.

### **Social Environment**

The physical and mental health of an individual depends to a great extent on social factors: the socialization process which he was submitted to by his parents, his present work situation, family life and group affiliation, and the modes of medical treatment he can economically afford and which are culturally prescribed. There is a dynamic relationship between the physical condition of a person and the social structure of which he is a part. Health as a normal condition of the body does not mean the absence of disturbances but

rather an effective bodily reaction toward them, which continuously reestablishes the precarious equilibrium between different physiological functions.<sup>4</sup>

The basic propositions by which we consider social environment an important factor for human health are that a successful and satisfying social life is partly responsible for health, and that the quality of social life is determined by characteristics of social environment and a person's handling of social environmental forces.

Evidence indicates that the physical and mental health of an individual is closely tied to one's attitudes toward life and living (Vaillant, 1979), one's style of coping (Lazarus, 1976), and the amount of understanding, love, and companionship one receives (Lynch, 1977). In postulating the notion that effective social adjustment is positively related to health and longevity, Wolf states that "one prototype of the healthy, long-lived, fulfilled person may be the fine symphony conductor, an individual who is persistently responsive to physical, intellectual, and aesthetic challenges and, also, who is more or less continuously the recipient of approbation from his audiences" (1981, p. 11).

More specifically, an individual's health is affected by the quality of social forces: opportunities in, and quality of, social interaction and affiliation; affective quality in dominant social situations, such as family, work, or neighborhood settings; and stresses generated in social life. A person learns how to cope with stresses and develops patterns of behaviors in dealing with life tasks and crises through the socialization process that takes place primarily in the family and primary social groups (B. H. Kaplan, Cassel, & Gore, 1977). In addition, a person also learns to behave according to social expectations, expectations of self and others that may be universal to all situations or particular to a given context. In this view, people having the same "diagnostic" condition may be healthy or sick according to the way they respond within the prescribed, expected, and desired rules of their social contexts of actions and interactions.

Conceptualization of social environment is rooted in the tradition of sociology. As stated earlier, Parsons considers social objects, that is, individuals and collectivities of individuals, as making up significant aspects of the object world in which an individual is engaged in actions and interactions. One crucial distinction between social environment and physical environment is the ability of social objects to act according to will. A person acts upon and reacts in a situation not only to "stimuli" given to him or her, but more importantly according to symbolic interpretations of the

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4. Dreitzel, H. P. (Ed.). (1971). *The social organization of health* (p. 3). New York: Macmillan.

stimuli that are made unconsciously and consciously. Thus, social environment represents multiplicity of human characteristics composed of organism-personality complexes.

In a social environment, a person brings with him or her different genetic and developmental characteristics, personality, social capabilities, and personal history. But because a person moves within society, within carefully defined systems of power, prestige, and expectations, the social environment of any given individual at any given time takes on somewhat predictable characteristics. In addition, the structures of society in which we live provide reasons for the coming together of certain individuals in a social situation. Hence, many children and other adults in addition to his or her parents surround a child of a kibbutz, and these comprise the ordinary social environment. In contrast, one sibling and parents probably surround a child of an ordinary American family.

The fabrics of social environment not only are reflected by individual characteristics but also by the meanings that are attached to them. To Parsons (1951), individuals in interactions are oriented to such actions in three respects: cathectic, cognitive, and evaluative orientations. This conceptualization can be extended for our exposition to classify conceptual meanings of social objects in an environment—to wit, each individual in a social environment projects to another person certain meanings through his or her presence, actions, or interactions with respect to affection (cathexis), information (cognition), and appraisal (evaluation). In turn, such meanings are translated by the second person as forces having certain values to him or her according to the social rules under which most social acts take place. In this way, social objects and the significance of them to the person become personalized within the boundary of social rules. Thus, recognizing social objects, a person literally embraces those individuals into his or her environment, and accepts affective, informational, and evaluative meanings from them. For example, a girl in a crowd takes in meanings and orientations of a special form when she sees or knows the presence of a close friend among them, which also would be entirely different from the meanings and orientations she takes in when she believes that she is totally among strangers.

Analytically, the social environment can thus be conceptualized in two ways: (a) in qualitative terms as social forces that are determined by characteristics of individuals in the environment generating affective, informational, and evaluative meanings; and (b) in quantitative terms as in social network and boundary, which are related to frequency and extent of affiliation, contact, and influence. For the first conceptualization, such phenomena as social support, expectation congruency, competition, and social control are but a few aspects of social environment that have been found to influence health status and health behaviors. For example, social control



that exists in work situations has been found to contribute to the occurrence of coronary heart diseases (Garfield, 1979), while Bruhn and Wolf (1979) attributed changes in social integration to increased rate of heart attack. Social support also has been shown to influence the occurrence of mental disorders, to modify illness responses to life's stresses, and to affect the rate and quality of health services utilization (Cassel, 1976; Cobb, 1976; Cohen and Sokolovsky, 1979; Gore, 1978). For the second conceptualization, marginality, social isolation, and disengagement have been found to have causative relationships with emotional distress and early death.

Within the social context of nursing practice, it is clear that the environment of health care produces specific meanings and contents to a client who is advertently or inadvertently affected by individuals in the situation. Nurses, as social objects, are the sources of affection, information, and appraisal to the client. Nurses provide a client with warmth, personal attachment, or emotional neutrality; impart new knowledge about health and health care; and appraise the client's behaviors as appropriate or inappropriate, dispensing approval/disapproval or rewards/punishments.

Clients, especially in nurse-controlled settings such as hospitals, are vulnerable to nurses' decisions to be an immediate part of their social environments, for clients are potential or sometimes unavoidable social objects of the nurses' environments. Distancing, avoiding, and several forms of social interaction have been found to be used by nurses to control clients' behaviors in hospital settings (Baider, 1976). In addition, nurses are also frequently in a position to control the makeup of the client's social environment, by limiting visiting hours, allowing rooming-in of family members for hospital care, or by placing the client in hospice care. The social environment of dying patients in our society has been studied and criticized for its impersonality and deception. Such a context seems to prescribe social interactions between professionals, family members, and patients that are psychologically destructive and detrimental to patients (Baider, 1976; Erickson & Hyerskay, 1975).

Thus, considerations of social environment for human health from the nursing perspective need to be made in two ways: as that influencing the health status of individuals through direct or intervening processes, and as that contributing to the process of health care and nursing practice.

### **Symbolic Environment**

The meaning of symbolic environment is closely connected with the "sociality" of human history and concomitantly with social environment. It is also closely tied to humans' ability to use language. It is not possible to imagine symbolic environment without people or language and historical accumulation of our thoughts, emotions, and acts. Elements of symbolic environ-

ment, if we can call them elements, are bound to human histories and human minds. Symbolic environment is composed of shared ideas on various levels: cultural values, scientific knowledge, social norms, and role expectations, among others. Analytically, an individual's ideas, attitudes, feelings, and knowledge belong to the individual as inherent parts of the individual; hence such elements become intrinsic parts of the individual as social object. In contrast, "shared ideas" are considered to represent the symbolic environment. In a strict sense, "shared ideas" belong to no one and to everyone. Symbolic environment has meaning for human life to the extent that our behaviors and human happenings are modified and patterned by them, and insofar as the person is able to take in the meanings of symbols. Therefore, for instance, an infant 3 days old has a very limited symbolic environment, compared to a child of 4 years old. In addition, the extent of the symbolic environment is irrelevant to the physical proximity of physical and social objects. Hence, the astronauts on the surface of the moon can be presumed to have had as extensive a symbolic environment as when they were on earth.

Sociologists consider such shared ideas functional to societies and social life. Cultural and social values and rules curtail human actions and control the fierce competition and conflict possible among individuals left alone to act according to their personal needs. Symbolic environment allows a client to behave in the "right" ways, while it permits a nurse to provide reinforcements for "right" behaviors. Symbolic environment provides a common reference point from which individuals in social as well as in solitary circumstances recognize and perform valued actions.

Viewed from the nursing perspective, symbolic environment has three specific components: (a) those elements that define what health and illness are, and what one should do about one's health and illness; (b) those elements that define available resources in dealing with health issues; and (c) those elements that prescribe role-relationships in health care.

The first component refers to cultural values and social norms regarding health and health behaviors. Cultural definitions of mental illness and controversial "deviance" are good examples of how individuals in a given culture interpret such behaviors as depression and homosexuality. Social norms exert pressures on individuals to behave in certain ways, as evidenced in fertility rates in societies, or in health-care seeking behaviors for certain kinds of symptoms. Thus, symbolic environments in the forms of cultural values and social norms exist for individuals and exert influences of many sorts on their behaviors.

Durkheim's study (1951) of societal differences in suicide rates of nineteenth century Europe provides an important background from which the proposition regarding symbolic environments can be reaffirmed: Ills of societies need to be examined and explained to a great extent by what

Durkheim called “collective tendencies,” i.e., social conscience. The affects of symbolic environment on an individual’s behaviors may be summarized as was done by Durkheim in relation to suicide rates.

At any given moment the moral constitution of society establishes the contingent of voluntary deaths. There is, therefore, for each people a collective force of a definite amount of energy, impelling men to self-destruction. The victim’s acts which at first seem to express only his personal temperament are really the supplement and prolongation of a social condition which they express externally.<sup>5</sup>

Social conscience as a form of symbolic environment provides a context in which members of a society evaluate the quality of life and behavioral consequences—thus, the occurrence of actual illness conditions and labeling of them are influenced by moral forces in societies.

The second component of the symbolic environment encompasses elements of social institutions, such as science, education, and polity. Scientific knowledge and technology are the major institutional elements that constitute a set of shared ideas in this sense. Fabrega (1974) contends that both health-care-seeking behaviors and health-care-providing behaviors are determined by theories of illness that are present and shared in a given society. This component of symbolic environment provides a general frame of reference from which a certain level of expectations for control and recovery from illness is formulated in individuals. In primitive societies, this component was mainly composed of notions about supernatural (demonic or godly) influences on human existence.

In addition, this component encompasses those symbolic aspects of a society that are defined by structures of institutions such as political, economic, labor, and health-care systems. Renaud (1975) argues that capitalist societies are constrained in their problem-solving endeavors relative to health by their economic structure. Health-care-providing behaviors appear to be different according to institutionalized structures of health care in different societies.<sup>6</sup>

The third component of the symbolic environment is more closely tied to social situations and refers to rules of behaviors for social roles. Individuals who come together in a social situation assume certain social roles that are congruent with the situation, and behave in accordance with mutual expectations and rules that have been socially learned. Parsons

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5. Durkheim, E. (1951). *Suicide: A study in sociology* (Trans. By J. A. Spaulding, & G. Simpson) (p. 299). New York: The Free Press.

6. See, for example, Alenxander Solzhenitsyn’s *Cancer Ward* for an illuminating insight into the health-care practices in the Gulag.

(1951) describes the sick-role expectations in modern Western societies as: (a) the person recognizing his or her state of illness considers this state undesirable and wants to get better; (b) the person is not considered to be responsible for his or her condition; (c) the person is excused from ordinary social role obligations; and (d) the person seeks professional help and cooperates with the health-care givers. The role expectations of helper and helped are also socially derived and usually known to client and practitioner who come together in service settings. Because such expectations do not belong to persons, although they are held by them and internalized by them, such elements are parts of the symbolic environment.

Important questions regarding the symbolic environment from the nursing perspective should deal with the nature of shared ideas, the extent to which such shared ideas govern behaviors, and characteristics of sharing among individuals in a given society with respect to health, health behavior, and nurse-client relations. When a society goes through disintegration, or when a persisting conflict exists among individuals having different vested interests, one might experience a lack of consensus in behavioral expectations, thus creating chaotic actions. In such cases, the symbolic environment is not enhancing to individuals' behaviors.

### **Health-Care Environment**

A person's environment when one becomes designated as a client of health care comes to have a rather special meaning both in empirical and symbolic senses. A health-care environment evolves around this client who is the recipient of health-care services from others who have been designated as health-care providers. The health-care environment of a client can exist for a short duration such as for a patient in a hospital for an episode of acute illness or for a long, extended duration such as for a patient in a nursing home or in a long-term care institution.

A health-care environment constitutes spatial and qualitative characteristics that are different from the person's ordinary and usual environment, even when the health-care or nursing service takes place in the client's home. Physically, the health-care environment may include elements that are only present in specialized situations that may be different from home, occupational, or recreational settings. Especially when the client is in an institution of health care such as a hospital or a nursing home, the environment contains many physical objects not found in ordinary living situations, such as various medical equipment, and is quite different spatially from the ordinary environment. Socially, it consists of individuals who are not usually present in the ordinary environment, and it may be lacking the usual social constituents such as family members and friends in the immediate part of the environment. Symbolically, the environment encompasses role expectations

that are specific to clients, subcultural values and ideas specific to that institution, and specialized knowledge systems of health care. Thus, the contents of an environment hold specialized meanings and generate different kinds of influences on a client as well as on health-care practices.

Although a health-care environment is a somewhat specialized type of environment, an individual can be viewed to be in the core of an environmental field, moving from one form of specialized environment to another throughout the life cycle. Thus, a person gets positioned in different sorts of specialized forms of environment for a certain duration through his or her self-determination and mobility as well as through universal, social, and institutional forces of living. A person is specifically in a health-care environment when one is in need of health-care services and assumes the role of a health-care client.

From the nursing perspective, the health-care environment is an important concept to consider in understanding and explaining clients' health-care experiences. Insofar as the health-care experiential phenomena of clients require special attention from nursing as suggested especially in Chapter 4, the study of such phenomena must be made through the specification and understanding of the health-care environment. Often, the health-care environment is the source for problematic experiences for clients, such as nosocomial infection, withdrawal, and confusion. On the other hand, the health-care environment also may be the source for positive influences for clients' recovery and illness experiences.

Health-care environment also is the context in which client-nurse interaction takes place. Various elements (physical, social, or symbolic) of the health-care environment may influence the duration, nature, and quality of client-nurse interaction positively or negatively. In addition, nursing practice takes place in a health-care environment. Nurses must practice in concert with other nurses and health-care providers, under the given organizational, and institutional constraints and prescriptions, and in the context of the cultural, professional, and social symbolic system.

The health-care environment hence needs to be specifically conceptualized in the nursing perspective for knowledge development for phenomena in the client, client-nurse, and practice domains. Understanding and explanation of selected phenomena from the health-care environmental perspective would be useful in developing nursing strategies that involve the management of environmental forces.

### **SELECTED CONCEPTUAL ANALYSES**

Among many possible concepts within the domain of environment appropriate for studying from the nurse perspective, sensory deprivation, social

support, and sick-role expectation have been selected for analysis in this section. These were selected from the examples listed in Table 7.1. Table 7.1 presents examples of concepts in the domain of environment that are thought to be appropriate for theoretical considerations from the nursing perspective.

**Table 7.1** Examples of Concepts in the Domain of Environment for Study in the Nursing Perspective

<b>Environmental Component</b>	<b>Concept</b>
Physical environment	<ul style="list-style-type: none"> <li>• Space, territory, proxemics</li> <li>• Time</li> <li>• Ecosystem</li> <li>• Energy</li> <li>• Noise</li> <li>• Crowding</li> <li>• Sensory deprivation</li> <li>• Sensory overload</li> <li>• Pathogens</li> <li>• Heat</li> </ul>
Social environment	<ul style="list-style-type: none"> <li>• Social support</li> <li>• Competition</li> <li>• Social control</li> <li>• Social isolation</li> <li>• Affective milieu</li> <li>• Marginality</li> <li>• Social proximity</li> <li>• Family</li> <li>• Significant others</li> </ul>
Symbolic environment	<ul style="list-style-type: none"> <li>• Power structure (authority)</li> <li>• Role expectations</li> <li>• Sick-role expectations</li> <li>• Institutional history</li> <li>• Ethical standards</li> <li>• Norm</li> <li>• Morality</li> <li>• Scientific knowledge</li> <li>• Rationality</li> <li>• Positivism</li> <li>• Metanarratives</li> </ul>

Sensory deprivation is considered as an example of physical environment phenomena; social support as that of social environment phenomena; and sick-role expectation as an example of symbolic environment phenomena. The main purpose of this section is to show how a first-level analytical approach is used to gain conceptual and empirical understanding of phenomena within the domain of environment. Each concept is analyzed with respect to (a) definitional clarification and conceptual meanings as reflected in the literature; (b) measurement and operationalization of concepts as a step toward an empirical analysis; and (c) the concept's relationships with other concepts that are important in nursing. The strategy and rationale for the conceptual analysis were discussed in detail in Chapter 2, and that rationale is adopted in this section for the analyses of sensory deprivation, social support, and sick-role expectation.

## **Sensory Deprivation**

### *Definition*

Environment is the source of sensory inputs for human perceptions: Sound, color, form, texture, temperature, and many other physical characteristics are perceived and sensed in order for a person to make assessments about the world around him or her and gauge his or her position in relation to it. A person recognizes familiar objects and persons, learns about new objects, and guards against unfamiliar objects that are judged to be potentially threatening. A person's life in a vacuum, if that is at all possible, may represent an ultimate state of absence of sensory input to the person. Persons placed in solitary confinement in jail or hospitals have been found to create sensory inputs by banging their heads on walls, scratching, or screaming. Lack of sensory input is threatening to adults who have learned to perceive the world through the senses. Thus, it tends to create a sense of disconnectedness with the world in persons when they are placed in a sensory-deprived environment. People receiving no sensory input may begin to doubt their own existence. Infants who are placed in a deprived (sensory) environment have also been found to assume the condition of "deprivation dwarfism" (Gardner, 1972).

The basic premises for the occurrence of such phenomena are that the human brain matures and develops through sensory stimulation, and that human behavior is shaped by functional and structural organization of information that occurs in the brain. Hebb's attempt (1949) to explain perceptual behavior in relation to the function of the central nervous system was the first link made between behavior and sensory experience. He postulated that perceptual behavior is influenced by early experience with deprivation of vision and other sense modalities and that monotonous,

unchanging stimulation resulted in a disorganization of the ability and capacity to think.

By definition, then, sensory deprivation is a lack or reduction of sensory stimulation in several different forms, varying in terms of intensity, duration, and characteristics. As early as 1949, Bakan described sensory deprivation as a state in which an organism is deprived of normal, complex sensory stimulation from the external environment for a specified period (Brownfield, 1972). Yet, there has been little agreement in the use and definition of the term describing the phenomenon. Rossi (1969) cites 25 different terms used more or less interchangeably with sensory deprivation in the literature. The problem of definition has been complicated because of the nature of research being done in the field. Many research studies adopt experimental conditions to "induce" the phenomenon of sensory deprivation artificially, and such procedural terms have been used interchangeably to denote the phenomenon in a limited sense.

In general, there are two broadly and distinctly different conceptualizations of sensory deprivation: (a) a state in which the focus is the environment; and (b) a state in which the focus is the individual organism experiencing the deprivation. The first conceptualization considers the phenomenon strictly in terms of the environmental characteristics as a lack, reduction, or monotonicity of sensory stimulation present in the environment. On the other hand, the second conceptualization refers either to the condition of the person being in a "deprived" state, or to a process in which a phenomenological experience of deprivation takes place in the person (Rossi, 1969). It appears that there is an analytical value in considering the phenomenon in two such separate ways. Our interest in the conceptualization of sensory deprivation is in line with the first type in which the environmental characteristics are the major focus.

Suedfeld (1969) categorizes sensory deprivation in terms of three major characteristics: the reduction of stimulus-input levels, the reduction of stimulus variability, and sensory-social isolation and confinement. Although these three characteristics have somewhat distinct meanings, there is circularity in meaning-relationships among them. Invariably, in nonexperimental situations, a reduction of stimulus variability that is produced by monotonous stimulation will result in a reduction of stimulus-input levels, and vice versa. In addition, sensory-social isolation and confinement frequently accompany both a reduction of stimulus variability and a reduction of stimulus-input levels.

#### *Differentiation of the Concept From Isolation*

The phenomenon of isolation encompasses a broader conceptual meaning than that of sensory deprivation. Isolation suggests removing a person to a



confined area without allowing normal contacts with the external world. Brownfield (1972) suggests four kinds of isolation: (a) confinement in which a person is placed in a limited space, restraining freedom of movement and in which sensory deprivation may vary according to the nature of the space; (b) separation in which a person is placed in an environment where personal contacts with particular persons, places, or things are not allowed, and which brings about deprivation of special kinds of sensory inputs; (c) removal from the total environment in which a person is placed in an environment of reduced stimulation or no stimulation, such as solitary confinement; and (d) monotony of stimulation in which a person is exposed to unchanging, invariable, and boring sensory inputs that eventually lose their ability to elicit responses.

Thus, the phenomenon of isolation may be induced by unconscious or conscious acts by a person (i.e., psychologically based), such as voluntary deprivation, self-punishment, or social isolation because of fear, religious beliefs, or conscience, and also may be imposed by external forces such as immobility, old age, loss of sensory ability, or impoverished early experience.

In general, isolation encompasses the aspects of social and psychological separation, while sensory deprivation is associated with the characteristics of the environment in terms of its sensory stimulation. Of course, isolation is a situation in which sensory deprivation is likely to occur. In differentiating the phenomenon of isolation and sensory deprivation, one source of confusion has been in the use of experimental "isolation" techniques in sensory deprivation research. Such techniques invariably combine reduction and monotonization of stimulation in isolating experimental subjects in order to manipulate sensory inputs.

### *Operationalization*

Sensory deprivation has been operationalized in research in two specific ways: as an environment in which there is a reduction of intensity of sensory inputs, and as an environment in which there is homogeneous and unpatterned input. Both of these operational definitions have been used to create an experimental environment.

The first type of operationalization generally refers to an experimental condition deliberately lacking in sensory stimulation, such as silence and darkness as used by T. I. Myers and his colleagues (T. I. Myers, Murphy, & Smith, 1963). The second type of operationalization refers to an experimental environment in which there is a limitation in the variability of sensory input such as constant masking of sensory input or white noise and diffused light, as used in McGill studies (Scott, Bexton, Heron, & Doane, 1959). Operationalizations used in such experimental conditions create

conceptual complications in that, when an environment has been manipulated to reduce sensory input, the remaining sensory elements in the environment take on different perceptual meanings to the person exposed to such an environment.

In addition, in most research studies, sensory deprivation has been operationalized to include the aspects of visual and auditory stimuli, with little emphasis on tactile, olfactory, kinesthetic, gustatory, and proprioceptive sense modalities. However, sensory deprivation operationalized in developmental research, in many cases includes the concept of multisensory deprivation. Deprivation of visual, auditory, tactile, and movement stimulations has been used specifically to indicate the deprivation of novelty in stimulation in those developmental studies. Stimulation for new learning is absent as a result of such deprivation (Riesen & Zilbert, 1975).

Operationalization of sensory deprivation referring to naturally occurring environmental conditions has been limited to hospital and nursing-home settings (Worrell, 1971). The most commonly studied settings of sensory deprivation in the health-care situation are: private room for a coronary patient; private room for a surgical patient, especially a patient undergoing cardiac surgery; elderly patient, especially the elderly who has decreased sensory abilities such as blindness, hearing loss, or other perceptual loss; "isolation" or "seclusion" room; hospital settings for immobilized patients such as those with stroke, in traction, or with spinal cord injury; and private room for a patient with eye surgery. These kinds of nursing care situations have a reduced rather than a complete lack of sensory stimulation and usually provide monotonous or unchanging stimulations of sounds and visual objects. Monotonous sensory input of a mute nature has been defined as perceptual deprivation, differentiating it from the general concept of sensory deprivation.

Perceptual deprivation, defined as such, is more commonly detectable in clinical, practice settings. L. F. Newman (1981) studied the isolette environment of preterm infants, in which the isolette environment is perceived as an auditory environment of high ground noise and intrusive sound of a disturbing nature. This isolette environment is conceived to provide infants with a situation in which human sounds are filtered by such ground noises. It is thus seen as producing perceptual deprivation in infants.

Social isolation, confinement, withdrawal, and neglect have also been used to denote sensory deprivation in sociological and psychological studies. In particular, the isolation and confinement of the elderly in single-occupancy hotel rooms in which variation in sensory input is lacking for an extended period of time have been considered as an environment of sensory deprivation for the elderly.

It appears that operationalization of sensory deprivation depends on one's definition of the term and can vary from deprivation of one sensory

modality to a complete deprivation of sensory input as well as monotony of sensory input.

### *Relationship With Other Concepts*

Most of the studies in the field of sensory deprivation may be categorized into those relating sensory deprivation to developmental consequences and those relating sensory deprivation to other behavioral aberrations such as hallucination.

There are many studies in the first category, emphasizing the maturational affects on specific senses and the general behavioral and developmental consequences. Animal and human studies found relationships between early visual experience (or the lack of it) and visual preference, indicating the influence of early sensory stimulation on sensory maturation (Annis & Frost, 1973; Tees, Midgley, & Bruinsma, 1980). In addition, Prescott (1980) suggests that sensory deprivation during early development leads to stimulus-seeking behaviors relative to the deprived sensory systems, and further that somatosensory, affectional deprivation from isolation rearing may be responsible for violent behaviors toward self and others. Alcoholism and drug abuse as stimulus-seeking behaviors have been postulated to be the results of such deprivation. Thus, the individual is assumed to be attempting to gain the sensory stimulation that he or she was deprived of early in life. Deprivation dwarfism has also been suggested as a secondary effect of hypopituitarism produced by sensory deprivation in animals and humans (G. M. Brown, 1976; Patton & Gardner, 1975; Powell, Brasel, & Blizzard, 1967; Wolff & Money, 1973).

One of the major variables identified as a consequence of sensory deprivation in the second category of studies is hallucinatory activity such as visual imagery and test performance found in McGill studies (Bexton, Heron, & Scott, 1954). Zuckerman (1969) explains the phenomenon of hallucination as a self-aroused imagery perceived by a person because of a lack of competing sensory inputs. A person in an environment without patterned and changing stimulation eventually may become sensitized to more organized images whose site of origin lies higher in the nervous system and that may be intensified by a high state of arousal or by reduction in competing stimuli, thus appearing as visual imageries localized in space in front of the person.

It also has been shown that visual deprivation is associated with an increased tactual acuity, pain sensitivity, auditory discrimination, and olfactory and gustatory sensitivity. In addition, other single-modality deprivation can also produce behavioral changes (Zubek, 1969). Biochemical changes, especially that produced by steroids and endorphins, have been the concern of many current studies, suggesting a linkage between sensory depri-

vation and behavioral changes mediated by internal processes of biochemical synthesis (Prescott, 1980; Zubek, 1969).

Zuckerman (1969) and Suedfeld (1969) have examined various theoretical approaches used in studies of sensory deprivation and found diversity in the explanations and in the inclusion of various types of dependent variables in the explanations.

In the nursing literature, sensory deprivation has been handled in a casual, cursory manner. Theoretical or empirical writings are rarely found on this subject, although sensory deprivation in practice settings is often seen in hospitalized and nursing home patients, and nurses have observed its deleterious effect on patients. Many nurses in clinical case studies and at clinical conferences have reported complaints of hallucination and confusion by postsurgical patients, elderly patients, and immobilized patients. The importance of sensory deprivation for a nursing study is apparent, in view of the fact that most of the naturally occurring sensory deprivations are present in health-care environments, and also that affects of sensory deprivation are general and nonspecific to the person and his or her development. Furthermore, sensory deprivation as a phenomenon of the client's environment may complicate the client's recovery from illness in a rather complex manner. The environment of nursing care may inadvertently be the source of sensory deprivation to the client, thus becoming a deleterious rather than enhancing surrounding for health-recovery and health-maintenance.

## **Social Support**

### *Definition*

In general, social support refers to positive, reinforcing attitudes generated by individuals in social relations with each other. Although it is this "supportiveness" that is central to the concept, it has been used in research synonymously with social network, social bond, and social integration. This has created some confusion in the theoretical formulation of the concept.

The main source of such confusion is embedded in viewing the source of "support," i.e., social relation and social network, interchangeably with the nature of "support." For example, Antonovsky (1979) states that social support is the extent to which a person is lodged in social networks to which the person is committed; and J. K. Myers, Lindenthal, & Pepper (1975), Eaton (1978), and Brown, Bhrolcháin, & Harris (1975) also conceptualize social support in terms of the extensiveness of social relationships. In addition, "meaningful social contact" (Cassel, 1976), availability of confidants (Miller & Ingham, 1976), human companionship (Lynch, 1977), social bond (Henderson, 1977, 1980), and social network (cf. Mueller, 1980; Norbeck, 1981) have been used to make inferences about

social support. Although the assumption is that social relationships and networks provide support, evidence indicates that the relationship between the intensity, size, and extensity of a social network and social support is not linear.<sup>7</sup>

Cobb (1976) and Turner (1981) consider social support in terms of information. Social support is viewed on the basis of three types of information:

- Affective information—information suggestive of being loved and cared for;
- Information of worthiness—information suggestive of being valued and esteemed;
- Information of partisanship—information suggestive of belonging to mutually influencing social relations.

In a similar fashion, B. H. Kaplan and his colleagues (B. H. Kaplan, Cassel, & Gore, 1977) define social support as the degree to which an individual's needs for affection, security, approval, belongingness, and identity are "met" through social interaction. This definition also assumes that the person's perception is an integral part of social support.

What does not emerge from these definitions is the suggestion of different kinds of support that are possible in social relations. Linking the conceptualization of social network as the source of social support and the reference-group theory proposed by Merton (1968) could raise this question. The reference-group theory suggests that individuals use their social contacts as the framework for receiving reinforcements, support, and evaluations when making behavioral choices and in expressing ideas and attitudes. Hence, the information one receives from relationships with others may be both emotional (affective) and cognitive (evaluative), and both types of information may be "supportive" to the person in general or in specific situations. Therefore, it is possible to conceptualize social support as information generated to a person in social relations, information that has either a general affective or a specific instrumental meaning of support.

### *Operationalization*

Different definitions of social support used in the field have resulted in varied and sometimes limiting operationalizations of the concept. In defining social support in terms of more "affective" than "instrumental" information, Turner (1981) used self-evaluation of the perceived level of informa-

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7. See, for example, Cohen, C. I., & Sokolovsky, J. (1979). Health seeking behavior and social network of the aged in single-room occupancy hotels. *Journal of the American Geriatric Society*, 27, 270-278.

tion generated by others to indicate the level of social support. He used vignettes developed by A. Kaplan (1977) as the basis of self-evaluation. LaRocco, House, and French (1980) also operationalized social support as perceived psychological and tangible support from supervisors, co-workers, spouse, family, and friends. They specifically defined social support as "emotional supportiveness." A limitation with this kind of operationalization is the lack of objective criteria to attest to the fit between perceived information and actual supportiveness present in social relations.

It is problematic to assume that "perceived" support equals "real" support present in the social environment. This difficulty is based on two issues: (a) perception can be influenced by a person's interpretation of meanings attached to self, others, situation, and happenings; and (b) supportiveness may not be apparent until actual "incidents" or occasions call for mobilization of support being offered or already given by others. The first problem points up the need for objective criteria for interpretations, and the second issue raises a further question regarding the need for differentiating generalized versus contextual or specialized support.

A more inclusive operationalization of the concept of social support is found in several studies. Gore (1978) operationalizes social support on three dimensions: (a) a person's perception of supportiveness of significant others; (b) frequency of activity outside the home with significant others that indicates amount of social interaction; and (c) perceived opportunity for engaging in supportive and satisfying social activities. Similarly, Lin and colleagues (Lin, Simeone, Ensel, & Kuo, 1979) define social support as support accessible to an individual through social ties to other individuals, groups, and the larger community. They measure the concept in terms of the degree of social interaction and involvement and the level of social adjustment. Other researchers also have operationalized social support on multidimensional levels, including social relations, perceptions, and type of support.<sup>8</sup>

However, operationalization of social support is in need of consensus. While most researchers consider the sources of support in terms of significant others, few research studies have included support from the community at large and from lay-support systems as important components of the

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8. Among many research writings on the subject, see: Kaplan, B. H., Cassel, J. C., & Gore, S. (1977). Social support and health. *Medical Care*, 15 (Supplement), 47-58; Dean, A., & Lin, N. (1977). The stress buffering role of social support. *Journal of Nervous and Mental Disease*, 165, 403-417; Walker, K. N., MacBride, A., & Vachon, M. L. S. (1977). Social support networks and the crisis of bereavement. *Social Science and Medicine*, 11, 35-41; and Henderson, S. (1977). The social networks, social support, and neurosis: The function of attachment in adult life. *British Journal of Psychiatry*, 13, 185-191.

total social support system. Furthermore, operational difficulties in differentiating the nature of affective and instrumental support and in attaining consensus regarding perceived support vis-a-vis "apparent" support need to be addressed.

### *Relationships With Other Concepts*

Social support has been used to explain various phenomena in an individual's life. The basic notion is that an individual's behaviors may be explained by factors in his or her social environment such as social network, interaction patterns, or structures of social institutions. This notion extends the explanation of human behavior beyond the attributes of individuals themselves. Social support has been applied in many studies to explain the relationships among social environment, occurrence and management of stress, health status, and other social behaviors. Social support has been viewed to have mediating or buffering effects on the way individuals handle stress, modify illness responses associated with life's stresses, and affect the rate and quality of health-services utilization.

In her study of the effects of social support in moderating the health consequences of unemployment, Gore (1978) suggested that the loss of self-worthiness through unemployment and confounded by the lack of social support contributed to negative health consequences. J. K. Myers et al. (1975) also concluded that persons with high social integration scores seem better able to cope with the impact of life's stresses, alluding to the idea that the accessibility to social support and integration contribute to better coping with stress. Many other researchers have also proposed the same mechanism.<sup>9</sup>

Evidence suggesting the relationships between the use of health services and social support are confusing. Salloway and Dillon (1973) found that different types of networks influenced the degree of speed with which one used health services. Large friend-networks may also be influential in encouraging a person to seek medical care. On the other hand, health-care seeking behaviors may be more influenced by the kinds of advice one receives rather than by the sources of the support.

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9. LaRocco, J. M., House, J. S., & French, J. R. P. Jr. (1980). Social support, occupational stress, and health. *Journal of Health and Social Behavior*, 21, 202-218; Liem, J. H., & Liem, R. (1978). Social class and mental illness reconsidered: The role of economic stress and social support. *Journal of Health and Social Behavior*, 19, 139-156; Andrews, G. C. et al. (1978). Life events, stress, social support, coping style, and risk of psychological impairment. *Journal of Nervous and Mental Disease*, 166, 307-316; and Cobb, S., & Kasl, S. V. (1977). *Termination: The consequences of job loss*, DHEW (NIOSH) Publication No. 77-224. Cincinnati, Ohio.

Effects of social support on a client's compliance to health-care practices and therapies have also been frequently documented in the nursing literature. It appears that clients who have support in their daily life are more likely to adhere to many unfavored and/or unpleasant regimens, compared to those individuals who are lacking in social reinforcement.

From the nursing perspective, three major phenomena seem important to study in relation to social support:

- The individual's patterns of coping with stress;
- The individual's reactions and behaviors related to illness experiences;
- The individual's compliance behaviors with regard to health-care regimens.

### **Sick-Role Expectation**

#### *Definition*

Parsons (1951) defines illness as a state of disturbance in the "normal" functioning of the total human individual, including both the state of the organism as a biological being, and the state of his or her personal and social adjustments. It is therefore viewed as a form of "social" deviance that requires management by mechanisms of social control. Hence, the sick role as "the institutionalized expectation system" is conceptualized by Parsons as the mechanism of social control for an individual's illness.

Parsons (1951) proposed that the institutionalized expectation system of the sick role is composed of four aspects:

- A sick person expects an exemption from normal social role responsibilities, an exemption of varying extent according to the nature and severity of the illness, and expects the exemption to be legitimized by someone and to members of immediate support groups.
- A sick person is relieved of "being responsible" for his or her illness.
- A sick person is expected to want to get well, since the state of being ill is viewed as undesirable.
- A sick person is expected and is compelled to submit to technically competent help.

Twaddle (1979) suggests that the conceptualization of the sick role is specifically tied to the view that "sickness" is a social label for the state of being unwell, or "unhealthy." He also differentiates three states that comprise "nonhealth": disease, referring to biological capacities; illness, encompassing subjective or psychological meanings; and sickness, referring to a social aspect of illness. Thus, to be sick is to have certain rights and obliga-



tions ascribed by social role expectations, while to be diseased means to have signs and symptoms of disturbance, and to be ill is to feel deviated from feelings of wellness.

Much of the debate regarding the concept of the sick role has centered on the four components identified by Parsons as the universal construct of the sick role. Freidson (1970a), especially, argues that the expectation of the exemption from social role obligations may be limited to certain types of disease; that societies attribute the causes of some illnesses to sick persons themselves; that the expectation to seek and cooperate with professional help can be universal neither for all types of illness nor for all societies; and that the basic constructs of Parsons are rooted in the value structures and institutional development of Western, modernized societies, and are thus not applicable to nonwestern societies.

Parsons proposed the sick role as containing symbolic properties of a society, especially those of American society. This role is an institutionalized basis of social control for illness in a society. Contents of the sick role reflect the major value structures of a given society. Therefore, it may be more useful to define the sick role as a system of expectations that are institutionalized and accepted as the general "guidelines" for defining the meanings of sickness and for model behaviors for the person who is sick. This goes along with Twaddle's notion that the sick role is an effect variable to be explained on a global scale with respect to societal differences (1979). The sick role, then, is a system of general norms and expectations that provide a context for "rightful" behaviors for sick individuals in a given society or culture.

### *Operationalization*

The operational definition of the sick role has suffered from the confusion that occurred when researchers applied the concept in research. Many researchers included both "expectations" and "behaviors" to indicate the sick role. For example, Twaddle (1969) included both stated expectations for behaviors and the actual behaviors to indicate the sick-role formulation, confounding the role-expectations that are tied to the role behaviors.

Probably Gordon's study of a large population sample of New York City (1966) is the only one that operationalized the sick-role concept as the generally held expectations for persons who are sick. As a system of value consensus and expectations for role behaviors, the concept needs to be operationalized on a general level, that is, at a societal level or for subsectors of a given society. For it to have any conceptual meaning as a concept representing phenomena in the symbolic environment, it is necessary to operationalize it in terms of generally held expectations, i.e., consensus, rather than as an individual's convictions.

*Relationships With Other Concepts*

There are three distinct theoretical and empirical questions related to the sick-role concept that appear to be relevant to the nursing perspective.<sup>10</sup>

- What are the contents of the sick role, and what are the variations of such contents?
- In what ways are variations explained? What are the relationships between the sick-role expectations and the individual's sickness behaviors?
- To what extent does the "sharedness" of the sick-role expectations between the professionals and the clients influence health-care behaviors?

The first question is concerned with the descriptive validation of the sick role and focuses on the nature of institutionalization of role expectations. As indicated earlier, very little work has been done to examine the universality of the four aspects of the sick role formulated by Parsons. Segall (1972) explored the sick-role expectations held by hospitalized female patients, and found that only (a) the dimension of undesirability of illness, and (b) the expectation for striving to get well, were agreed upon as sick-role expectations held in common by patients. This questions the validity of the four dimensions as the universally held expectations of the sick role.

Several researchers have also suggested that the four dimensions of the sick role do not apply to all types of illness. For example, Kosa and Robertson (1969) suggest that the sick role only applies to chronic illness. In contrast, Freidson (1961) argues that the sick role is most appropriate in considering nontrivial, acute illnesses. Furthermore, the legitimacy and social definition of certain illnesses, such as mental illness, alcoholism, or drug addiction, confound the sick-role concept whenever a society holds the individual personally responsible for the illness and its consequences. It is also apparent that the prevailing philosophy and knowledge that exist in a given society regarding health, disease, and health-care practices influence the way a system of value expectations becomes institutionalized in a society.

Additionally, since in an earlier section of this chapter it was proposed that the symbolic environment may be considered in terms of proximity to individuals, it is necessary to question whether or not the sick-role expectations are different on a subcultural level or in social stratification sectors.

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10. Twaddle compiled a set of propositions related to sickness behavior and the sick role. See: Twaddle, A. (1979). *Sickness behavior and the sick role (Appendix B, pp. 199-206)*. Cambridge, MA: Schenkman Publishing.

Although some variations in sick-role expectations are found among different socioeconomic status groups (Berkanovic, 1972; Gordon, 1966; Twaddle, 1969), the question raised by Segall (1976) is still appropriate: Are the dimensions and contents of the sick role similar among people from different segments of society or different population groups?

The second question poses relationships between the sick role as independent variable and individuals' behaviors as dependent variables. The basic assumption stems from Parsons' formulation of the theory of action in which individuals' actions are explained in terms of the actors' motivations, values, and orientations to the situations. Thus, individuals are expected to behave in ways that are in agreement with sick-role expectations. However, evidence indicates that the relationship between sick-role expectations and actual behaviors reflecting such expectations seems modified by many factors. The nature of the illness appears to have a highly modifying affect on whether or not the sick person will assume the sick-role behaviors. A person's other role obligations specified by what Merton calls "role-set" (1968) also seem to influence the behaviors related to assuming the sick role. A person's position in the social stratification system may also determine the presence or absence of opportunities for behaving in accordance with sick-role expectations (Twaddle, 1979).

Furthermore, the degree to which an individual adheres to social norms and identifies with the value structure of society, that is, the degree of social "belongingness" or the level of social assimilation, may influence the way one behaves when sick. This may result from either the presence or the lack of validation and reinforcement offered to individuals who are behaving in a certain fashion. This would be more apparent in cases of socially stigmatized illnesses or of ambiguously defined illnesses such as depression, anorexia nervosa, or essential hypertension.

The question of alignment in sick-role expectations and behaviors between professionals and clients has direct implications for nursing. Nurses' behaviors as well as their beliefs about the sick role certainly influence the approaches nurses use toward clients. Since an assumption of the sick role requires validation of the role by others, especially by the professional, this process of validation requires empirical attention. Wolinsky and Wolinsky (1981) found that physicians do not necessarily legitimize the sick role for everyone who assumes this role. Legitimization is offered more often to those clients who come from a lower socioeconomic background, who are seeking validation from a regular source of professional contact, and who have more frequent contact with medical care. There may be two distinct mechanisms that influence the process of validation and alignment of evaluations: (a) The systems of the sick-role expectations are, in fact, different according to the nature of illness, to the extent that professionals and laypeople define illness differently; and (b) the systems of sick-role

expectations vary greatly according to substrata and segments of society, to the extent that a majority of the professionals belong to a specific subculture or substrata that is quite different from that of the general population. Consequences to the clients of disparity and disalignment in the validation of the sick role have not been adequately studied in the field.

It is possible to imagine a case in which a person who considers himself to be sick is turned away by a physician or a nurse. The person may be thought of as a malingerer or not being "ill enough." As a consequence, the person may experience frustration, stress, distrust, or relief in an immediate sense, and the person furthermore learns a new normative basis for symptom evaluation that may influence his or her future behaviors.

As pointed out by Twaddle (1979), conversion of sick-role expectations into behaviors on an individual level hinges on "decisions" made by the person to classify himself or herself as sick. Since all two-category decisions of this kind, e.g., sick versus not sick, or hungry versus not hungry, require a criterion of threshold, the problem rests critically on the decision rules used by individuals. Thus, as the primary validators of the sick role, nurses are frequently exposed to situations of disparity. Or, as participants in the provision of health care, nurses are in situations where legitimation has already occurred that may or may not align with the nurses' own validation rules. Conflicts of this type may result in negative behaviors toward clients.

### **SUMMARY**

The purpose of this chapter has been to offer conceptualization of environment as a separate entity from that of client. This is done to sharpen the distinction between phenomena within the domain of client and those phenomena within the domain of environment. Consideration of environmental phenomena in a separate context should also highlight the integration between humanity and the environment. The basic premise for this chapter is the notion that environment is the source of forces exerting influences on a person and his or her existence, and that it is also a context in which living (many facets of it) takes place. Therefore, environment, either taken as a whole or as having many distinct classes of phenomena, is an essential component for theoretical thinking in nursing.

While environment as a unity is considered to have specific meanings when taken as a whole, it is also proposed in this exposition that there are specific benefits in considering the domain of environment as composed of separate components.

The typology of environment used here includes three qualitative components of a physical, social, and symbolic nature, combined with the two dimensions of space and time. Variability of environment can thus be con-

sidered in these terms. The most elementary proposition regarding space might be that the more immediate environmental elements are likely to produce a greater impact on a person than the more remote environmental forces. This proposition of proximity requires both theoretical and empirical examination, first in a holistic sense, then on a compartmentalized level. Specification of dependent phenomena, i.e., aspects of a person on which the impact of the environment is inferred, depends on the scientific perspective of the study. Hence, from the nursing perspective, we would be mostly interested in explaining certain aspects of health-related states and health-related behaviors as affected by environment.

Time dimension in relation to environment poses two types of variability. Duration of environmental presence is the first variability. Some environmental elements are with us continuously, intermittently, or only fleetingly. Rhythmicity of the presence of environmental elements (that is, regularly appearing or randomly present) is the second variability. In many ways, the temporal aspects of one's environment are closely related to the person's habits and patterns of behavior. Continuous exposure to polluted air has a great impact on the human respiratory system, and at the same time an exposure to a highly potent radioactive substance for a fleeting moment can be fatal.

The aspect of quality is inherent in three components of environment, since these components are thought to be characteristically different. Sensory deprivation, social support, and the sick role as differently conceived characteristics of environment have been considered as independent variables impinging on various dependent phenomena in the domain of client. Biological and chemical aspects of environment have been linked to many disease conditions, ranging from smallpox to cancer. Relationships between health and social and symbolic elements of environment are beginning to be explored. Rheumatoid arthritis, coronary heart disease, hypertension, as well as many psychological stress syndromes and mental illnesses have been linked to unfavorable aspects of the environment.

In addition, a person's behaviors in seeking health care, responding to diseases, forming habits of everyday life, as well as gaining patterns of growth and development, and learning and unlearning behaviors and knowledge, also have been found to be related to environmental phenomena of various kinds.

Another important consideration of environment within the nursing frame of reference concerns the environment in which nursing care takes place. The environment of nursing care raises quite different kinds of theoretical and empirical questions for nursing scientists. Elements of such an environment, i.e., the physical, social, and symbolic environments, affect not only clients who are placed in it but also the ways in which nursing care is provided. Nurses' actions are to some extent created, developed, modi-

fied, and constrained within the given environmental contexts. Studying phenomena of the environment from the nursing perspective, then, requires focusing on relationships between nursing-care variations and environment as well as those between a person's health and health-related behaviors and environment.

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# 8

## *Theory Development in Nursing*

*Theories are the key to the scientific understanding of empirical phenomena, and they are normally developed only when previous research has yielded a body of information, including empirical generalizations about the phenomena in question. A theory is then intended to provide deeper understanding by presenting those phenomena as manifestations of certain underlying processes, governed by characteristic laws which account for, and usually correct and refine, the previously established generalizations.*

—Carl G. Hempel

### OVERVIEW

This chapter aims to show the nature of theoretical study of phenomena in the proposed four domains of nursing. While the previous chapters are more critically concerned with the nature of concepts within each domain, this chapter is concerned with the nature of theories as they culminate from relevant concepts. Attempts are made to show how concepts delineated within the four domains can be developed into systems of theoretical statements. Here the purpose is not to propose theories, but rather to point to the general theoretically descriptive and explanatory ideas possible for each domain. The idea is to lead to thinking about developing theoretical systems through a systematic and logical linking of concepts that compose nursing's relevance structure.

The chapter presents for each domain general models of explanation, which may guide the development of theories for the domain. Such models can be used as generic guides in developing theories at various levels. The models proposed for the four domains are primarily founded upon the assumption that a theory at the most comprehensive level must account for as complete an explanation as possible. However, this is not meant to convey that *all* theories must be built at the most comprehensive level. Theories using a comprehensive model of explanation as a guide may be developed selecting certain aspects of the total framework, depending on their explanatory foci, the scope of explanation, and paradigmatic orien-

tation. Hence, theories and systems of theoretical statements may bring together concepts and variables from a single domain only or across different domains. Theories may then be “within domain” or “across domains” theories. Theoretical statements referring to phenomena within the same domain are important for two reasons: (a) such statements lead us to a more refined conceptual system by which phenomena may be reclassified and differentiated from one another; and (b) a set of such theoretical statements may make up a theory for the domain (i.e., a “within domain” theory). My approach, consisting of holistic and particularistic conceptualizations of phenomena within domains, also suggests three levels of relationships:

- A holistic concept with one or more holistic concept(s);
- A holistic concept with one or more particularistic concept(s);
- A particularistic concept with one or more particularistic concept(s).

On the other hand, theoretical statements among concepts drawing from two or more domains are oriented to developing “across domains” theories. Such theories may contain different types of theoretical statements as shown in Table 8.1. Types of theoretical statements with the explanatory focus on the client, client-nurse, and practice domains are given in this table.

Ideas with the explanatory focus on the environment domain are not included in this table, as the theoretical development with this focus is not very relevant to nursing. It certainly is necessary to have the knowledge about environment domain phenomena from the nursing perspective, however. Theories for the environment domain phenomena are not likely to be developed within this typology of four domains, but may be developed from the nursing perspective. This will be discussed in a later section.

Theoretical statements linking concepts and phenomena within each domain and across the domains are examined in order to indicate that relevant and critical relationships may be brought together in “theories in nursing” and “theories of nursing.” For each domain, I present general models of explanation, and proceed to examine different theoretical systems that deal with phenomena of the domain at various levels.

In Chapter 2, the major terms of importance in theory development were defined. A theoretical statement may be descriptive or explanatory. A descriptive statement provides specifications regarding the nature of concepts in terms of existence, variability, quality, and essential features, while an explanatory statement is a proposition that links two or more concepts in basically three relational forms: associational, i.e., covariance, causal, and dynamic relationships. This means that a theoretical statement of a propositional type specifies the relationship of at least one class of phenomena

**Table 8.1** Types of Across-domain Theoretical Statements

<b>EXPLANATORY FOCUS OF DOMAIN</b>		
<b>Client Domain</b>	<b>Client-Nurse Domain</b>	<b>Practice Domain</b>
<i>Client Domain Concept(s) with:</i>	<i>Client-Nurse Domain Concept(s) with:</i>	<i>Practice Domain Concept(s) with:</i>
<ul style="list-style-type: none"> <li>• client-nurse domain concept(s)</li> <li>• practice domain concept(s)</li> <li>• environment domain concept(s)</li> <li>• client-nurse and practice domain concepts</li> <li>• client-nurse and environment domain concepts</li> <li>• practice and environment domain concepts</li> <li>• client-nurse, practice, and environment domain concepts</li> </ul>	<ul style="list-style-type: none"> <li>• client domain concept(s)</li> <li>• practice domain concept(s)</li> <li>• environment domain concept(s)</li> <li>• client and practice domain concepts</li> <li>• client and environment domain concepts</li> <li>• practice and environment domain concepts</li> <li>• client, practice, and environment domain concepts</li> </ul>	<ul style="list-style-type: none"> <li>• client domain concept(s)</li> <li>• client-nurse domain concept(s)</li> <li>• environment domain concept(s)</li> <li>• client and client-nurse domain concepts</li> <li>• client and environment domain concepts</li> <li>• client-nurse and environment domain concepts</li> <li>• client, client-nurse, and environment domain concepts</li> </ul>

to another class of phenomena in order to elucidate an explanation of one set of the two. An explanatory statement can be simple or complex in that it may link two concepts in a simple association or it may link several concepts in a set of dynamic relationships. In this chapter, primarily this definition is used to illustrate the types of theoretical statements examined for our purpose.

## **THEORETICAL IDEAS FOR THE CLIENT DOMAIN**

In Chapter 4, several conceptualizations regarding phenomena in the domain of client were presented. Such conceptualizations appear to be related to theoretical models, and were, in most instances, developed in a deductive fashion. In addition, the use of the inductive method and a combined inductive and deductive method for conceptual clarification were evident in nursing research literature.

A review of three nursing journals (*Nursing Research*, *Research in Nursing and Health*, and *Advances in Nursing Science*) in 1982 revealed that 51 articles out of a total of 316 dealt with conceptualization of client domain phenomena, as presented in Table 8.2. This picture changed dramatically during the ensuing period to the present. We now often see two or three articles in a given nursing journal that deal with concept development, concept clarification, or concept analysis. In addition to what are shown in Table 8.2, we now have conceptualizations of phenomena in the client domain that range from transcendence, self-efficacy, chronic sorrow, suffering, fatigue, restlessness, confusion, homelessness, and energy-use to many nursing diagnosis concepts developed within the NANDA system. Concept development associated with the nomenclature of nursing diagnoses proposed by NANDA has been very active during the past decade. Mostly, nursing diagnoses, as problematic concepts within this typology, have been identified descriptively through empirical generalizations for identification purposes in nursing practice, without much effort devoted to developing explanatory theories for them.

In addition to the conceptual work, there are mainly three types of theoretical efforts for knowledge generation for this domain: (a) grand-level theory formulation and refinement of general nursing theories having their focus on the client domain; (b) development of middle-range theories and refinement of them; and (c) empirical testing of theories for specification, reformulation, and adaptation from the nursing perspective. The first type of effort has been evident in the works associated with nursing's so-called grand theories and theoretical models, which are oriented to providing explanatory frameworks for client phenomena, such as those advanced by Rogers, Roy, Orem, Neuman, and Parse.

**Table 8.2** Concepts and Phenomena Examined in the Published Works in the Selected Nursing Journals\* (1978–1981)—The Domain of Client

Holistic Concepts	Particularistic Concepts
Adaptation	Anxiety
Adaptation as “healthy”	Attachment behavior
Behavioral system	Boredom and confusion
Denver developmental system	Child abuse and neglect
Depleted health potential	Cognitive development
Duration experience	Decision making
Family growth and development	Exploratory behavior
Growth vs. persistence	Fatigue
Health	Fear
Health need	Grief
Holistic health	Health-belief
Independence	Interpersonal conflict in
Life event	marital matters
Perceived uncertainty in illness	In vitro fertilization
Process of recovery	Locus of control
Pronominalization	Love
Self-care agency	Maternal attachment
Stress and coping	Menopause
	Neonatal perception
	Obesity
	Pain
	Paternal attachment
	Privacy
	Psychophysiological stress
	Self-esteem

\*Nursing journals reviewed for this table are *Nursing Research*, *Research in Nursing and Health*, and *Advances in Nursing Science*.

The second type of effort is evident in the works using the framework of grounded theory in nursing as summarized by Benoliel (1996), middle-range theory development and theoretical modeling work such as those in the areas of women's health (Voda & George, 1986; Woods, 1993), fatigue (Lenz, Suppe, Gift, Pugh, & Milligan, 1995), self-transcendence (Reed, 1991), uncertainty in illness (Mishel, 1988, 1990), elderly health, chronic



sorrow, suffering, and confusion. The third type of effort has been summarized partly by Barnard (1983), Denyes (1983), and Flemming (1986) for works in the area of child phenomena, by Stevenson (1984) for those in adult phenomena, and by Adams (1986) for works in aging phenomena. Kirkevold (1994) has also shown that there have been numerous works that present theoretical development with a focus on phenomena in the client domain. She found in her review of the nursing literature from 1983 to 1993 that about 32% of the articles dealt with client domain phenomena. The articles dealt with themes in the client domain phenomena, ranging from 16 thematic areas pertaining to essentialistic phenomena, 9 areas pertaining to developmental phenomena, 12 areas pertaining to problematic phenomena, and two health-care experiential phenomena. She suggests that cumulative knowledge development leading to theoretical ideas is evident in the following areas<sup>1</sup>:

1. Patterns of stress-coping
2. Mothering/parenting role enactment and decision making
3. Explanation of fatigue
4. Caregiver burden
5. Patient falls
6. Elderly care

Kirkevold (1994) also found that much of the empirical research is carried out within common theoretical frameworks such as the Lazarus' stress-coping model and the theory of rational decision making. This review suggests that nursing scholars are moving forward to codifying their work with a view toward theoretical development. With this type of effort, diverse theoretical models in physiology, psychology, anthropology, and sociology have been empirically tested in an effort to refine and redefine theories within the nursing context.

The major thrusts for knowledge development in this domain should be oriented toward the development of nursing theories of humanity dealing with general and holistic phenomena and the development and testing of middle-range theories that deal with particularistic phenomena in the client domain. In order to provide a starting point for further analysis and additional expansion of theoretical knowledge for the client domain, three generic models of explanation are presented in the following section. The three explanatory models presented below are the generic prototypes for thinking theoretically about phenomena in the client domain.

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1. Kirkevold, M. (1994). The contribution of nursing research—Knowledge about client. *The Proceeding of 7th Biennial Conference of the Workgroup of European Nurse Researchers: The Contribution of Nursing Research: Past-Present-Future*, Oslo, Norway, p.9.

**Explanatory Model 1—“Within domain” Formula**

An explanation of phenomena in the client domain may be offered eliciting other phenomena in the client as has been done in many theories in physiology, psychology, and nursing. This model focuses on seeking explanatory factors or processes by looking into those aspects that are intrinsic and internal to humans and human conditions. In this model, selected human phenomena are thought to be providing associational, processual, or causal influences to the other human phenomena that are the focus of attention for a given theory.

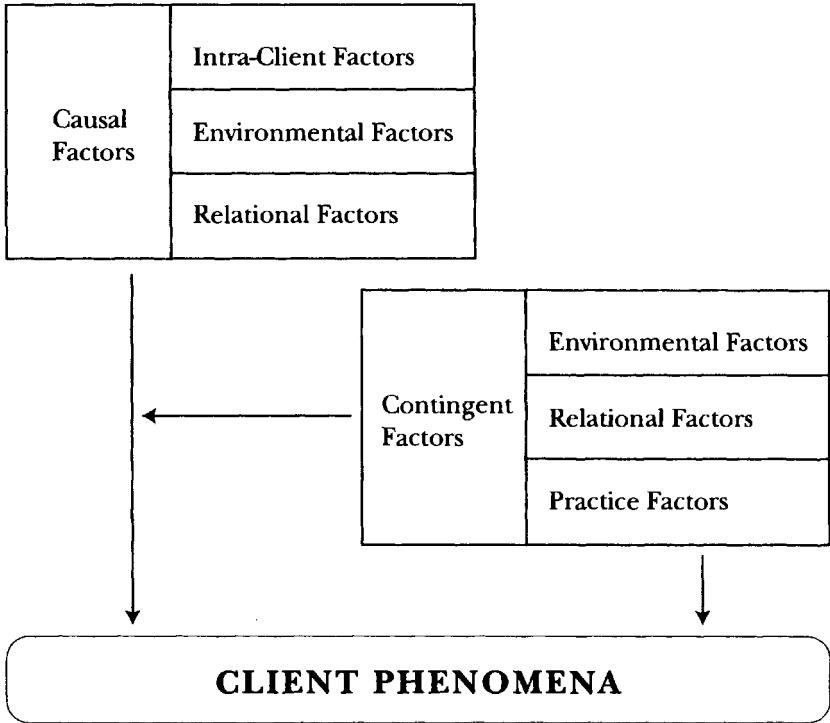
For example, the theory of self-transcendence advanced by Reed (1991) proposes the relationship between transcendence and developmental level in the elderly. In the theory of parenting, parental self-esteem is proposed to influence parenting efficacy (Barnard, 1983). Many psychological and cognitive theories being examined in the nursing literature, such as the theory of reasoned action, self-efficacy theory, and theory of learning, adopt this model of explanation. Many physiological theories, including the genetic theory of disease and structural theory of functioning are also examples adopting this model.

In addition, this model is also applicable in delineating out conceptual categories among closely related, often coexisting phenomena through the Concept Differentiation Model (Kim, 1992). For example, conceptual differentiation between pain and suffering would be an important beginning for a theoretical development regarding human experiences associated with pain.

**Explanatory Model 2—Additive Model (“Across domains” Formula)**

The second explanatory model refers to the thinking that a given set of client domain phenomena are associated with factors and conditions that exist not just in the client domain but also in different domains and other phenomenal spheres, producing additive, non-intersecting influences. This is depicted in Figure 8.1.

Roy's propositions in her adaptation model (Roy & Andrews, 1991) explain a person's adaptation in terms of the person's existing adaptation level with the environment being the source for external stimuli. The Roy adaptation model includes propositions that pose relationships among particularistic phenomena in the self-concept, role-function, and interdependence modes of adaptation, as well as those in the physiological needs mode (Roy & Andrews, 1991; Roy & Roberts, 1981). The major propositions in the model are concerned with concepts in the domain of client in relation to other concepts in the domain of client and those in the domain of environment. For example, the following selected propositions from the theory considered together illustrate an adoption of this additive model of explanation in her theory.



**Figure 8.1** An additive model of explanation for client domain phenomena.

- Characteristics of internal and external stimuli a person receives influence his or her adaptive responses.
- Structural and functional integrities of subsystem of a person influence his or her adaptive responses.
- Mastery with which a person responds to stimuli influences consequent processing of internal and external stimuli.
- The positive quality of social experience in the form of others' approval positively influences the level of feelings of adequacy.
- The amount of clarity of input in the form of role cues and cultural norms positively influences the adequacy of role-taking.
- The optimum amount of environmental changes positively influences the adequacy of seeking nurturance and nurturing.<sup>2</sup>

2. Roy, S. C., & Roberts, S. L. (1981). *Theory construction in nursing: An adaptation model*. Englewood Cliffs, NJ: Prentice-Hall.

In the evolving theory of unpleasant symptoms, Lenz and her colleagues (Lenz, Suppe, Gift, Pugh, & Milligan, 1995) identify three sets of variables for the explanation of unpleasant symptoms such as fatigue, adopting the additive model of explanation. Many of the theories developed within the framework of grounded theory have adopted this model of explanation, including as antecedent variables those residing in the person, in the environment, and in interactive patterns. Orem's statements (1991) that "universal self-care requisites and ways of meeting them may be modified by the age, sex, or developmental or health state of individuals," and "some self-care requisites have their origins in the environment," are also depicted within this model of explanation. This form of explanation is multifactorial and additive.

### **Explanatory Model 3—Dynamic, Comprehensive Model**

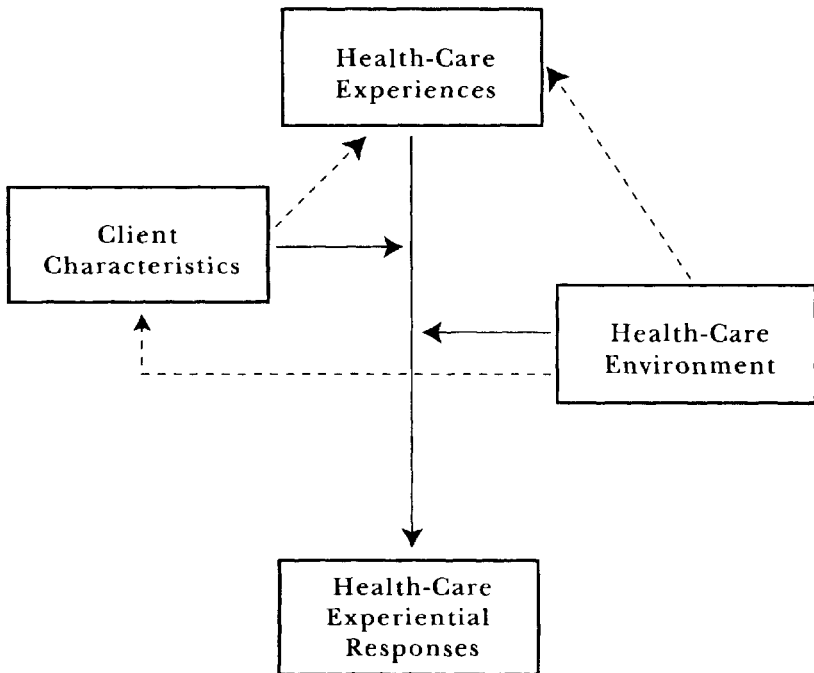
This model of explanation for a theory for the domain of client brings in various factors and aspects in a dynamic, interactive fashion in order to provide a comprehensive, total explanation of a given phenomenon. Nursing theories of the client domain adopting this model invariably include factors from the individual (the client domain), the nurse (the practice domain), interaction (the domain of client-nurse), and the environment. While in model 2 explanatory variables are viewed to have additive influence, in this model the influences of the variables in a given theory are interactive, modifying, and dynamic.

For example, Rogers (1970, 1980, 1992) proposes as the main thrust in her theory of unitary humans the synergistic, evolutionary repatterning of the human energy field in relation to the environmental energy field. The three theoretical principles in this theory consider the existing pattern characteristics of the human energy field with its creative, evolutionary potential to move unidirectionally toward greater complexity in concert with the environmental energy field. The relationships between the human and environment energy fields are interactive, interpenetrating, and dynamic. Cartwright and her colleagues (Cartwright, Archbold, Stewart, & Limandri, 1994) propose a theory regarding enrichment processes of family caregiving developed through the grounded theory approach that includes factors in the caregiver and care receiver, and dyadic relations in a dynamic relationship.

Theories for health-care experiential phenomena may be developed from this explanatory model. In the literature, there is little evidence of theory development for health-care experiential phenomena. Health-care experiential phenomena arise from a person's experiences in receiving health care. Such phenomena are by-products of a person's involvement in

the health care system, and are not necessarily germane to the problems that bring the individual to the attention of health care professionals. While they are experiential, they may be influenced by the person's health problems, but more importantly they may impact on the processes of health care, such as recovery. A generic theoretical model adopting this form (Model 3) of explanation is proposed as an overall framework for theoretical and empirical considerations for studying health-care experiential phenomena, as shown in Figure 8.2.

Theoretical development for the domain of client, therefore, may be oriented to any of these three models. Various theory construction methods, both inductive and deductive, may be applied to develop theories for the domain of client. The form of a theory may be identified to hold any of these three explanatory models—whether a theorist begins with a mental picture of a specific explanatory model prior to the development of a theory or a theory as a product assumes a specific explanatory model may not be an important question.



**Figure 8.2** An explanatory model for health-care experiential phenomena.

## **THEORETICAL IDEAS FOR THE CLIENT-NURSE DOMAIN**

Theory development for the client-nurse domain has been rather limiting in nursing. In the 1960s, there were several nurse scholars who paid attention to client-nurse interaction as an important aspect of nursing work. For example, both Orlando (1961) and Wiedenbach (1964) considered client-nurse interaction as a helping process that is dynamic in nature, affecting the way clients cope with the demands of a healthy life. Peplau (1952) defines nursing as a therapeutic, interpersonal process that helps the client solve problems and likewise moves the client toward the direction of creative, constructive, productive, personal, and community living. After a hiatus of nearly two decades during which little theoretical attention was given to client-nurse interaction, King (1981) proposed a theory of goal-attainment in which transaction between a client and a nurse is considered the major factor influencing goal-attainment in the client. Cox's theory of client-nurse interaction (1982), and the theory of collaborative decision making in nursing practice (Kim, 1983) are middle-range theories that focus on explaining client-nurse phenomena. There have also been some theoretical works oriented to reformulating sociological theories to explain client-nurse phenomena, such as Riehl's work in symbolic interactionism in nursing (1980) and Leininger's transcultural nursing (1995). Garvin and Kennedy (1990) in their review of the state of knowledge regarding communication between nurses and patients found four areas of study pertaining to the client-nurse domain: empathy, self-disclosure, interpersonal support, and confirming communication. However, the theory development in nursing with a focus on the client-nurse domain still remains at a beginning stage.

Two generic explanatory models for theory development in the client-nurse domain are proposed. An essential point in developing theories for the client-nurse domain is an inclusion of client phenomena either as a manifest or latent aspect. This does not mean that a client phenomenon must be a component of a client-nurse theory, but that if one is not identified as such a theoretical assumption should specify the theory's connection to client phenomena.

### **Explanatory Model 1—"Within domain" Formula**

Theories that link the properties and processes of client-nurse interaction must be developed as the first-level theoretical work for understanding and explaining client-nurse domain phenomena. Such theories may be developed adopting this model of explanation. This model of explanation appeals to an elaboration and understanding of the nature of the client-nurse relation by making theoretical connections among different aspects

of the relationship between a client and a nurse. For example, client-nurse negotiation may be elaborated by considering interpersonal understanding or client-nurse mutuality.

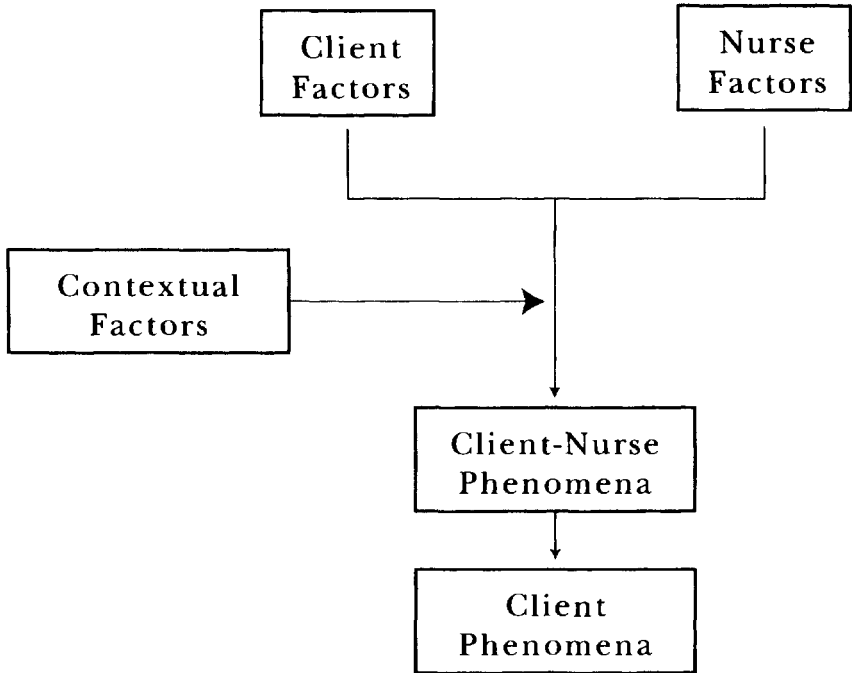
Some of the studies of client-professional encounters using narrative analysis are oriented to developing theories of client-professional communication from this explanatory model. Language use and the construction of talk are investigated to understand the process of communication.

### **Explanatory Model 2—Comprehensive Model**

As suggested earlier, many theories of human interaction require reformulation within the nursing perspective to the extent that the ultimate concepts for explanation of significance in this perspective have to reside in the client. Since client-nurse phenomena with any of the three orientations of client-nurse relation, i.e., the media, therapy, and care orientations, have either vicarious or intentional impact on clients, it is necessary to develop nursing theories adopting an explanatory model that include client phenomena as one of their components. There is a need to develop and refine theories of client-nurse relations that can be applied to examine influences on client outcomes of nursing's interactive therapies, from the process of mediation, and as a result of the process of care. There are at least four sets of variables identified as components of this explanatory model: (a) individual actors (client and nurse), (b) context of interaction, (c) nature of interaction—process and property, and (d) client health-related phenomena. Theoretical linkages among the four components are specified in Figure 8.3 as this model of explanation for the client-nurse domain.

The first component includes aspects of the individual actors who are participants in an interaction, namely the client and nurse within the client-nurse domain conceptualization. The participant set may not be limited to just client and nurse, but may refer to parents (parents of a child patient) and nurse, or caregiver and nurse. Individual actors bring with them physical, psychological, cognitive, social, and ethical characteristics, including abilities, values, attitudes, and interactive patterning developed through past social experiences into interaction. Such attributes may be considered predisposing, enabling, or hindering factors for the process and properties of interaction. Garvin and Kennedy (1990) found that most of the studies in the literature focused on patient communicative elements and nurse communicative elements as the major factors included in the explanation of client-nurse communication.

The interactive encounters between client and nurse may be initiated, developed, or terminated in various forms and contents according to individual orientations the participants bring with them to interactive situations. Theoretical work in therapeutic touch and empathy suggests the



**Figure 8.3** An explanatory model for client-nurse phenomena.

influence of nurses' abilities, attitudes, and orientations on the nature of the client-nurse interactive process. The literature in the area of stigmatization and labeling suggests also that socially undesirable facets of personal characteristics tend to affect the ways in which people maintain social distance from each other (see Goffman, 1963 and Scheff, 1966). From the critical, hermeneutic perspective, Mishler (1984) proposes that interactional processes progress and encounters are shaped based on the "voices" or the perspectives with which the participants carry on the conversation in client-professional encounters. Participants' perspectives as "voices" orient their aims and experiences in client-provider encounters. These and other studies point to a need for in-depth understandings and reformulation regarding the effects of participants' attributes on the client-nurse relation.

The second component refers to the context of client-nurse relation. The context of relation includes all aspects of environment, the physical, social, and symbolic aspects, which exist in the situation of the client-nurse relation. Social aspects of the context have been studied a great deal in sociology. The social context of interaction may not only be influential as



a prerequisite condition for interactional encounters in nursing but may actually become a significant aspect of therapeutic communication. Several studies of social interaction from the perspective of symbolic interactionism, such as the study of pain management by Fagerhaugh and Strauss (1977), suggest that the context of interaction influences the ways in which clients' experiences and patterns of interaction are developed according to the established rules of behavior, the meanings of specific communicative symbols, and the structural orientations of the context. Bogdan, Brown, and Foster (1982) also suggest that the context of patient care predetermines the kinds of information that are transmitted to parents of sick children. Client-nurse interactions take place in somewhat specialized social contexts in which the power distribution is unequal among the participants, role prescriptions are socially well institutionalized, instrumental requirements vary, and the system of control is often preestablished. The major theoretical focus of interest for nursing is in gaining understanding about how different aspects of the interactional context influence the interactive processes between client and nurse.

The third component pertains to the client-nurse relation itself. The client-nurse relation is considered along two dimensions: (a) the process of relation, and (b) the property, form, or quality of relation. The process of relation refers to the relational sequence, trajectories, progression, and patterning. On the other hand, the property of relation refers to the form and quality of relation in terms of the elements of exchange such as information, affection, energy, support, resources, and communication types. This component, as the middle component, is essential both for understanding the nature of the client-nurse relation and for explaining client phenomena as influenced by phenomena in the client-nurse relation.

The fourth component pertains to client phenomena, especially those related to clients' health and health-care outcomes. All major explanatory and predictive models in nursing ultimately have to deal with clients' well-being as the main explanatory focus, and in so doing, place theories within the nursing framework. Client phenomena in relation to the client-nurse relation reported in the literature are recovery, compliance, coping, information retention, relief of pain, satisfaction, goal-attainment, and sense of control. While many studies suggest a beginning for an emergence of important theoretical ideas, there still exists a paucity of theories for phenomena in the client-nurse domain.

While there has been a great deal of rhetorical emphasis on the importance of the client-nurse relation in the delivery of nursing care, very little has been done either in theory development or in empirical testing of theories. There is a rich array of theoretical and empirical work accomplished in sociology, social psychology, and medicine that are adaptable to the study of this domain. However, there is a critical need to have an understanding

of how the *special* nature of client-nurse relation modifies sociological, social psychological, and communication theories for explanation of client-nurse domain phenomena and client outcomes.

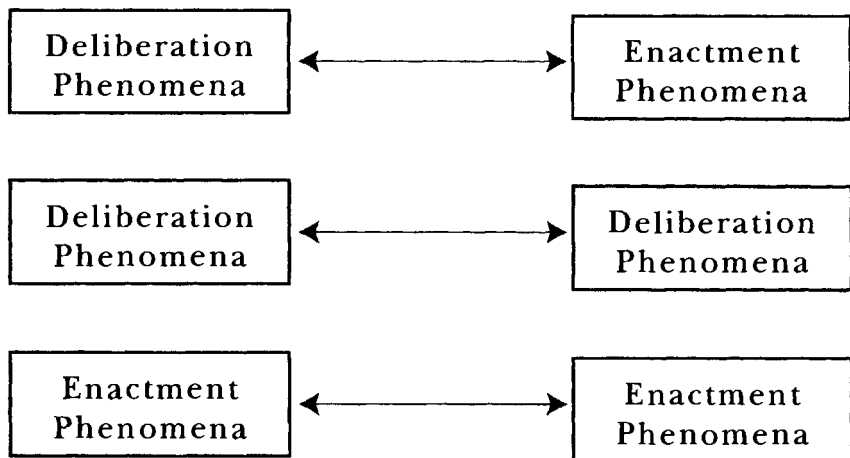
## **THEORETICAL IDEAS FOR THE PRACTICE DOMAIN**

Theories for phenomena in the practice domain are essential for understanding what goes on in practice situations and also for developing ways to normatively influence the way nurses practice, that is, shape their work. My review of the literature on the practice domain in 1994 (Kim, 1994) revealed the beginning development of theories for this domain related to intuitive knowing in nursing, clinical decision making, ethical decision making, and knowledge utilization in nursing. However, much of the work is at the concept development or descriptive level, pointing to the need to move toward developing explanatory theories. Two explanatory models are proposed for this domain.

### **Model of Explanation 1—"Within domain" Formula**

As presented in Chapter 6, the phenomena in the practice domain are conceptualized within two dimensions: the deliberation and enactment dimensions. The "within domain" formula for theory development for phenomena in this domain leads to several areas of emphasis. Theories need to be developed which examine (a) relationships among phenomena within each of the two dimensions of nursing practice; (b) critical linkages between the deliberation phenomena and the enactment phenomena; and (c) relationships among many different aspects of nursing practice (see Figure 6.2). For example, the work by Benner (1984) and Benner and Tanner (1987) is oriented to developing a theory of skill development in nursing in relation to intuitive process. And, the refinement of various theoretical formulations regarding clinical decision making such as the information processing theory and the prospect theory is a movement toward developing descriptive theories of nurses' diagnosing and clinical decision making in practice.

Theories adopting this explanatory model are oriented to understanding and explaining the nature of nursing practice in terms of various aspects of practice itself or from what nurses bring to practice. Figure 8.4 shows three possible sets of theoretical formulations possible as "within domain" theories in the practice domain.



**Figure 8.4** Within-domain explanations in the practice domain.

### **Model of Explanation 2—Comprehensive Formula**

This model of explanation for phenomena in the practice domain encompasses four components: (a) exogenous component, (b) nurse component, (c) practice domain phenomena component, and (c) client phenomena component. Two components are primarily linked to the phenomena of the practice domain: one set refers to the exogenous aspects of the nurse in practice and the other is inherent in the nurse in practice. Secondly, phenomena in the practice domain are theoretically linked to client phenomena, as both nurses' deliberations and enactment are viewed as influencing clients in various ways. This generic model is shown in Figure 8.5.

The sources for the exogenous component are the structural elements outside of the nurse-agent, as specified in the preceding section for the deliberation and enactment dimensions. These include attributes within the structures of client and situation of nursing practice and some areas of the structures of nursing goals and nursing means, which reside externally to the practicing nurse. Aspects of the exogenous component that may provide explanation about practice phenomena are organizational structure and forces that exist in the clinical situation, nursing service structure, the client's nursing-care requirements, peer support, climate of nursing care, the culture of nursing, etc. For example, a theory may be proposed to suggest that the quality of the nursing process is influenced by the normative expectations apparent in the nursing-service setting, the amount of actual as well as perceived time available to nurses to systematize nursing care, and the complexity of nursing care requirements presented to nurses by clients.



Organizational and external stresses have been attributed to less ideal provisions of nursing care and to the phenomenon of "reality shock" in new graduates. The atmosphere of practice and its meanings to the nurse, contextual changes that occur within the nursing situation, and the complexity of a situation that requires complicated management of skills are some of the external forces that may influence the nature of nursing practice and nursing-practice outcomes.

The intrinsic component refers to various aspects of the nurse in practice. It includes characteristics, attributes, and experiences that are intrinsic parts of the nurse. Nurses' deliberations and enactment are affected by many factors inherent in the nurse. The nurse's knowledge level, educational preparation, intellectual skill, personality, past experiences, world views, ethical and moral commitments, and physical and feeling states may affect the "quality" and process of nursing practice. For example, as Fagermoen (1997) suggests, the nature of nursing practice may be influenced by nurses' value commitments. Wrong clinical decisions may result from the way a nurse evaluates the situation in light of her or his limited knowledge base, or because the nurse has a limited experience with specific life and nursing situations with which he or she can develop evaluative frameworks. The model of learning adopted by a nurse may also influence the way a nurse practices, as suggested by Argyris, Putnam, and Smith (1985).

The third component refers to phenomena of the practice domain, treated as the primary level of focus for explanation. It is essential and critical to understand and have explanations about how differences in the quality of deliberation and enactment, and the structure and patterns of deliberative and enactment processes are brought about through both exogenous and intrinsic components. For example, what influences the way nurses make individualized nursing-care planning or how nursing-care strategies are modified to meet patients' needs or to meet the demands of the situation are important theoretical questions.

The fourth component pertains to client phenomena. Theories of the practice domain must consider directly or indirectly the impact of nursing practice on clients. Clients' experiences through their involvement in nursing practice and client outcomes of care must be linked to the ways nursing is practiced in relation to clients.

There are several areas of importance in the domain of practice, which require rigorous theoretical work. One such area is the uncertainty that is inherent in nursing practice. The uncertainty in nursing practice is parallel to that found in medical practice (Coser, 1978; Fox, 1957; Merton, 1976), and refers especially to uncertain outcomes of nursing interventions. However, the uncertainty in nursing practice is also present in making assessments about a client's presenting problems. Apparent interactions among physiological, psychological, and cognitive aspects of human responses

produce complex phenomena in the client, making it rather difficult to make cause-effect linkages in a nursing assessment. Even though the prescriptiveness in the way nursing interventions are recommended for different client problems in several nursing models is suggestive of the deterministic nature of nursing practice, the practice implications of any prescription remain uncertain in judgment as well as in outcome.

Thus, actual and potential uncertainty in nursing practice may influence the behavioral patterns of the nurse. Grier and Schnitzler (1979) examined the nurse's risk-taking behaviors in decision making, and found that a nurse's propensity to take risk is related to the nature of the decision making situation as well as the nurse's educational level. Nursing decisions are uncertain to the extent that the outcomes of decisions are probabilistic or multifactorially complicated and that the decisions themselves are based on incomplete information. Such uncertainty will, in turn, influence the nurse's actual decision making and practice behaviors. The phenomena of uncertainty in practice may need to be examined from a comprehensive framework that brings in both the exogenous and intrinsic components.

Another area of importance is related to knowledge utilization in nursing practice. Quality of nursing practice is essentially dependent upon the richness and rigor of scientific knowledge from which the prescriptions of nursing activities are derived. Practice without a scientific foundation will flounder as a result of the inadequacy of trial-and-error by itself. However, the fact that nursing practitioners are educated to use systematic knowledge for practice, and that nursing practice is based on prescriptive theories, is no guarantee that nursing practice in reality will be implemented accordingly (Kim, 1993). The issue is how nursing knowledge that is internalized and learned by an individual nurse as a system of individualized knowledge becomes transformed into nursing actions, that is, into knowledge-in-use. What prompts the nurse to behave in a specific way? Is there a mental or psychological explanation that specifies why one nurse might behave differently from another in a given nursing situation, provided that there is a standardized level of knowledge? A nurse's perception of the world and situation, value structures used to evaluate the situation, personal relationships, psychomotor and cognitive skills of generalized and specialized types that are acquired from experience, and the ability to focus have all been found to influence the degree of congruency between the knowledge and knowledge-use in practice.

Thus, theories for the practice domain should aim to provide explanations regarding various aspects of nursing practice and their relationships to client outcomes. The aim of such theories inherently would be to produce "better" nursing practice, and "better" outcomes and experiences in clients.

## **THEORETICAL IDEAS FOR THE ENVIRONMENT DOMAIN**

Theory development for the domain of environment is not central to nursing in general. However, nursing may need to pay attention to developing theories about phenomena of the environment domain, to the extent that explanation about phenomena of the environment domain illuminates and provides deeper understanding about clients, client-nurse phenomena, and nursing practice. Especially important areas for theory development pertain to phenomena in the health-care environment, such as institutionalized forms of nursing practice, professional standards of nursing care, structural patterns within nursing service organizations, and the nature of public knowledge in nursing. Theories regarding how certain characteristics of the nursing-care environment such as the structure of routinization are brought about through interactive processes of the setting, or how the service practice model is adopted as a political process are important for understanding nurses' practice behaviors (Esposito, 1998). Theoretical explanations about such phenomena are essential as they impact nursing practice and client outcomes.

### **SUMMARY**

This provisional look suggests a need to develop systems of theories and theoretical statements dealing with phenomena appropriate for nursing attention at several different levels and with different focuses. Indeed, theoretical questions for the domains of client, client-nurse, practice, and environment can be appropriately addressed on three levels of theories: grand theories, meso- and middle-range theories, and micro-theories.

*Grand theories.* The nursing models by Rogers, Roy, and Orem, among others, may be extended to include propositions that link client phenomena of holistic and particularistic types with client-nurse interaction and nursing practice. Grand theories contain propositions dealing with nursing problems that may exist in various types of clients and nursing-care situations. Thus, grand theories should be comprehensive in their explanations of nursing phenomena. A grand theory of nursing should contain a complex system of propositions, based on assumptions about human nature. So far, nursing's grand theories tend to focus on the domain of client with the exception of Rogers's theory of unitary humans. I believe it is necessary to have grand theories specifically to focus on each domain rather than trying to develop grand theories of nursing that deal with all relevant phenomena in nursing. This is because both the ontological and epistemological orientations must be delineated with a differing focus for each domain. It is

also critical that the existing so-called grand theories of nursing must be further developed to include systematic formulations of theoretical propositions based on their assumptions and conceptualizations.

*Meso- and Middle-Range theories.* King's system of propositions for the theory of goal attainment is an example of a middle range theory. A theory of patient teaching is emerging in the literature, as propositions are being tested with a variety of clients (e.g., surgical patients, pregnant couples, children, hypertensive clients, and the elderly). As a middle-range theory, this theory of patient teaching may be applied to explaining and/or influencing such client phenomena as compliance, distress, anxiety, coping, recovery, and rehabilitation.

Theoretical and empirical studies of empathy are also developing into a middle-range theory, encompassing such client phenomena as loneliness, withdrawal, depression, pain, dying, and stress. There are many more appropriate areas for development of middle-range theories, such as theories of comfort, nurse-client interaction, pain, energy transfer, and collaboration.

*Micro-theories.* Many micro-theory developments are in progress. Theoretical efforts dealing with a limited range of application, such as maternal attachment, pressure sores, wound healing, and positioning, have culminated in micro-theories. In many instances, as theoretical development becomes enriched, several micro-theories together may become a middle-range theory. Micro-theories provide the backbone for more general, complex theories. Efforts in micro-theory development are also closely related to efforts in empirical generalization, which some scientists value as the first step in theory development.

Our efforts in theoretical developments should be continued on all three levels if we are to develop a knowledge system that offers comprehensive "answers" to nursing questions that are posed for different domains.

My review of the literature presented in this chapter is by no means comprehensive, but is used to illustrate the usefulness of the theoretical approaches presented here. The examples shown in this chapter are indeed only examples of (a) what might be appropriate to question for nursing study; (b) what might be necessary for explanations; and (c) how phenomena might be approached for different kinds of explanations. The nursing perspective, the nursing way of viewing the "reality," comes out more clearly in these examples, even if the examples are only selective. By no means are the examples noted in this chapter intended to be taken as representative or comprehensive. Yet they tell the story about the status of nursing in terms of subject matter and theoretical concerns. The burden,



then, is on the systematic thinkers, who must strive to define, classify, codify, and explain whatever is essential for what we are all about, nursing.

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## 9

# *Concluding Remarks: Issues in Theoretical Development in Nursing*

*There must be a clear and distinct separation of the subjective and objective components in any situation in order for us to take rational hold of the problem. The objective problem, thus isolated, is to be dealt with by a logical procedure that seeks to resolve it into a finite number of steps or operations.*

—William Barrett

The discipline of nursing has been subjected to some grand and also to some stifling effects of modern developments and philosophies within the scientific world. By arriving late at the scene of twentieth-century scientific development, nursing's scientific movement, in a way, had to adopt quickly the prevailing ideas of how scientific theories should be developed and what structure theories should have. Nursing science had to adopt behaviors similar to those adopted by developing countries in their efforts to "catch up" with the accomplishments of the developed countries. Nursing had to scramble, leap, and make far-reaching connections in order to catch up with the developments taking place in many scientific fields. Now, we are at a stage where our development of scientific knowledge has to go beyond "what nursing is all about" to "what problems nursing knowledge can 'take on' as its subject matter."

The discipline has approached development of scientific knowledge in a multifaceted fashion. On the one hand, during the 1970s and 1980s the prevailing, unwitting commitment to logical positivism encouraged and stimulated nursing scientists to consider theory building in nursing in a dogmatic fashion or to follow the route of empirical generalizations. Through the use of deductive logic, theory development is possible, although there is no evidence that any nursing scientist is seriously com-

mitted to this method in a strict sense. However, as shown in the preceding chapter, there has been some effort to systematize nursing knowledge into various levels of theories through both imaginative and quasiductive forms of theoretical thinking. Empirical generalization has also been tried in nursing to develop theories. However, because there has been so little systematically presented empirical evidence in nursing, theories based on inductive generalizations have not been well developed. Isolated cases of empirical generalizations have not reached the level of inductive hypotheses (either deterministic or probabilistic) that is required for development of theories. Lately, nursing scientists have rediscovered the inductive method of generating knowledge, especially adopting the position taken by Glaser and Strauss for "discovering grounded theories."

On the other hand, several other nursing theorists and researchers have been engaged in theory development in the spirit of Toulmin. Toulmin (1967, 1972) suggests that the function of science is to build up systems of explanatory techniques and that theories in science are devices used to describe and explain phenomena in a scientific field. To Toulmin, it is proper or even preferable in science to introduce "theories, techniques of representation, and terminologies together, at one swoop" (1953, p. 146). Toulmin further suggests that scientific problems facing a discipline at a given time are posed by the differences between the intellectual explanatory ideals of a discipline and its current capacity to account for the phenomena in the scientific domain (1972).

Nursing scientists, in general, appear to be following this position for scientific development in nursing. Thus, the maturity of a scientific discipline is present in the way rational objectivity is adopted by the scientific community to select and maintain those conceptual schemes that have a relatively higher ability to resolve the conceptual problems of the discipline.

Furthermore, there has been a growing mistrust and disalignment with the positivistic ideals of science. Many researchers and scholars have flocked to the notion of human science from the tradition of hermeneutics as the correct epistemological attitude for nursing. A great deal of work has come into the literature during the past decade with the orientation of phenomenology and hermeneutic philosophy to study phenomena in the domains of client, client-nurse, and practice. In addition, nursing's subject matter has been studied from various postmodern perspectives, including critical philosophy and poststructuralism (Omery, Kasper, & Page, 1995).

The discipline of nursing is experiencing an influx of many types and levels of understanding regarding the problems of the discipline. It may be useful, thus, to file a "status report" regarding scientific advancement. My summarization of this status report deals with (a) identification of subject

matter, (b) conceptual clarification, and (c) nursing orientations of philosophies, (d) theory development, (e) methodology, and (f) the theory-practice-research link.

## **IDENTIFICATION OF SUBJECT MATTER**

Donaldson and Crowley (1978) summarized three themes that recur in the literature as the essence of nursing: (a) concern with principles and laws that govern the life processes, well-being, and optimum functioning of a human being—sick or well; (b) concern with the patterning of human behavior in interaction with the environment in critical life situations; and (c) concern with the processes by which positive changes in health status are affected. These three themes point to the domains of client, client-nurse, practice and environment proposed in this book as the fundamental categorization scheme for phenomena essential for nursing studies.

Fawcett (1984) also categorizes essential phenomena in nursing theory as man, health, environment, and nursing. While there is a general agreement in the typology of nursing's subject matter, the actual delineation of subject matter within the typology is still tentative. The evidence has been presented in Chapters 4, 5, 6, and 7. The basic premise for our attempts has to be that of elasticity in identifying disciplinary boundaries.

Identifying subject matter for nursing has to come about within the nursing discipline. This, I believe, can be accomplished by taking a nursing perspective for conceiving of and analyzing phenomena in the four domains. Pain as a phenomenon, for example, can be made an appropriate subject matter for nursing by conceptualizing it from a specific nursing perspective that is different from a medical, biological, or psychological perspective. Therefore, identification of subject matter is a definitional issue that has to be performed with a clear idea of what the nursing perspective consists of.

## **CONCEPTUAL CLARIFICATION**

Activities in conceptual clarification are the first-level scientific work that culminates in theories. This phase of theoretical work is especially important when a scientific discipline is striving to develop theories and theoretical systems, transplanting many concepts that have been developed in other scientific fields. Conceptual clarification requires analytic and empirical identification of definitional terms.

The phases of conceptual clarification involve the following:

1. A concept is selected as appropriate subject matter for a scientific explanation from the nursing perspective.
2. The level of abstraction for conceptual analysis becomes defined.
3. Definitional terms for the concept are organized into an interlinked system in order to have a theoretically appropriate meaning.
4. Empirical referents are identified.
5. Empirical inquiry is made of the definitional meanings and the definitional terms are reaffirmed, refined, and revised.

Conceptual clarification has been fervently pursued in nursing during the past decade in preparation for development of theories, as shown in the preceding chapters. Conceptual clarification may also serve to redefine, narrow, or broaden concepts that have already been used in theoretical systems. By combining both inductive and deductive methods in the process, concepts become more clearly and rigorously defined and differentiated from similar concepts.

### **NURSING ORIENTATIONS OR PHILOSOPHIES**

Orientations and philosophies regarding nursing influence the way nursing's subject matter is viewed, and provide the general frameworks within which theories and research methodologies are developed in nursing.

The general worldviews of nursing scientists also influence the way nursing theories are developed. Currently, such philosophical stands as realism, pragmatism, relativism, and postmodernism as epistemological philosophies, and holism, humanism, existentialism, phenomenology, general systems philosophy, and material dialectics as ontological philosophies are found in nursing theorists' writings. Such orientations direct the theoretical formulations of each theorist toward somewhat different directions in terms of the kinds of phenomena selected for study and the approaches developed for nursing strategies.

Nursing scholars often hold these orientations concurrently with philosophies of scientific inquiry. For example, empirical positivism, physicalism, rationalism, and logical positivism are held in combination with specific philosophies regarding humanity, life, and the world to produce a specific set of nursing knowledge. Such philosophical commitments specifically influence the way scientific knowledge is generated. In nursing, the level of sophistication regarding the philosophy of scientific inquiry is maturing. The number of books and articles espousing specific philosophical approaches is growing, indicating a need for our awareness and examination of the philosophical impact on scientific development.

My position regarding these philosophies is that nursing needs to develop an epistemological framework that ties together multifaceted aspects of its subject matter in a comprehensive framework. Such an epistemological framework must be built on specific ontologies fundamentally appropriate for nursing regarding human nature, human living, and human practice.

### **THE NATURE OF NURSING KNOWLEDGE— NURSING EPISEMOLGY**

Carper's seminal article (1978) proposing four patterns of knowing raised the consciousness of nursing scholars regarding the ways nursing can develop its knowledge. It has led theoretical thinking to move beyond the scientific/empirical modes of knowledge generation in nursing. However, Carper (1978, 1988) has not been clear as to whether the patterns of knowing refer to the processes of gaining knowledge or to four types of knowledge in nursing having different characteristics. This has created misconceptions in the literature. For example, some have considered the fundamental patterns as the modes with which individual nurses arrive at their own knowledge, while others thought of these patterns as four specific types of nursing knowledge.

In a similar vein, Donaldson and Crowley (1978) proposed a syntax of nursing composed of two sets of value systems, i.e., that of science and that of professional ethics, as criteria for acceptance of true statements for the discipline of nursing. Thus, nursing knowledge is viewed to be composed of two sets of statements syntactically organized as either the science or the ethics. Revising the thinkings of the works by Carper, and by Donaldson and Crowley, and incorporating the idea that nursing knowledge must be considered from four sets of ontology about humans, an epistemology of nursing is proposed.

Even a cursory look at the nursing literature points out the fact that nursing scholars have adopted not only diverse theoretical orientations (cognitive models such as self-efficacy framework, biobehavioral models, self-care and functional models, symbolic interactionism, psychodynamic model, psychosocial model, and unitary models) and different modes of inquiry but also different ontological and epistemological philosophies in their theoretical advances. Omery, Kasper, and Page (1995) present nine different philosophical orientations viewed to have relevance to nursing knowledge development, which range from empiricism, pragmatism, paradigmatic historicism, science as problem-solving, feminism, phenomenology, hermeneutics, and critical philosophy to poststructuralism. It is evident that we are grappling with philosophical pluralism as well as theoretical pluralism in nursing.



Pluralism is certainly evident in nursing (see Allen, Benner & Diekelman, 1983; Gortner, 1993; Kim, 1996a; and Reed, 1995), but it is also evident in most other scientific disciplines. Staats (1989) talks of psychology as having developed into fields of study identified as separate entities holding oppositional positions such as “nature versus nurture, situationism versus personality, scientific versus humanistic psychology,” with little or no planning with respect to their relationships to the rest of psychology. Good (1994) also identified four different approaches to the anthropological study of illness and health as “the rationalistic-empiricist” tradition, the cognitive orientation, the “meaning-centered” tradition, and the critical medical anthropology. Bhaskar (1986) suggests it as inevitable that “on the new, integrative-pluralistic world-view which emerges, both nature and the sciences (and the sciences in the nature) appear as stratified and differentiated, interconnected and developing” (p. 101).

Nursing’s realization that scientism or the positivistic inquiry is limiting in its ability to address its subject matter satisfactorily began in the 1980s (among many discussions, see Meleis, 1987; Thompson, 1985; and Watson, 1985). This debate continuing into the 1990s has created a deep chasm between “the tough-minded” and “the tender-minded” among the scholars, and the discourse continues as though the two camps must be opponents and as though an either/or position needs to be firmly established as *the epistemological* position for nursing.<sup>1</sup> In viewing pluralism, especially in terms of worldviews in nursing, as creating diversity and fragmentation, Reed (1995) suggests a “neomodernist” worldview that is specified as the “developmental-contextual” worldview to be the unifying perspective for nursing’s knowledge development. Her position represents one of those who advocates adopting a singular paradigm as a desirable and necessary step in dealing with the pluralism.

However, as Emden (1991) suggests, there apparently is an increasing a cross-camps discourse that may bring about a deeper understanding regarding what kinds of contributions the different types of inquiry make for the development of nursing knowledge. Several voices vote for the acceptance and necessity of multiparadigm epistemology for nursing that embraces a multiplicity of theories, perspectives, and philosophies (Booth, Kenrick, & Woods, 1997; Engebretson, 1997; Geanellos, 1997; Schultz &

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1. The terms “the tough-minded” and “the tender-minded” were coined by William James (1955) and reiterated by Phillips (1987). The descriptors identified by Phillips (1987, p. 84) for “the tender minded” are rationalistic, intellectualistic, idealistic, free-willist, anti-naturalistic, anti-realist, hermeneutic/interpretive, relativist, qualitative, and epistemologically charitable, and for “the tough-minded” are empiricist, sensationalist, materialistic, fatalistic, skeptical, naturalistic, fallibilist, epistemologically uncharitable, and pro-scientific rationality.

Meleis, 1988). In the same spirit, Omery, Kasper, and Page propose that “a plurality of philosophies may be necessary to reflect the many facets of nursing science; that is, no one view may be sufficient to embrace or drive nursing knowledge in its totality” (Omery, Kasper, & Page, 1995, p. X).

I believe that it is necessary to have a unifying framework for epistemological discussions about nursing knowledge. By discerning the philosophies, intellectual commitments, and theoretical orientations, we may be able to gain an insight for a unifying framework that brings together multiple, sometimes rival, and complementary knowledge in nursing.

### NURSING EPISTEMOLOGY

From this background, then, I propose a *Nursing Epistemology* as a way of critically comprehending our knowledge both for knowledge development and practice. I have proposed my perspective for this epistemology as a *critical normative epistemology* (Kim 1997a, 1997b). This philosophy is an integrated view coming from epistemological realism, emancipatory epistemology, and a normative/ideological perspective of human practice. This is based on the sentiments expressed by Good and Bhaskar. Byron Good stated for medical anthropology that “Disease and human suffering cannot be comprehended from a single perspective. Science and its objects, the demands of therapeutic practice, and personal and social threats of illness cannot be comprehended from a unified or singular perspective. A multiplicity of tongues are needed to engage the objects of our discipline and to fashion an anthropological—scientific, political, moral, aesthetic, or philosophical—response” (Good, 1994, p. 62). The position Bhaskar takes is that “. . . any social science must incorporate a historically situated hermeneutics; while the condition that the social sciences are part of their own field of enquiry means that they must be self-reflexive, critical and totalising in a way in which the natural sciences typically are not. But there is neither antinomy nor unbridgeable chasm nor the possibility of mutual exclusion between the sciences of nature and of (wo)man” (Bhaskar, 1986, p. 101).

My view of nursing epistemology is, to begin with, based on the belief that the reality or the essence of reality must be considered to exist *a priori* to any science, but is “obtained” for knowledge development by contextually (historically and socially) situated specific human agents who engage in producing knowledge within given hermeneutically constrained horizons. This preunderstanding must motivate us to view knowledge to be relativistic, but at the same time to strive toward self-critique that can bring our knowledge to come, closer to what truly exists (this view aligns with evolutionary realistic epistemology adopted by Campbell). In addition, the fact of knowing as well as our lives must be viewed to be constrained by our own

language and language-use, history, and contexts, and knowledge development needs to be framed within continuous reflection and self-critique.

My view is furthermore based on the notion that nursing is a human practice discipline, and that nursing knowledge must be what provides the foundation from which the practice is shaped for the discipline and for individual practitioners. Nursing knowledge for a human practice discipline with a specific focus on people's health must be about human phenomena of interest to nursing, both those of clients and of nursing practice itself. In addition, I base this epistemological position on several assumptions which follow.

- Human beings, ontologically, are complex in that humans are natural beings existing concretely as individuals, in concert with others, and contextually engaged in their environment. But, at the same time, humans are also symbolic entities resulting from constructions by selves and others, and constrained by history and situation, capable of free will, intentions, and self-propelled activities. Hence, there are aspects of humans that are of nursing's epistemic concerns and are knowable objectively and are based on generalizable features, and there are aspects of humans which are only knowable by experiencing selves or only through interpretations, as they are contextually embedded phenomena.
- It is not possible for one to know (i.e., understand and explain about) human beings all at once in a unified, comprehensive fashion. We must tease out aspects of humans based on different ontological foci for proper understanding. This requires a development of specific nursing ontology of humans that can direct us to adopt appropriately different epistemological modes of knowledge generation.
- Nursing practice as a form of human practice requires mutuality that upholds emancipation of involved human agents. Human agents engaged in practice (both clients and nurses/practitioners) must coordinate their freedom, meanings, and desires as a means of gaining emancipation, mutuality, and goal-attainment.
- Nursing practice is founded upon a normative, moral, and aesthetic grounding that is formulated through historical, social, and personal processes that go beyond the way scientific knowledge is produced.
- While knowledge needs to be developed partially and selectively within the given ontological and epistemological foci appropriate for nursing, such knowledge must be considered complementary and inclusive rather than competitive and exclusive.
- The highest and most mature form of nursing knowledge must be the knowledge of synthesis that is only possible in actual practice, and can be known only by accessing the practice.

These premises for the critically normative epistemology for nursing ground us to view our knowledge development from four ontological foci that point to four spheres of nursing knowledge as shown in Figure 9.1.

As shown in this figure, these four spheres are joined into the central sector, *Knowledge Synthesis*. My contemplation and development of this nursing epistemology has been stimulated and influenced by Habermas' ideas on human cognitive interests. Habermas (1986) laid out three forms of cognitive interests as "establishing specific viewpoints from which we can apprehend reality as such in any way whatsoever" and the basis for thinking about social science knowledge: "empirical-analytical sciences" as governed by a "technical" interest in the prediction and control of objectified processes—"the facts relevant to the empirical sciences are first constituted

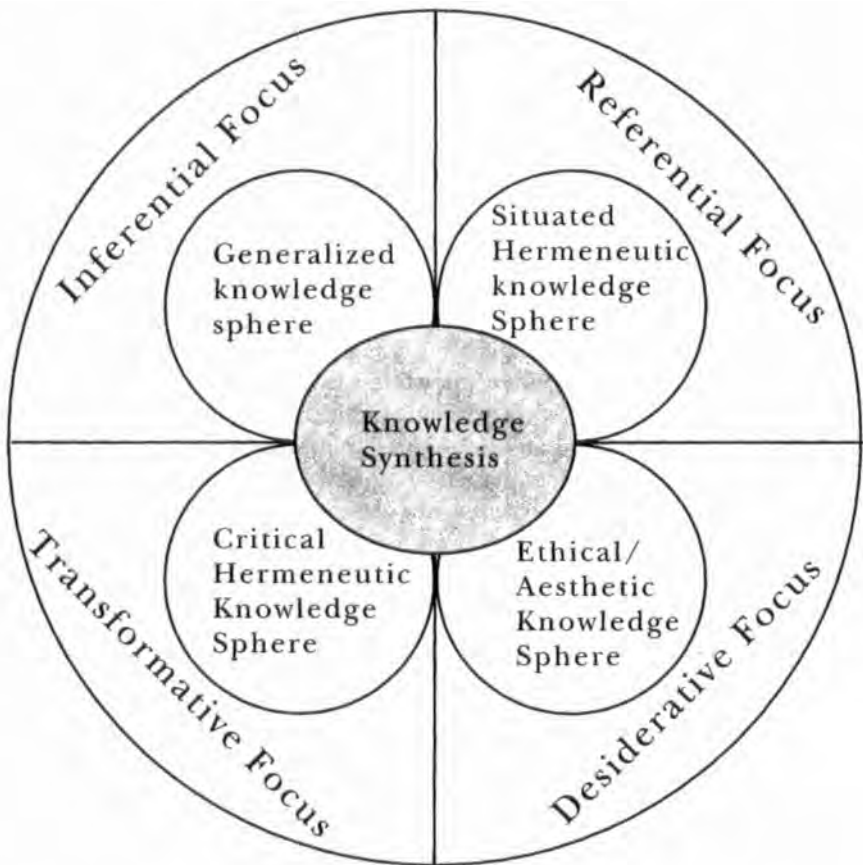


Figure 9.1 Schematic representation of nursing epistemology.

through an a priori organization of experience in the behavioural system of instrumental action," the historical-hermeneutic sciences as governed by a "practical" interest in intersubjective understanding, that is, toward mutual understanding in the conduct of life, and critical sciences as oriented to emancipation from "ideologically frozen relations of dependence that can in principle be transformed," that is, toward emancipation from seemingly natural constraint (1986, pp. 308–311).

This conceptualization, of course, was intended and used as exhaustive categories by many social scientists (both for and against Habermas's philosophy) as well as Habermas to differentiate sciences into tripartite groups as natural (empirical) sciences, interpretive sciences, and critical sciences. This is where I diverge from Habermas's ideas. I believe that human practice sciences differ from many of the human sciences (sociology, psychology [excluding clinical psychology], anthropology, politics, and economics). The knowledge orientation of human practice sciences is in "practice" with other humans for some form of "good" involving interactive, intersubjective processes that involve knowledge beyond understanding and emancipation. Nursing as a human practice science furthermore is grounded with a focus on specific empirical constructs (such as health, illness, functioning, recovery, and health-care). What I believe is that nursing knowledge has an integrative, synthesizing cognitive interest that must embrace four foci for knowledge content, and that this integrative, synthesizing cognitive interest must be identified as the central aspect of nursing epistemology.

The four spheres are: *the generalized sphere, the situated hermeneutic sphere, the critical hermeneutic sphere, and the ethical/aesthetic sphere*. The *generalized sphere* focuses on generalizable knowledge regarding human processes, mechanisms, conditions, changes, experiences, and patterns relevant to nursing. The orientation is on developing knowledge that provides general understandings, systematic explanations, and predictions through objective validation. This does not mean that theories and knowledge developed in this sphere must be global in their generalizations. Generalizations may be limited to specific population groups or contexts. Knowledge in this sphere provides the foundation for identifying patterns, regularities, and tendencies that can be used to frame individual clients' problems, situations, and experiences for understanding, explaining or predicting the case in point. Often, the knowledge in this sphere is developed from the empirical basis and from the positivistic scientific modes. The knowledge in this sphere is oriented to the need for *an inferential base* in nursing.

The *situated hermeneutic sphere* refers to the knowledge of enlightenment, understanding, illumination, and appreciation regarding human experiences as it is lived in subjective, meaning-making, and situation-bound fashion. The focus is on humans' subjective, experiencing, living selves in situations and their meanings to them, which are idiographically etched

and reveal private ways of being and experiencing. Knowledge developed in this sphere for nursing is *referential* rather than *inferential* in that it can give us insights, appreciation, sensibility, and in-depth understanding about individual clients' experiences as well as our own (i.e., nurses') experiences.

The *critical hermeneutic sphere* refers to the knowledge of interpretation, critique, and emancipation that is embedded in human living in contexts and with others. Humans' lives in general and more specifically in the context of health and nursing care are intertwined with and interpenetrated in history, context, and other human beings. The focus is on coordinated living between people, including between clients and nurses. It includes knowledge about mutual understanding through interpretation, hermeneutic understanding through fusioning of horizons in an interactive sense, and emancipatory projects oriented toward "autonomy and responsibility" and the removal of distortions and domination in human living. The knowledge in this sphere is *dialogical* and *reformative*, and depends on the use of language, and in nursing it gives us the base from which the coordinated work of practice, of getting well, and of living together is formulated.

The *ethical/aesthetic sphere* refers to knowledge having the desiderative focus. The desiderative focus is oriented to the knowledge that is necessary for nursing to determine what is desired, normatively expected, and aspired in its practice. It refers to the knowledge regarding the general and specific normative standards of nursing practice, value orientations embedded in the discipline of nursing and practice, and the grounds for ethical and aesthetic practice. It provides the grounding for making connections between "what is known" and "what must be or is desirable" in nursing practice. The focus is disciplinary. Knowledge in this sphere addresses what the nature of ethical and aesthetic frameworks for practice are, how they get established, generated, or changed, and their relationships to the larger culture and context. Hence the orientation is *desiderative* and *normative*.

Nursing has been unwittingly developing knowledge for all of these four spheres; however, the empirical and positivistic orientation is still quite dominant in our knowledge development. On the other hand, as the knowledge in the situated and critical hermeneutic spheres is important with respect to insights provided by the methodologies and at the same time because the knowledge contents themselves are broadly applicable to experiences of human living, there certainly is a critical need to further develop nursing knowledge in these two spheres as well.

Knowledge in these four spheres is critical as it is the comprehensive, unifying base from which nurses must draw knowledge that is applicable and useful in singular, clinical situations. It means then that the ultimate synthesizer and knowledge generator must be the nurse in practice. Practicing nurses must be able to come to know the critical aspects of their

clients, the situation, and their own practices by alternately dissecting each strata to view from one lens and at the same time layering and knitting together the multiple strata in order to produce "her or his practice." Synthesis of knowledge in practice involves *how* (that is, method) nurses bring forth knowledge that exists in many different sectors (such as in the public domain, in themselves, in clients and families, and in situations) to bear relevance in specific situations, and *what* (that is, content) sorts of knowledge become incorporated into nursing work carried out in specific situations. Knowledge synthesis is carried out by nurses in practice by eliciting nurses' personal knowledge, drawing situation-specific knowing, and accessing public knowledge. Viewed from the knowledge development perspective, we need to have access to exemplary knowledge syntheses that are produced by nurses in practice. Hence, I propose that in addition to the need to develop knowledge in the four spheres, we need to develop methods and approaches appropriate for an accumulation of synthesized knowledge in nursing.

### **THEORY DEVELOPMENT**

Throughout the book, the level of theory development has been explicitly and implicitly expressed. Major theoretical work in nursing still is at the level of theoretical orientations, consisting of major assumptions about the way essential concepts are identified and developed. Propositions in the theories are seldom stated in predictive terms. In general, nursing's theoretical models are mostly descriptive, with some evidence of development toward explanatory frameworks.

The testability of theoretical statements in nursing theories (especially of grand nursing theories) tends to be limited because of a deficiency in precise designations of empirical referents in the theories. Formalization of theoretical statements have not been attempted, and may be premature with the current state of affairs. A need exists for extensive conceptual clarification of essential phenomena in nursing in order to develop testable theories.

### **THEORY-PRACTICE-RESEARCH LINK**

Although there is evidence that suggests the narrowing of gaps among these three sectors of the nursing knowledge system, real and "artificial" gaps do exist. Real gaps result from the lack of dialogue among the practitioners of the three areas and from the structural arrangement that segregates practitioners into different organizational settings.

Artificial gaps are the artifacts of discontent, power struggles, and competition among the practitioners in the three functional roles and which result in mutual accusations. In the earlier decades, concerns of the profession focused on economic security, public image, and recognition. The profession has emerged into a new spirit of scientific discipline in the 1990s. Attempts such as the Rush model, which incorporates three functional areas (teaching, research, and practice) into one nursing role, may be one way of solving the problems of gaps.

Indeed, it is through a close scrutiny of theory in practice and research that nursing can evolve into a viable science, and it is by grounding theoretical formulations in practice and aligning practice problems for research that nursing can expand its scientific richness. Such close scrutiny is needed in order to overcome the real gaps among these three sectors.

## **METHODOLOGY**

It is an attractive idea to be highly competent in one or two methodologies of scientific inquiry. However, a growing scientific discipline needs to be diverse in its use of techniques of inquiry. The theme for nursing science has to be "discovery" and "expansion." The diversity of subject matter for nursing science necessitates the application of various techniques and methodologies of inquiry and scientific study. This is especially appropriate if we accept the notion of nursing epistemology proposed in the preceding section as the general framework for the development of nursing knowledge. Four different ontological foci point to various methodological orientations not only as possibility but as necessity. In addition, nursing inquiries should test the applicability and limitations of various heuristic methods including both inductive and deductive methods, and the appropriateness and fidelity of both quantitative and qualitative techniques of research.

## **FINAL REMARKS**

My exposition in this book has focused on the nature of theoretical thinking rather than on the substance of theories. Since I believe that systematic formulation and reformulation are necessary in nursing for identifying the subject matter and developing theories, I have suggested several different ways of viewing aspects of the world that are of interest to nursing. I have not attempted to evaluate or criticize theories in a systematic or comprehensive manner. I have included in the book those appropriate aspects of nursing and other theories mainly for the purpose of illustration, expan-



sion, and application of ideas under discussion. As suggested in Chapter 1, both theories of nursing and theories in nursing need to be developed, tested, and refined in order to develop a codified body of scientific knowledge that is ultimately required for responsible practice of nursing.

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# *Appendix*

## *Synopsis of Selected Nursing Theorists and Conceptual Models*

### **ABDELLAH, FAYE G.**

Abdellah proposed a classificatory framework for identifying nursing problems based on her idea that nursing is basically oriented to meeting individual client's total health needs. Her major effort was to differentiate nursing from medicine and disease-orientation. Her framework identifies 21 nursing problems around which nurses must organize patient care. Although these 21 problems refer to specific aspects of patients' needs, they point to what nurses should do in meeting these needs. She did not offer specific general assumptions guiding the identification of these needs, but included among them needs associated with physical, psychological, spiritual, communicative, interpersonal, and social aspects of individual's well-being associated with health.

[Sources: Abdellah, F. G., Beland, I. L., Martin, A., & Matheney, R. V. (1960). *Patient-centered approaches to nursing*. New York: Macmillan; and Abdellah, F. G., Beland, I. L., Martin, A., & Matheney, R. V. (1973). *New directions in patient-centered nursing*. New York: Macmillan.]

### **HENDERSON, VIRGINIA**

Henderson was one of the pioneers who tried to identify the unique contributions of nursing within the health care arena. Henderson identified 14 components of basic nursing care in association with her definition of nursing that supports the major goal of nursing as assisting individuals to

gain independence in relation to the performance of activities “contributing to health or its recovery (or to peaceful death)” (Henderson, 1966, p. 15). These 14 components refer to basic human needs and everyday functioning, including bodily needs, the need for safety in relation to environment, communication, and human activities associated with worship, occupation, enjoyment of life, and continuous learning. To Henderson, nursing’s role is in being substitutive, supplementary, or complementary to patients who lack “knowledge, physical strength, or the will” (Henderson, 1960, p. 7) to be independent in their daily lives.

[Sources: Henderson, V. (1960). *Basic principles of nursing care*. Geneva: International Council of Nurses; Henderson, V. (1966). *The nature of nursing*. New York: Macmillan; and Henderson, V. (1991). *The nature of nursing—Reflections after 25 years*. New York: Macmillan.]

### KING, IMOGENE M.

King presented a systems-oriented conceptual framework for nursing and proposed a theory of goal attainment. The conceptual framework representing knowledge essential for nursing consists of three interacting systems of the personal, the interpersonal, and the social systems, and encompasses goal, structure, function, resources, and decision making. The theory of goal attainment is the essential theoretical component of the interpersonal system within this conceptual framework. King considers the theory of goal attainment critical for nursing as interaction between clients and nurses is the essential process through which clients can be assisted to attain and/or maintain health in order to function in their roles. Several concepts are introduced in the theory of goal attainment: action, reaction, interaction, transaction, perception, judgement, role, growth and development, and goal attainment. Three specific propositions linking perceptual accuracy, role congruence, communication, transaction, goal attainment, growth and development, and satisfaction are advanced in the theory. The key to this theory is in the thinking that the outcome of nursing care is influenced by client and nurse transaction.

[Sources: King, I. M. (1971). *Toward a theory for nursing: General concepts of human behavior*. New York: Wiley; King, I. M. (1989). King’s general systems framework and theory. In J. Riehl-Sisca (Ed.), *Conceptual models for nursing practice* (3rd ed.) (pp. 149–158). Norwalk, CT: Appleton & Lange; and King, I. M. (1990). *A theory for nursing: Systems, concepts, process*. Albany, NY: Delmar. (Originally published in 1981 by Wiley.)]

**NEUMAN, BETTY**

The Neuman Systems Model is based on the systems perspective within which clients are viewed to be open systems responding to environmental stressors in order to maintain system stability and integrity. The client system is identified by the core component of basic structure and energy resources that are protected by lines of resistance, normal line of defense, and flexible line of defense organized in a concentric circle. These lines of resistance and defense and the dynamic relationships among five variables (i.e., physiological, psychological, sociocultural, developmental, and spiritual) of the system determine how the client respond to stressors. Nursing's role is to help the client system in relation to stressors, reactions, or reconstitution in the modes of primary, secondary, and tertiary prevention.

[Sources: Neuman, B. (1998). *The Neuman systems model* (4th ed.). Norwalk, CT: Appleton & Lange.]

**NEWMAN, MARGARET**

Newman developed her theory of health as an expanding consciousness drawing ideas from Rogers' holistic and unitary view of humans, David Bohm's notion of implicate and explicate orders of universe, and Young's idea of the acceleration of evolution of consciousness. Newman conceptualized consciousness as pertaining to all information of a system that specifies the system's capacity to interact with its environment. Consciousness as the essence of all things that exist, including humans, is embedded within time, reflected in movement. Health as expanding consciousness is manifested in human experiences in time and space, and is expressed as transformation to more highly organized pattern of the whole. Newman proposed a hermeneutic, dialectic approach to study health and nursing aimed at pattern recognition, and a participatory research engagement that is itself a human experience of transformation.

[Sources: Newman, M. A. (1990). Newman's theory of health as praxis. *Nursing Science Quarterly*, 3, 37-41; and Newman, M. A. (1994). *Health as expanding consciousness* (2nd ed.). New York: National League for Nursing.]

**OREM, DOROTHEA E.**

Orem's general theory of self-care consists of three, interrelated sub-theories: the theory of self-care, the self-care deficit theory, and the theory of nursing systems. These three theories are founded upon the concept of self-care, which refers to "the practice of activities that individuals initiate

and perform on their own behalf in maintaining life, health, and well-being" (Orem, 1991, p. 115). The theory of self-care is structured about the concepts of self-care agency, and three areas of self-care requisites identified as universal, developmental, and health deviation, and therapeutic self-care demand. The theory of self-care deficit identifies the connection between nursing and individuals in need of "help" due to self-care deficit. Orem delineates five modes of helping in this theory. The theory of nursing systems describes three forms of nursing systems, i.e., wholly compensatory, partly compensatory, and supportive educative systems, through which nursing agency is exercised to meet self-care requisites of patients. [Sources: Orem, D. E. (1991). *Nursing: Concepts of practice* (4th ed.). St. Louis: Mosby.]

### ORLANDO, IDA JEAN

Orlando developed her theoretical ideas about nursing based on her work related to the dynamic nurse-patient relationship, and extended them to encompass the unique contribution of nursing to patient care. She introduced four terms to categorize nurses' responses to patients' needs as automatic, deliberative, disciplined professional, and nursing process disciplined. The disciplined professional and nursing process disciplined actions and reactions are viewed to be the major processes through which nurses can deliberately address patients' immediate needs by investigating patients' immediate experiences and associated thoughts, feelings and perceptions and responding to them interactively. To Orlando nursing is unique in addressing patients' immediate situational needs through communicative and interactive processes so that patients will be relieved of distress or gain greater sense of adequacy or well-being.

[Sources: Orlando, I. J. (1972). *The discipline and teaching of nursing process*. New York: G. P. Putnam's Sons; and Orlando, I. J. (1990). *The dynamic nurse-patient relationship: Function, process and principles*. New York: National League for Nursing. (Reprinted from 1961's publication by G. P. Putnam's Sons.)]

### PARSE, ROSEMARY RIZZO

Parse cited Rogers' science of unitary human beings and existential phenomenology of Heidegger, Sartre, and Merleau-Ponty as providing the core assumptions that undergird her theory of human becoming. Her theory is based on the view that humans are evolving, unitary entities in constant mutual interrelationships with the universe. Health is the expression of this evolving, experienced by humans as a process of becoming and negen-

tropic “unfolding” characterized by meaning, rhythmicity and cotranscendence. Key concepts of the theory are imaging, valuing, languaging, revealing-concealing, enabling-limiting, connecting-separating, powering, originating, and transforming. These nine concepts are structured into three theoretical statements, which are the basis for Parse’s research and practice methodology.

[Sources: Parse, R. R. (1992). Human becoming: Parse’s theory of nursing. *Nursing Science Quarterly*, 5, 35–42; Parse, R. R. (Ed.). (1995). *Illuminations: The human becoming theory in practice and research*. New York: National League for Nursing; Parse, R. R. (1996). The human becoming theory: Challenges in practice and research. *Nursing Science Quarterly*, 9, 55–60; Parse, R. R. (1997). The human becoming theory: The was, is, and will be. *Nursing Science Quarterly*, 10, 32–38.]

### **PEPLAU, HILDEGARD E.**

The focus of Peplau’s theory is in interpersonal processes in nursing, especially those pertaining to relationships between patients and nurses. Her theory of interpersonal relations is generative, as she believed that encounters between patients and nurses influence the development and maturing of both participants. She identified four phases of interpersonal relations as orientation, identification, exploitation, and resolution. Within these four phases, nurses are believed to assume the roles of teacher, resource, counselor, leader, technical expert, and surrogate according to the needs of the patient during the interpersonal process. To Peplau, nursing is a “maturing force and an educative instrument” (Peplau, 1988, p. 8) and a therapeutic process that involves interpersonal relations between patients and nurses.

[Sources: Peplau, H. (1952). *Interpersonal relations in nursing*. New York: G. P. Putnam’s Sons; and Peplau, H. (1988). The art and science of nursing: similarities, differences, and relations. *Nursing Science Quarterly*, 1, 8–15.]

### **ROGERS, MARTHA E.**

Rogers’ theory is based on the basic assumption that human beings are unitary beings engaged in evolutionary life processes that are unidirectionally oriented and involve the mutuality with environment. The major concepts of the theory are human and environmental energy fields, which define humans and environment, and are irreducible and indivisible, signified as single-wave patterns, existing pandimensionally. Humans and their environment as energy fields are in constant, mutual interaction and inter-



penetrating with each other. Three principles of homeodynamics are specified as governing life processes and energy field patterns. The principle of integrality accounts for the mutual and simultaneous changes that occur in the interaction between human and environmental energy fields, and the principle of resonancy refers to dynamic, rhythmic changes in wave-patterns that accompany the mutual process of human and environmental energy fields. The principle of helicy focuses on the nature of change in energy fields through mutual processes identified as innovative, moving toward increasing complexity and diversity, rhythmic, and unpredictable. Rogers viewed her theory as a science of unitary human beings providing the foundation for developing theories in nursing.

[Sources: Rogers, M. E. (1970). *The theoretical basis of nursing*. Philadelphia: Davis; Rogers, M. E. (1989). *Nursing: A science of unitary human beings*. In J. Riehl-Sisca (Ed.), *Conceptual models for nursing practice* (3rd ed.) (pp. 181–188). Norwalk, CT: Appleton & Lange; Rogers, M. E. (1990). *Nursing: science of unitary, irreducible, human beings: Update 1990*. In E. A. M. Barrett (Ed.), *Visions of Rogers' science-based nursing* (pp. 5–11). New York: National League for Nursing; and Rogers, M. E. (1992). *Nursing science and the space age*. *Nursing Science Quarterly*, 5, 27–34.]

### ROY, CALLISTA

The Roy Adaptation Model was developed based on key ideas in von Bertalanffy's general system theory and Helson's adaptation level theory. Roy conceptualized persons as adaptive systems, which handle inputs of stimuli, identified as focal, contextual, and residual stimuli, through two sets of control processes in relation to presenting adaptation level. Two sets of control processes are designated as regulator and cognator subsystems. Through such processing adaptive systems exhibit behavioral responses as outputs that are either adaptive or maladaptive (or ineffective). Within the model, four adaptive modes are identified as the specific areas in which adaptive responses would be observed. These are physiological, self-concept, role-function, and interdependence modes, which are oriented to specific goals for and needs of the adaptive system. Roy introduced as an additional foundational idea for her theory the concept of veritivity, which refers to the common purposefulness of human existence.

[Sources: Roy, C. (1984). *Introduction to nursing: An adaptation model* (2nd ed.). Englewood Cliffs, NJ: Prentice-Hall; Roy, C., & Andrews, H. A. (1991). *The Roy adaptation model: The definitive statement*. Norwalk, CT: Appleton & Lange; and Roy, C., & Roberts, S. (1981). *Theory construction in nursing: An adaptation model*. Englewood Cliffs, NJ: Prentice-Hall.]

**WATSON, JEAN**

Watson based her theory of caring and human care on the assumption that health refers to harmony within the mind-body-spirit as a whole being and is expressed by the congruency between the perceived and experienced self. To Watson, her theory is a humanistic approach to nursing that emphasizes human to human responsiveness rooted in upholding humanistic values. Caring as the central component of nursing is oriented to health promotion and growth. Watson identified ten carative factors as the basis from which caring can be operationalized in nursing. These carative factors are the essential characteristics, attitudes, and processes through which nurses can promote health and growth in individuals.

[Sources: Watson, J. (1979). *Nursing: The philosophy and science of caring* Boston: Little, Brown and Company; Watson, J. (1988). *Nursing: Human science and human care*. New York: National League for Nursing; Watson, J. (1988). New dimensions of human caring theory. *Nursing Science Quarterly*, 1, 175–181; and Watson, J. (1997). The theory of human caring: Retrospective and prospective. *Nursing Science Quarterly*, 10, 49–52.]

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# Glossary

**Abstract concepts**—Concepts referring to general classes of phenomena without specific spatio-temporal reference. Hence, abstract concepts are ideational rather than empirical.

**Across-domains theory**—A theory with theoretical statements among concepts drawn from two or more domains of nursing, such as a theory relating to a concept from the client domain and a concept from the client-nurse domain.

**Aesthetic nursing practice**—An example of concepts in the practice domain referring to the aspects of nursing practice that are involved in “careful” individuation of actions and oriented in gaining a harmony among the object of acting (i.e., the client), the world in which the actions take place, and the acting self (i.e., the nurse). This harmony is produced through creative presentation of the self in consideration with what is desired, meaningful, and beautiful in practice.

**Client-nurse phenomena in three meaning orientations**—Client-nurse phenomena may be identified to have one of three distinct meaning orientations from the nurses’ perspective: client-nurse encounter may be identified to have *the therapy orientation* when the essential objective(s) of the occurrences of specific client-nurse phenomena are to intervene or treat clients’ health-oriented problems; *the medium orientation* when client-nurse encounters are the media through which certain nursing actions are performed; and *the philosophy of care orientation* in which nurses’ approaches to clients are based on viewing clients as human beings requiring humane care and concern.

**Clinical expertise**—An example of concepts in the practice domain, referring to nursing practice evidenced in skillfulness in technical execution of nursing activities, possession of advanced knowledge and problem-solving ability, ability to produce client outcomes with efficiency, effectiveness, and correctness, and recognition by peers.

**Compliance**—An example of concepts in the client domain, referring to the degree in clients' behaviors in concordance with clinical, professional prescriptions or directions that are oriented to clients' health promotion and maintenance, or treatment of health-related conditions.

**Concept**—Term or a symbolic statement used to denote and label a class of phenomena, which could be things, events, experiences, ideas, and other forms of reality. Concept has a specific meaning and a semantic value. Concepts may be very general, shared by a given linguistic culture, or very specific to a given scientific discipline.

**Concept analysis**—A critical study and evaluation of a given concept.

**Concept formation**—Naming of a class of phenomena, expressing it in a term that is understood by many to have a same or agreed meaning.

**Conceptualization**—An intellectual act of delineating aspects of reality into like-categories in order to give specific labels or terms. It is the first step in developing scientific theories about phenomena of interest to a discipline.

**Concrete concepts**—Concepts referring to classes of phenomena having immediate and empirically identifiable references to time and space.

**Critical philosophy**—A twentieth century social philosophy that originated as the Frankfurt school philosophy, advanced by Horkheimer, Marcuse, and Habermas among others. It questions the forms of distortions, dominations, and alienation existing in social life, and projects emancipation from such forms of social life.

**Deductive approach of theory development**—Theory development that begins with generalized ideas about phenomena as a set of foundational notions, and proceeds using a system of deductive logic to come up with a theory moving from general ideas about phenomena to specific theoretical relationships.

**Domain**—An area of study that is identified by a common phenomenal boundary. For the nursing discipline, a typology of four domains is proposed to be composed of client, client-nurse, practice, and environment domains.

**Environment**—The entity that exists external to a person or to humanity in general, conceived either as a whole or as that containing many distinct elements, constituted by spatial, temporal, and qualitative aspects. The qualitative aspects of environment are identified as physical, social, and symbolic aspects.

**Epistemology**—The study of human knowledge in terms of its nature, origin, and structure.

**Essentialistic concepts**—Concepts in the client domain referring to phenomena that pertain to essential characteristics and processes of human nature and human living that are important for understanding humans and health from the nursing perspective.

**Explanatory models**—Generic, prototypic models that are used to depict theoretical explanations about phenomena in a given domain.

**Grand theory**—A theory that provides scientific description or explanation for an overall or general area of a scientific field or discipline.

**Holistic analysis**—Analysis focusing on properties and forces of an object or a situation as a whole.

**Human practice sciences**—Scientific disciplines that constitute professional practice in the service of human welfare and human needs.

**Inductive approach of theory development**—It refers to developing or constructing theories beginning with empirical data or phenomena as they exist in a specific situation. In the inductive approach, generalizations are developed from the specific situation and are formulated into theoretical statements.

**Meso-theory**—Nursing theories that are less general than grand theories but broader than middle-range theories, dealing with a broad spectrum of phenomena in a specific domain of nursing.

**Metaparadigm**—It refers to the epistemological considerations at a general philosophical level, concerned with general issues of the subject matter of a discipline in terms of what the general contents are, how such contents are organized, and what a discipline is concerned with as a knowledge structure.

**Metaparadigm concepts**—Four concepts, i.e., health, person, environment, and nursing, have been treated as the metaparadigm concepts for nursing by many nursing scholars since their introduction by Yura and Torres (1975) and Fawcett's claim (1978) of them as such.

**Metaparadigm framework**—A boundary specifying guide for delineating conceptual and theoretical issues regarding nursing's subject matter. In this book, it refers to the typology of four distinct conceptual domains of client, client-nurse, practice, and environment (See also, the typology of four domains).

**Metatheory**—It refers to the analytical work regarding issues associated with theory development and knowledge generation germane to a given discipline.

**Micro-theory**—Theories consisting of a set of specific hypotheses regarding narrowly defined phenomena, both in their scope and generalizability (e.g., theory of parental attachment with preterm infants in neonatal intensive care units; theory of fatigue associated with pregnancy).

**Middle-range theory**—Theories for well-defined, empirically identifiable classes of phenomena within a given domain of study (e.g., theory of uncertainty in illness; theory of unpleasant symptoms).

**Nursing epistemology**—A view of nursing knowledge as a structure, encompassing ontological ideas about human beings and human practice, and organized around four epistemological requirements for nursing that are specified as inferential, referential, transformative, and normative/desiderative interests.

**Ontology**—The study of being and existence in terms of the basic and essential characteristics.

**Operationalization**—Putting a concept into practice.

**Paradigm**—Scientific perspective that encompasses a specific orientation and approach for a given subject matter, including the perspective about the nature and form of explanation and the dominant methods of scientific work.

**Particularistic analysis**—An analysis that focuses on a specific aspect or element of a situation or an object without having an explicit regard for the whole.

**Phenomenon (phenomena)**—Aspects of reality that are relatively regular and enduring, requiring delineation of general features for systematic description and possible explanation.

**Pluralism**—Using more than one philosophical, paradigmatic, theoretical, and/or methodological approaches.

**Popper's 'world 1'**—knowledge pertaining to physical world.

**Popper's 'world 2'**—the world of states of consciousness that belong to specific subjective humans.

**Popper's 'world 3'**—the world of objective contents of thought, i.e., knowledge consisting of theories, objective problems, and objective arguments.

**Retroductive approach of theory development**—An approach combining both deductive and inductive methods in order to reconstruct and revise an existing theory.

**Symbolic environment**—One of the qualitative aspects of environment consisting of ideational (e.g., ideas, values, beliefs, history, and knowledge), nor-

mative (e.g., rules, laws, expectations, norms, and sanctions), and institutional elements (e.g., roles, organizations, institutions, society, and culture).

**Theoretical statement**—Theoretical statements designate relationships among the conceptual elements of a given theory, and may be descriptive or explanatory. Explanatory theoretical statements may be propositions or hypotheses. While a proposition is a theoretical statement that specifies relationships among general classes of concepts, a hypothesis is a theoretical statement that is to be tested in a specific empirical situation for verification. A hypothesis has a referent proposition from which it is drawn.

**Theory**—a set of theoretical statements that specify nature of phenomena or relationships between two or more classes of phenomena, providing the basis for understanding a problem or the nature of things. A well-formed theory contains at least three components, assumptions, concepts, and theoretical statements that are integrated together to provide a specific type of scientific understanding. Theories may be descriptive, explanatory, or prescriptive.

**Typology of four domains**—A metaparadigm framework for nursing's conceptual system to be used as an analytical device for systematizing phenomena and concepts of interest to nursing study. It divides the universe of interest to nursing into an order so that each phenomenon or concept can be located within a conceptual boundary specified within the typology. It is composed of four conceptual domains: client, client-nurse, practice, and environment.

**Within-domain theory**—A theory with theoretical statements among concepts drawn from one domain of nursing.



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