

Unit Two

*The obvious is that which
is never seen until someone
expresses it simply.*

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Kahlil Gibran

NURSING THEORIES

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Unit 2 Chapter 6

Nursing Theories Applied to Vulnerable Populations: Examples from Turkey

Behice Erci

In this chapter we present the areas in which nursing models and theories guide nursing practice related to vulnerable populations. Nine nursing theories are presented with detailed clinical examples for several of those theories believed to be more applicable. Readers are referred to the primary sources for complete description and explanation of the theoretical concepts.

Importance of Theories in Advanced Nursing Practice

The dilemma for nurse educators is how best to prepare nurses for advanced practice roles. Is nursing theory important? Does it contribute to clinical practice? Which theories form sound foundations for advanced practice? Theories exist to challenge existing practice, create new approaches to practice, and remodel the structure of rules and principles. Furthermore, theories should ultimately improve nursing practice. Usually, this goal is achieved by using theory or portions of theory to guide practice.

Defining the scope of advanced practice requires that the role of nurses be considered unique. For nursing practice to be viewed as professional, it is essential that practice is based on theory. Theory and theoretical frameworks are intended to provide guidance and rationale for professional practice, but as advanced practice roles evolve in nursing, the incorporation of nursing theory becomes problematic. It has been suggested that the wide variety of definitions and concepts discussed in most nursing theories do not explain or predict anything. Therefore they cannot practically be applied to clinical situations and are of little use to nurses in advanced practice.

Orem's General Theory of Nursing

The self-care theory (Berbiglia, 1997; Orem, 1995) linked patient assessments with nursing diagnosis, expected patient outcomes, discharge planning, quality assurance, clinical research, and external agency reports. There are three subtheories within Orem's

theory. The *theory of self-care deficit* details how individuals can benefit from nursing because they are subject to health-related or self-derived limitations. The *theory of self-care* states that care is a learned behavior that purposely regulates human structural integrity, functioning, and development. The *theory of nursing systems* describes how nurses use their abilities to prescribe, design, and provide nursing care.

Application to Vulnerable Populations

To provide nursing care, Orem identifies operations that are specifically professional-technological, including diagnostic, prescriptive, treatment or regulatory, and case management. The application of Orem's theory to nursing practice is relevant as a framework in a variety of settings, including acute care units, ambulatory clinics, community health programs, high-rise senior centers, nursing homes, hospices, and rehabilitation centers. The theory is applied to patients with specific diseases or conditions, including adolescents with chronic disease, alcoholics, the chronically ill, head and neck surgery, rheumatoid arthritis, and cardiac conditions (Conway, McMillan, & Solman, 2006). The theory is also applied to selected age groups, including the aged, children, and mothers with newborns.

Example

Yeliz is 29 years old, married, and 5 months pregnant. She has anemia, is underweight, and is under the care of a primary healthcare center. Complete data have been compiled from the client's records and a home visit. The nurses are concerned that her self-care requisites (or requirements) are not being met. These are food, healthy activity, and rest. She requires assistance in food preparation but can eat on her own. Her priority diagnoses are inadequate food intake, low activity level, and fatigue due to inadequate rest.

Diagnostic and Prescriptive Operations All three priority diagnoses previously listed are related to preventing health deterioration. In this client's case the self-care deficit theory of nursing proposes a supportive educational nursing system that is designed to individualize her care. The individualization of the nursing system is accomplished through the overlay of basic conditioning factors and developmental self-care requisites (or requirements for life and health) on the therapeutic self-care demands (those processes necessary to maintain life or health). The expected outcome is health status maintenance, health promotion, and prevention of further health deterioration through the strengthening of the self-care agency. Unless expected outcomes are provided, the nursing system design will change.

Regulatory Operations The self-care deficit theory of nursing is especially useful with this client. The theory changes the focus away from disease to the strengths and/or weaknesses of the self-care agent. It is evident that the client does seek to prevent and/or manage the conditions threatening her health, yet she requires assistance in this area. The most significant self-care deficit is in the area of nutrition. Guided by the theory, the nurse ana-

lyzed the self-care agency from the perspective of the basic conditioning factors. Cultural variety should be considered in reaching for the expected outcome.

Data collection for the client in terms of self-care requisites led to the following proposed outcomes: maintenance of the healthy environment, ability of the client to feed herself, and discussion of her condition and medical regimen with the home health nurse and aide and the client's family. The nursing diagnosis showed a potential for anemic complications such as falls and decreased mobility. Methods of help and/or intervention included teaching, guiding, and providing and/or maintaining direction in an environment that supported personal development. Self-care agency is inadequate and implies the necessity to gain better understanding of the cause and subsequent prevention of problems. The nursing diagnosis is "potential for exacerbation and increased disability related to knowledge deficits concerning problems." Teaching, guiding, and directing are methods of helping. For the nursing diagnosis, "inability to maintain ideal body weight related to cultural attitudes toward eating and weight gain and meal preparation by aide," the methods of helping are to provide and maintain an environment that supports personal development.

Roy's Adaptation Model

Roy drew upon expanded insights in relating spirituality and science to present a new definition of adaptation and related scientific and philosophical assumptions (Connerley, Ristau, Lindberg, & McFarland, 1999; Roy, 1976). Her philosophical stance articulates that nurses see persons as coextensive with their physical and social environments. Furthermore, nurse scholars take a value-based stance rooted in beliefs and hopes about the human person, and they develop a discipline that participates in enhancing the well-being of persons and of the earth. Roy viewed persons and groups as adaptive systems with cognator and regulator subsystems acting to maintain adaptation in the four adaptive modes: physiological-physical, self-concept-group identity, role function, and interdependence.

Application to Vulnerable Populations

Roy used a problem-solving approach for gathering data, identifying the capacities and needs of the human adaptive system, selecting and implementing approaches for nursing care, and evaluating the outcome of the care provided. The approach includes assessment of behavior and stimuli and is consistent with the nursing process of assessment, diagnosis, planning, implementation, and evaluation.

Example

Hasan is a 35-year-old man recently admitted to the oncology nursing unit for evaluation after undergoing surgery for class IV prostate cancer. He has smoked approximately two packs of cigarettes a day for the past 9 years. He is married and lives with his wife. He has done well after surgery except for being unable to completely empty his urinary bladder.

Hasan is having continued postoperative pain. When he goes home, it will be necessary for him to perform intermittent self-catheterization. His home medications are an antibiotic and an analgesic as needed. In addition, he will be receiving radiation therapy on an outpatient basis. Hasan is extremely tearful. He expresses great concern over his future. He believes that this illness is a punishment for his past life.

Physiological Adaptive Mode The client's health problems are complex. It is impossible to develop interventions for all his health problems within this chapter. Therefore only representative examples are given. Physiological adaptive mode refers to the basic and complex biological processes necessary to maintain life.

Assessment of Behavior Postoperatively, the patient is unable to completely empty his urinary bladder. He states that he is "numb" and unable to tell when he needs to void. Catheterization for residual urine has revealed that he is retaining 300 ml of urine after voiding. It is necessary for him to perform intermittent self-catheterization at home. Unsanitary conditions at Hasan's home place him at high risk for developing a urinary tract infection. He states that he is scared about performing self-catheterization.

Assessment of Stimuli In this phase of the nursing process, the nurse searches for the stimuli responsible for certain observed behaviors. After the stimuli are identified, they are classified as focal, contextual, or residual. The focal stimulus for the client's urinary retention is the disease process. Contextual stimuli include tissue trauma resulting from surgery and radiation therapy. Anxiety is a residual stimulus. Infection is a potential problem. The focal stimulus is the need for intermittent self-catheterization. Contextual stimuli include altered skin integrity related to surgical incision, poor understanding of aseptic principles, and unsanitary conditions at Hasan's home.

Nursing Diagnosis From the assessment of behaviors and the assessment of stimuli, the following nursing diagnoses are made:

1. Altered elimination: urinary retention related to surgical trauma, radiation therapy, and anxiety
2. Potential for infection related to intermittent self-catheterization, altered skin integrity resulting from surgical incision, poor understanding of aseptic principles, and unsanitary conditions at the client's home

Goal Setting Goals are set mutually between the nurse and the client for each of the nursing diagnoses. The goals are (1) complete urinary elimination every 4 hours as evidenced by correct demonstration of the procedure for intermittent self-catheterization and (2) continued absence of signs of infection of the surgical incision and urinary tract.

Implementation To help the client attain these goals, the following nursing interventions were implemented:

1. To address the issue of incomplete elimination, the client is taught the importance of performing intermittent self-catheterization every 4 hours to prevent damage to the urinary bladder. He is taught to assess his abdomen for bladder distention and the proper procedure for intermittent self-catheterization. He is instructed to keep a record of the exact time and amount of voiding and catheterizations. In addition, the client is taught relaxation techniques to facilitate voiding so it will not be necessary for him to catheterize himself as often.
2. To address the potential for infection, the client is taught the importance of washing hands before touching the surgical incision or doing incision care. After the procedure for incision care is demonstrated by the nursing staff, and the client is asked to perform a return demonstration. After the intermittent self-catheterization procedure is explained and demonstrated, the client is asked to perform a return demonstration.

Evaluation An evaluation of the client's adaptive level is performed each shift.

Self-Concept Adaptive Mode

Assessment of Behavior The client is extremely tearful. He expresses great concern over his future. Exploration of the client's tearfulness revealed that the client is afraid of dying. Also, the client has not asked the nurse any questions about sexuality. His hesitancy to introduce the subject may be related to his cultural background. In this case the nurse introduces the topic. Salient findings are as follows: (1) the client recently learned of a diagnosis of prostate cancer, (2) he has undergone a recent operation, (3) he is receiving radiation therapy in the hospital and this therapy will continue when he leaves the hospital, and (4) the client has a lack of information about the impact of prostate cancer and chemotherapy on sexuality.

Assessment of Stimuli The client is an adult, married, and has a fifth grade education. He is in an emotionally distant and sometimes abusive relationship. Being diagnosed with prostate cancer at an early age has resulted in a maturational crisis for the client. This is complicated by the fact that several of his relatives have died of cancer. It is important for the nurse to assess coping strategies. One coping strategy that is mentioned is that the client is frequently tearful.

Nursing Diagnosis The following nursing diagnoses are made:

1. Fear and anxiety of dying related to medical diagnosis and witnessing other family members' deaths as a result of cancer

2. Spiritual distress related to severe life-threatening illness and perception of moral–ethical–spiritual self
3. Sexual dysfunction related to the disease process, need for radiation therapy at home, weakness, fatigue, pain, anxiety, and a lack of information about the impact of prostate cancer and chemotherapy on sexuality
4. Grieving related to body image disturbance, lack of self-ideal, and potential for premature death

Goal Setting To help the client achieve adaptation in the self-concept adaptive mode, the following goals are set:

1. Decrease fear and anxiety of dying as evidenced by less tearfulness, relaxed facial expression, relaxed body movements, verbalization of new coping strategies, and fewer verbalizations of fear and anxiety
2. Decrease spiritual distress as evidenced by verbalization of positive feelings about self-verbalization about the value and meaning of his life, and less tearfulness
3. Resume sexual relationship that is satisfying to both partners and evidenced by verbalization of self as sexually capable and acceptable, verbalization of alternative methods of sexual expression during the first 10 weeks after surgery
4. Progression through the grieving process as evidenced by verbalization of feelings regarding body image, self-ideal, and potential for premature death

Implementation The following nursing interventions are implemented to help achieve these goals in the self-concept adaptive mode:

1. *Fear and anxiety of dying related to medical diagnosis and witnessing other family members' deaths as a result of cancer*

Although the client's prognosis appeared to be good, he remained fearful of dying. Time is taken to sit with the client, make eye contact, and actively listen. The client is asked to share an extremely difficult experience he encountered in the past. He is asked how he coped with that experience. Once his present coping strategies are assessed, new coping strategies are suggested.

He is encouraged to express his feelings openly. After allowing the client adequate time to express his feelings, truthful and realistic hope based on the client medical history is offered. A cancer support group meets each week in the hospital where the client is a patient. The client is given a schedule of the meeting times and topics. He and his partner are encouraged to attend the cancer support group meetings.

2. *Spiritual distress related to severe life-threatening illness and perception of moral–ethical–spiritual self*

The client is encouraged to express his feelings openly about his illness. It is suggested that times of illness are good times to renew spiritual ties. The client is supported in positive aspects of his life.

3. *Sexual dysfunction related to the disease process, need for radiation therapy at home, weakness, fatigue, pain, anxiety, and a lack of information about the impact of prostate cancer and chemotherapy on sexuality*

A complete sexual assessment is conducted to evaluate the perceived adequacy of the client's sexual relationship and to elicit concerns or issues about sexuality before his diagnosis with prostate cancer. A private conversation is initiated with the client to gain an understanding of his sexual concerns resulting from his therapy and his beliefs about the effects of prostate in regard to sexual functioning. The client is instructed regarding possible changes in sexual functioning, such as a temporary inability to achieve or sustain an erection, for up to several months.

4. *Grieving related to body image disturbance, loss of self-ideal, and potential for premature death*

The client's perceptions regarding the impact of the diagnosis of prostate cancer on his body image, self-ideal, roles, and his future are explored. Hasan is encouraged to verbally acknowledge the losses he is experiencing. The client is observed to determine which stage of the grief process he currently experiences. The grieving process is explained to the client and to his family, and they are assured that grieving is a normal process. The nursing staff should offer realistic reassurance about the client prognosis. The client is encouraged to attend the cancer support group so he can talk to others who better understand his grief.

Evaluation Behavior change is expected.

King's Theory

The focus of King's theory (1971) is on individuals whose interactions in groups within social systems influence behavior within the systems (Gonot, 1989). In other words, the perceptions that people experience as a result of their surroundings influence their own behavior. King's theory is system based. Concepts of self-growth and development and body image are important (Frey & Norris, 1997; Gonot, 1989). The goal of nursing is to help individuals maintain their health so they can function in their roles.

Application to Vulnerable Populations

It is within this interpersonal system of nurse–client that the traditional steps of the nursing process are carried out. Nurse and client meet in some situation, perceive each other, make judgments about the other, take some mental action, and react to each one's perceptions of the other. Because these behaviors cannot be directly observed, one can

only draw inferences from them. The next step in the process is interaction that can be directly observed. When interactions lead to transactions, goal attainment behaviors are exhibited. An assumption underlying the interaction process is that of reciprocally contingent behavior in which the behavior of one person influences the behavior of the other and vice versa (Gonot, 1989).

Example

Elif is 50 years old and has heart failure. She is married and lives with her husband. She describes him as emotionally distant and abusive at times. She is having continued cardiac pain and palpitation. She will be receiving cardiac therapy on an outpatient basis. Elif is extremely tearful and anxious. She expresses great concern over her future.

From King's framework, Elif is conceptualized as a personal system in interaction with other systems. Many of these interactions influence her health. In addition, her recent diagnosis of heart failure influences her health. Together Elif and the nurse communicate, engage in mutual goal setting, and make decisions about the means to achieve goals.

Nursing care for Elif begins with assessment, which includes collection, interpretation, and verification of data. Sources of data are Elif herself, primarily perception, behavior, and past experiences; knowledge of concepts in the systems framework; critical thinking skills; ability to use nursing process; and medical knowledge about the treatment and prognosis of heart failure. Care should well cover the full range of nursing practice: maintenance and restoration of health, care of the sick, and promotion of health.

The nurse forms an interpersonal system with Elif. The transaction process includes perception, judgments, mental actions, and reactions of both individuals. The nurse assesses and applies knowledge of concepts and processes. Critical concepts are perception, self-coping, interaction, role, stress, power, and decision making. The nurse's perception serves as a basis for gathering and interpreting information. Elif's perceptions influence her thoughts and actions and are assessed through verbal and nonverbal behaviors. Because perceptual accuracy is important to the interaction process, the nurse analyzes her own perceptions and her interpretation of Elif's perceptions with Elif. It is expected that perceptions might be influenced by her emotional state, stress, or pain.

According to King, self is the conception of who and what one is and includes one's subjective totality of attitudes, values, experiences, commitments, and awareness of individual existence. Elif reveals important information about herself. She is tearful and expresses fear and concern. Her past behavior provides some basis for her present feeling in that Elif has not taken actions to promote and maintain her own health. Clearly, feelings about self and situation are psychological stressors.

Elif has physical and interpersonal stressors as well. Physical stressors are a result of the illness. Cardiac function, pain, and palpitation are identified as immediate problems. In the interpersonal system, Elif identifies a distant and abusive relationship with her husband. There is a major lack of emotional support during this very difficult time. Her husband's inability to provide basic emotional support is likely to change Elif's physical status.

An additional stressor is the living situation. It is also possible that the lack of personal and perhaps family space contributes to stress. Coping with personal and interpersonal stressors is likely to influence both health and illness outcomes. Elif may need additional resources to help her cope with the immediate situation and the future.

Communication is the key to establishing mutuality and trust between Elif and the nurse and the means to establish patient priorities and move the interaction process toward goal setting. Elif is expected to participate in identifying goals. However, direction from the nurse will likely be necessary because of Elif's overwhelming needs and lack of resources.

Nurses can find direction for assisting patients to identifying goals based on the assumptions that underlie King's systems framework. Nurses assist patients to adjust to changes in their health status. Decisions about goals must be based on the capabilities, limitations, priorities of the patient, and situation. In this situation the immediate goals seem to be controlled by cardiac pain and palpitation, although this needs validation by Elif.

The first nursing action is to perform psychological assessment and provide crisis intervention. Other important goals and actions will be directed toward mobilizing resources, especially husband support. However, it is possible that nursing goals and client goals may be incongruent. Continuous analysis, synthesis, and validation are critical to keep on track.

In addition to decisions about goals, Elif is expected to be involved in decisions about actions to meet goals. Involving Elif in decision making may be a challenge because of her sense of powerlessness over the illness, treatment, and ability to contribute to family functioning. Yet empowering Elif is likely to increase her sense of self, which in turn can reduce stress, improve coping, change perceptions, and lead to changes in her physical state.

Goal attainment needs ongoing evaluation. For Elif, follow-up on pain, palpitation, and cardiac function after discharge is necessary. An option might be to arrange for in-home nursing services. Having a professional in the home would also contribute to further assessment of the family, validation of progress toward goals, and modifications in plans to achieve goals. According to King, if transactions are made, goals will be attained. Goal attainment can improve or maintain health, control illness, or lead to a peaceful death. If goals are not attained, the nurse needs to reexamine the nursing process, critical thinking process, and transaction process.

Leininger's Theory of Culture Care

Leininger's interest in cultural dimensions of human care and caring led to the development of her theory (Leininger, 1995). She subscribed to the central tenet that "care is the essence of nursing and the central, dominant, and unifying focus of nursing" (Leininger, 1991, p. 35). The unique focus of Leininger's theory is care, which she believes to be inextricably linked with culture. She defines culture as "the learned, shared, and transmitted values, beliefs, norms, and life ways of a particular group that guides their thinking, decisions, and actions in patterned ways" (Leininger, 1991, p. 47). The ultimate purpose of

care is to provide culturally congruent care to people of different or similar cultures to “maintain or regain their well-being and health or face death in a culturally appropriate way” (Leininger, 1991, p. 39).

Example

A group of Iraqi refugees fled to a city in southeastern Turkey to seek refuge from political unrest, persecution, and extreme poverty. Providing culturally congruent nursing care to this group of people is difficult because of differences in language. This leads to difficulty in understanding the lifeways of this group. The children have diarrhea, and it is difficult for the nurse to observe, interview, and collect data related to cultural practices that might explain the diarrhea. The nurse helps the group to preserve favorable health and caring life-styles about poverty and diarrhea. The nurse provides help for cultural adaptation, negotiation, or adjustment to the refugees’ health and life-styles. The nurse can reconstruct or alter designs to help clients change health or life patterns in ways meaningful to them.

Watson’s Theory of Human Caring

The caring model or theory can also be considered a philosophical and moral–ethical foundation for professional nursing and part of the central focus for nursing at the disciplinary level. Watson’s model of caring is both art and science; it offers a framework that embraces and intersects with art, science, humanities, spirituality, and new dimensions of mind–body–spirit. Concepts of the theory include nursing, person, health, human care, and environment. Watson’s relevance to nursing ethics is particularly appropriate (Watson, 2005).

Application to Vulnerable Populations

Watson emphasizes that it is possible to read, study, learn about, even teach and research the caring theory; however, to truly “get it,” one has to personally experience it. Thus the model is both an invitation and an opportunity to interact with the ideas, experiment with, and grow. If one chooses to use the caring perspective as theory, model, philosophy, ethic, or ethos for transforming self and practice or self and system, then a variety of questions related to one’s view of caring and what it means to be human might help (McCance, McKenna, & Boore, 1999; Watson, 1996; Watson & Smith, 2002).

Example

Nesim is 60 years old, married, and lives with his family. His primary diagnosis is hypertension. Under older models of care the patient might be convinced that he would simply overcome his hypertension—that it would “go away.” In the Watson model, however, the nurse should aim to sustain a helping–trusting, authentic, caring relationship to develop the capacity of the patient to problem solve and to teach him and his family proper care. The nurse educates the patient about hypertension and about improving self-health,

thereby enabling and authenticating the deep belief system of the patient. The nurse is supportive of the expression of positive and negative feelings by the patient. Nesim improves as the nurse creates a healing environment at all levels (physical as well as nonphysical).

The patient should be assisted in the creative use of self and all ways of knowing as part of the caring process. The nurse must engage Nesim in the artistry of caring–healing practices that are “human care essentials,” which potentate alignment of mind–body–spirit, wholeness, and unity of being in all aspects of care (Watson, 1996, p. 157). The patient should be followed to evaluate the medical and dietary treatment of hypertension.

Rogers' Science of Unitary Human Beings

Rogers formulated a theory to describe humans and the life process in humans (Daily et al., 1994; Rogers, 1990, 1992, 1994). Over the ensuing years four critical elements emerged that are basic to the proposed system: energy fields, open systems, pattern, and pandimensionality (Rogers, 1992). The final concept, pandimensionality, was previously known as multidimensionality and four-dimensionality. Though Rogers never updated her work, the theory still provides much that is useful (Malinski, 2006).

Application to Vulnerable Populations

Within Rogers' model the critical-thinking process can be divided into three components: pattern appraisal, mutual patterning, and evaluation. The critical-thinking process begins with a comprehensive pattern appraisal. The life process possesses its own unity and is inseparable from the environment. This holistic appraisal requires the identification of patterns that reflect the whole. The pattern appraisal is a comprehensive assessment.

Knowledge gained in the appraisal process is via cognitive input, sensory input, intuition, and language. The nurse gains a great deal of appraisal knowledge during the interview with the client by using the feeling or sensing level of knowing. Often described as instinctual, intuitive knowledge is best realized through reflection. Reflection assists in appraising patterns. Manifestations of patterns are not static but partial perceptions of the synthesis of the past, present, and future. These perceptions provide the basis for intuitive knowing. Manifestation, patterns, and rhythms are an indication of evolutionary emergence of the human field. Pattern appraisal and rhythm identification, along with reflection, provide the content for appraisal validation with the patient.

Once the client and nurse have consensus with respect to the appraisal, then nursing action is centered on mutual patterning of the client human–environmental field. The goal of the nursing action is to bring and promote symphonic interaction between human and environment. This is done to strengthen the coherence and integrity of the human field and to “direct and redirect patterning of the human and environmental fields” (Rogers, 1990, p. 122). Patterning activities can be devised with respect to the initial pattern appraisal.

The evaluation process is ongoing and fluid as the nurse reflects on his or her intuitive knowing. During the evaluation phase the nurse repeats the pattern appraisal process to

determine the level of dissonance perceived. The perceptions are then shared with the client and family and friends. Further mutual patterning is directed by the perceptions found during the evaluation process. This process continues as long as the nurse–client relationship continues (Bultmeier, 1997).

Example

Ayse is a 32-year-old woman recently admitted to the infection-nursing unit for evaluation after experiencing urinary infection and late-stage AIDS. Her weight is 58 kilograms, down from her usual weight of about 80 kilograms. She has smoked approximately one pack of cigarettes a day for the past 16 years. She has two children and is married and lives with her husband in conditions she describes as less than sanitary. She describes her husband as emotionally distant and abusive at times. She is having continued pain and nausea. It will be necessary for her to perform intermittent self-catheterization at home. Her home medications are an antibiotic, an analgesic, and an antiemetic. She will soon be receiving radiation therapy on an outpatient basis. Ayse is extremely tearful. She expresses great concern over her future and the future of her two children. She believes that this illness is a punishment for her past life.

Within the Rogerian model, the process of caring for Ayse begins with pattern appraisal, the most important component of the nursing process. The nurse must engage in caring–healing practices that are human care essentials. The purpose is to potentiate alignment followed by mutual patterning and evaluation.

Pattern Appraisal The history provides a major portion of the pattern appraisal. Ayse has a pattern of smoking, which has been associated with poor health. This visible rhythmical pattern is a manifestation of evolution toward dissonance. In addition, Ayse has a pattern manifestation that has been labeled AIDS. This emergent pattern manifests as dissonant. Ayse has a low educational level, which is relevant as patterning activities are introduced. The nurse has reported that Ayse has a manifestation of fear. Ayse reports the fear of dealing with her life after this illness, and the nurse senses this manifestation of fear. Ayse’s self-knowledge links the illness to her personal belief of “being punished” for past mistakes. History and focusing on the “relative present” to explore the pattern of punishment is imperative. It is important that the nurse appraise the environment of the hospital and of the others who share her existence. The pain and fear are dissonant manifestations. Dissonance can be perceived in many aspects of Ayse’s appraisal: her unsanitary living conditions and her relationship with her husband, the manifestations of AIDS, weight loss, pain, nausea, and tobacco use. Finally, dissonance is also conceptualized as fear and is manifested in the emotional distance that she feels.

On completion of the pattern appraisal, the nurse presents the analysis to the patient. Emphasis can be placed on areas in which dissonance and harmony are noted in the personal and environmental field manifestations. Consensus needs to be reached with Ayse before patterning activities can be suggested and implemented.

Mutual Patterning Patterning can be approached from many directions. The process is mutual between nurse and patient. Medications are patterning modalities. Ayse is receiving medications. Decisions are made in conjunction with Ayse regarding the use of the medications and the patterning that emerges with the introduction of these modalities. Personal knowledge regarding the medications empowers Ayse to be a vital agent in the selection of modalities. Ayse possesses freedom and involvement in the selection of modalities. Options include therapeutic touch, humor, meditation, visualization, and imagery.

Therapeutic touch can be introduced to Ayse, particularly to reduce her pain. Touch in combination with medications provides patterning that Ayse can direct. The nurse can introduce the process of touch to Ayse's husband and teach him how to incorporate touch into her care. Another option would be to teach Ayse how to center her energy and channel it to the area that is experiencing pain.

Patterning directed at the manifestation of fear is critical. Options include imagery, music, light, and meditation. Fear manifests as her apprehension about self-catheterization. Emphasis needs to be placed on having Ayse direct how, where, when, and with whom the self-catheterization is taught. Establishing a rhythm to the catheterization schedule that is harmonious with Ayse's life would reduce dissonance. Patterning of nutrition and catheterization based on the pattern appraisal can assist in empowering Ayse to learn self-catheterization. A rhythm will evolve that is harmonious with Ayse and her energy field rhythm and that empower Ayse to direct this phase of her treatment.

Human-environment patterning needs to involve the other individuals who share Ayse's environment, including her husband and children. Options relate to increased communication and sanitation patterns. The nurse talks with the family and Ayse to determine what Ayse would prefer to change in her environment to improve sanitation. Options are introduced that allow pattern evolution integral with her environment that is not perceived as dissonant.

Evaluation The evaluation process centers on the perceptions of dissonance that exist after the mutual patterning activities are implemented, to determine whether they were successful. Specific emphasis is placed on emergent patterns of dissonance that are still evident. Manifestations of pain, fear, and tension with family members are appraised. The nurse continually evaluates the amount of dissonance that is apparent with respect to Ayse as he or she cares for her. A summary of the dissonance and/or harmony that the nurse perceives is then shared with Ayse, and mutual patterning is modified or instituted as indicated based on the evaluation.

Roper, Logan, and Tierney's Model of Nursing

In the United Kingdom the model of nursing used most predominantly is that of Roper, Logan, and Tierney (2002) that bases its principles on a model of living. The model is made up of five components: activities of daily living, lifespan, dependence/independence

continuum, factors influencing activities of daily living, and individuality in living. Roper et al. suggest that these five components are as applicable to a model of living as they are to a model of nursing. Their work has applicability to a variety of clinical situations (Mooney & O'Brien, 2006; Timmins, 2006).

Example

Hatice is 55 years old. She has difficult respiration and constipation. She cannot do her own cleaning. First, considering 12 activities of daily living and affecting factors, the nurse collects data about the client and sets nursing diagnoses, goals, and activities.

Diagnosis: Difficult breathing

Goal setting: Effective breathing

Activity: The nurse monitors breathing patterns and respirations and provides clean and normal temperature of the client's room.

Diagnosis: Constipation

Goal setting: Normal defecation

Activity: The nurse provides warm water for the client every morning and encourages appropriate exercise. After these activities, the nurse should evaluate the results.

Peplau's Interpersonal Model

Peplau's interpersonal relations model relates to the meta-paradigm of the discipline of nursing (Forchuk, 1993). These concepts are the view of the person, health, nursing, and environment. Peplau's model describes the individual as a system with components of the physiological, psychological, and social. The individual is an unstable system where equilibrium is a desirable state but occurs only through death. This is supported by Peplau's statement that "man is an organism that lives in an unstable equilibrium (i.e., physiological, psychological, and social fluidity) and life is the process of striving in the direction of stable equilibrium (i.e., a fixed pattern that is never reached except in death)" (Peplau, 1992, p. 82). Despite the early publication of the model, Peplau's work continues to have high applicability (McCamant, 2006; Moraes, Lopes, & Brage, 2006; Stockmann, 2005; Vandemark, 2006).

Application to Vulnerable Populations

The interpersonal relationship between the nurse and the client as described by Peplau (1992) has four clearly discernible phases: orientation, identification, exploitation, and resolution. These phases are interlocking and require overlapping roles and functions as the nurse and the client learn to work together to resolve difficulties in relation to health problems. During the orientation phase of the relationship, the client and nurse come together as strangers meeting for the first time. During this phase the development of

trust and empowerment of the client are primary considerations. This is best achieved by encouraging the client to participate in identifying the problem and allowing the client to be an active participant. By asking for and receiving help, the client will feel more at ease expressing needs, knowing that the nurse will take care of those needs. Once orientation has been accomplished, the relationship is ready to enter the next phase.

During the identification phase of the relationship, the client in partnership with the nurse identifies problems. Once the client has identified the nurse as a person willing and able to provide the necessary help, the main problem and other related problems can then be worked on, in the context of the nurse–client relationship. Throughout the identification phase both the nurse and the client must clarify each other's perceptions and expectations. The perceptions and expectations of the nurse and the client affect the ability of both to identify problems and the necessary solutions. When clarity of perceptions and expectations is achieved, the client will learn how to make use of the nurse–client relationship. In turn, the nurse will establish a trusting relationship. Once identification has occurred, the relationship enters the next phase.

During the phase of exploitation the client takes full advantage of all available services. The degree to which these services are used is based on the needs and the interest of the client. During this time the client begins to feel like an integral part of the helping environment and starts to take control of the situation by using the help available from the services offered. Within this phase clients begin to develop responsibility and become more independent. From this sense of self-determination, clients develop an inner strength that allows them to face new challenges. This is best described by Peplau: "Exploiting what a situation offers gives rise to new differentiations of the problem and to the development and improvement of skill in interpersonal relations" (Peplau, 1992, pp. 41–42). As the relationship passes through all the aforementioned phases and the needs of the client have been met, the relationship passes to closure or the phase of resolution.

The strength of the model is the focus on the nurse–client relationship. The focus on this relationship allows for the nurse and the client to work together as partners in problem solving. The model encourages and supports empowerment of the client by encouraging the client to accept responsibility for well-being. The focus on the partnership of the nurse and the client and the emphasis on meeting the identified needs of the client make the model ideal for short-term crisis intervention. Although focusing on getting sick people well, the model is also applicable to health promotion. The focus of the Peplau model on the nurse–client relationship provides a foundation for many types of interactions between the nurse and the client that enhance health.

Example

Tarkan is a 46-year-old married man scheduled for a heart operation next week. The client has had a few hospitalizations and is anxious about the operation. The first phase of Peplau's model is orientation. Because the client has previously been cared for at the hospital, he is familiar with the layout of the facility as well as the general rules and regulations

of the facility and orientation is quickly established. In the next phase of the relationship, identification, the nurse and Tarkan identify problems that require attention, including his feelings about the operation and potential to die as a result. The nurse should also identify that the client is experiencing mixed emotions about the operation because he understands it is necessary. Then the nurse also identifies that the client requires additional support because he has been relatively stable for a time and yet requires this operation. In the next phase, exploitation, Tarkan quickly begins making use of the available resources and services at his disposal and talks with the nurse about his fears and hopes. He expresses feelings of mixed emotions, and the nurse comforts him by reminding him that his feelings are normal. In turn, he expresses relief.

Because the client had been hospitalized twice within a 1-year period, the client was provided with information on services that could be accessed to assist him further should the need arise. With the client making full use of the available services, the nurse–client relationship then entered the final phase, resolution. During resolution the client becomes less dependent on the nurse for one-on-one interactions and no longer seeks further assistance.

Neuman's Health Care Systems Model

The Neuman Health Care Systems Model (Neuman, 1995) is related here to the meta-paradigm of the discipline of nursing. Like other models of nursing the major concepts are person, health, nursing, and the environment, but Neuman uses a systems approach to explain how these elements interact in ways that provide nurses with guidance to intervene with patients, families, or communities. Her view of health seems to be that of a continuum rather than a dichotomy of health and illness (Ross, 1985). Not much is found in the current nursing literature on Neuman's model as newer models have developed, but her legacy should be honored.

Example

Dilek is a 25-year-old woman experiencing violence from her husband and auditory and visual hallucinations. An intrapersonal stressor for Dilek is the limited effect the current medication regime is having on her acute symptoms, including difficulty sleeping. Both interpersonal and extrapersonal stressors exacerbate these intrapersonal stressors. The interpersonal stressors are the strained relationship with her husband related to the charges brought against him for sexual and physical abuse. The extrapersonal stressor is identified as inadequate community resources that could help her stay in her home. Once the stressors have been identified, a determination of the level of prevention required to strengthen the flexible line of defense is made.

In Dilek's situation the identified stressors have penetrated the line of defense. Therefore the goal is to prevent further regression. This is a tertiary level of intervention. As tertiary prevention is concerned with maintaining and supporting existing strengths of the client, this is best achieved through intensive conversations of the nurse with the

client to emphasize her existing strengths. Dilek is encouraged to express her mixed feelings of relief and sadness about her relationship with her husband, and her feelings are validated as normal. The alleviation of her psychiatric symptoms is achieved without alteration to her established medication regime.

The primary level of intervention is aimed at health promotion. One of the identified stressors is inadequate community resources. The client attends the local mental health center on a regular basis. However, these appointments with the mental health center occur only once a month. The client should be provided with information related to crisis centers, emergency support, and grief counseling. The nurse follows up to ensure that client makes contact with these resources to strengthen the flexible line of defense.

Conclusion

In this chapter we reviewed of some of the major nursing theories. Although the examples are from Turkey, the elements of these models are global and timeless.

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Unit 2 Chapter 7

Culturally Competent Care for Samoans

Karen Joines and Mary de Chesnay

The purpose of this chapter is to discuss how Samoan beliefs might be considered in designing culturally competent nursing interventions for Samoan patients using Watson's Theory of Human Care. Though the focus here is on Samoans in America, the principles also apply to Samoans who have settled in other countries. The principles of providing culturally competent care are relevant globally as world immigration patterns challenge nurses in many countries to meet the needs of their newest citizens.

Emigrating from the South Pacific during the past few decades, Samoans have contributed to the cultural diversity of the United States, particularly along the West Coast. Americans often view the territories of the Pacific Islands in terms of exotic tourism to this tropical paradise. However, many Samoans in their native land live in impoverished conditions, and although they might view their homeland as paradise, they are limited in the degree to which they can advance economically. According to McGrath (2002), over 60% of American Samoans have moved to the continental United States in recent decades in search of better educational and economic opportunities.

Dietary patterns are particularly relevant to nursing practice among Samoan immigrants, particularly to New Zealand and the United States, because the high-fat low-fiber diet of many Samoans is related to increased risk of cardiovascular disease. In a New Zealand study, Galanis, McGarvey, Qusted, Sio, and Amuli (1999) found differences in dietary patterns among western Samoans and American Samoans, with westerners tending toward a diet high in fat primarily from coconut cream. American Samoans tended to eat more processed foods and had higher blood levels of cholesterol, protein, and sodium.

Similarly, diabetes is of concern to Samoans, and a unique partnership among Pacific Islanders has led to the development of coalitions to educate people about the risks of the disease. Braun et.al. (2003) described a coalition-sponsored training program in the South Pacific. Among the outcomes of the project for American Samoans has been the creation of community-building efforts to sponsor programs in diabetes awareness, education, and screening. Designing such programs will hopefully facilitate prevention and early intervention.

Fritsch (1992) identified the need for nurses of the South Pacific to take the lead in efforts to improve the health of their people. In a speech to the South Pacific Nurses Forum, she urged nurses to become actively involved in formulating health policy. As nurses and Samoans, they are in a particularly powerful position to develop policy for Samoans. For example, researchers in preventing suicide argue that Western models of health promotion and suicide prevention are not appropriate and argue that resilience strategies must be culturally relevant, that is, “developed by the people for the people” (Stewart-Withers & O’Brien, 2006, p. 209). These authors point out that despite Western influence and governance, Samoans retain their culture and traditions and maintain political power at the tribal level.

Samoan views on health often conflict with those held by practitioners in the American health care delivery system, so to provide appropriate care to Samoans, American health-care providers must learn how to integrate Samoan culture into care plans in a culturally competent way. In particular, there are three Samoan beliefs that primarily influence their health perception and practices: holistic view of self, collective involvement, and spirituality. Though the Samoans’ views are different from Americans’ views, it is not impossible to incorporate Samoan beliefs into quality health care. Watson’s Theory of Human Care provides direction for how nurses might design interventions that are culturally based (Watson, 2002, 2005; Watson & Smith 2002).

Watson’s Theory of Human Care

Watson’s Theory of Human Care is one of many models and theories created to help nurses understand how culture influences well-being. Watson described a central focus of her theory as addressing the “ontological questions of what it means to be, to be ill, healed, caring and humane” (as cited in Bernick, 2004). With this focus at the forefront of their practice, nurses create a healing environment for their patients that reach deep facets of the human experience, encompassing the soul, mind, and body. Watson developed 10 carative factors to aid nurses in using the theory in nursing practice:

1. Humanistic–altruistic system of values
2. Faith–hope
3. Sensitivity to self and to others
4. Helping–trusting, human care relationship
5. Expressing positive and negative feelings
6. Creative problem-solving caring processes
7. Transpersonal teaching–learning
8. Supportive, protective, and/or corrective mental, physical, societal, and spiritual environment
9. Human-needs assistance
10. Existential–phenomenological–spiritual forces (as cited in Bernick, 2004)

Using these 10 carative factors, the healing–caring model serves as an appropriate guideline in creating culturally competent interventions because of its inherent focus on what is meaningful to the individual. In applying Watson’s theory, the work of Mendycka is particularly relevant.

Mendycka (2000) explored Watson’s theory in a case study in which he provided a strong rationale for the applicability of Watson’s work to culturally competent practice and identified three reasons. First, Watson utilized a phenomenological approach to understand what health and illness means to the patient. When nurses work with clients of a different ethnicity or culture, it is essential for the nurse to understand the clients’ perceptions and meanings of health and illness before performing any care or teaching. Without a basic understanding of the client’s culture, the client and nurse may experience cultural conflict and confusion, and the client may not return for care. Second, the theory involves an intersubjective process that teaches the nurse how to identify with himself or herself and with others by engaging with clients in their experiences. This promotes an environment in which a therapeutic relationship can develop and also assists nurses in developing care plans in concert with patients and families rather than for them. Third, the goal of the theory is to establish holistic harmony within mind, body, and soul.

In particular, the third aspect of holism is relevant to Samoans and has been discussed in regard to other cultures. Erci (2005), in reviewing Watson’s theory, noted that the healing environment is key. That Erci applied the theory to a patient from Turkey reinforces the universality of the model. Irish nurses also validated the theory in terms of individual healing processes that are strengthened through authentic relationships defined by caring practices (McCance, McKenna, & Boore 1999).

Because Samoans view care holistically and value collective family involvement, Watson’s theory provides a useful basis for interventions with Samoans:

- Develops a helping and trusting relationship with the patient (carative factor 4);
- Develops a capacity to problem solve with the patient and family (carative factor 6);
- Educates, enables, and empowers the client while authenticating his or her beliefs (carative factors 3, 7, and 10);
- Creates a healing environment on all levels to reach harmony (carative factor 8).

These interventions capture the essence of Watson’s theory and are consistent with Samoan beliefs. Indeed, one might argue that Watson’s principles are universal.

Samoan Perceptions on Health and Traditional Treatments

One of the issues related to providing culturally competent care to populations from small countries or isolated regions of the world is that data-based literature is not available to guide practice. As more studies are conducted, the state of the art of literature will evolve and more sophisticated approaches can be designed. One key study was conducted by a team of Samoan and Japanese nurses and involved qualitative interviews with

Samoan caregivers and family members. The philosophy underlying the research was to develop culturally based ways in which nurses could conduct workshops to help caregivers of Samoan elderly provide better care and relieve their own stress (Mulatilo, Taupau, & Enoka, 2000).

Holistic View of Self

The Samoan concept of self is holistic in that each person has three parts—physical, mental, and spiritual—that together make the person complete. Based on the belief in holism, Samoans assert that a person is healthy when all elements are in balance and harmony. When a patient is not well in one part, all other parts are affected. Therefore when illness affects a person, Samoans believe treatment should be aimed at all three parts, with the goal of reaching harmony and balance (Tamasese, Peteru, Waldegrave, & Bush, 2005). The family is key to successful intervention with Samoan patients (Mulatilo et al., 2000).

Rather than focusing on cures, traditional Samoan healing emphasizes achieving balance and wellness. Traditional remedies use medicinal plants in a variety of ways. Samoans boil leaves or bark to create a drinkable tea and cook roots into a healing meal. In addition to plants, Samoans use oils, massage, and hot and cool applications as treatments (Rogers, n.d.; Saau, 1996). For example, a common approach used by elderly Samoan women to heal headaches is heating tea leaves with water and massaging them into the forehead (Saau, 1996).

Contrast with Western Medicine

Holistic views regarding health and treatment are in sharp contrast with traditional American health care, which is aimed primarily at curing physical ailments and disease. Conventional treatments focus on alleviating biological or physical symptoms using modern technologies and treatments established through scientific research. To accommodate their beliefs in America, many Samoans continue to practice traditional healing as adjuncts to American treatments, rather than as replacements (Rogers, n.d.).

Issues Contributing to Vulnerability

Many Samoans attempt to find traditional healers who have knowledge of ancient healing practices. In Seattle, few Samoan healers are available to elderly clients, and as a result many families perform traditional healing practices to the best of their knowledge with the supplies that are available to them (Saau, 1996). This may cause emotional stress and feelings of cultural isolation if they attempt to create the remedies themselves and feel unsuccessful and limited by resource constraints. The homemade remedies may also be harmful if the client is not fully knowledgeable of what plants to use and how to use them properly. In addition, elderly Samoans may feel alienated or not respected by American healthcare providers who discourage their traditional practices. As a result, many choose not to access American health care.

Interventions

In applying Watson's theory, several carative factors are used. Carative factor 3 is used when nurses approach elderly Samoans in a nonjudgmental and unbiased manner. Beginning with a comprehensive assessment, the nurse converses with the client to elicit the client's perspective on the meaning of the ailment, using carative factor 10 in discovering the patient's phenomenological beliefs regarding health. By asking for information concerning his or her perceptions and cultural practices, the nurse conveys genuine appreciation and interest in the client's priorities. Thus a door opens in the nurse-patient relationship that enables the nurse to establish trust (carative factor 4). Demonstrating respect is critical to success in working with vulnerable clients (de Chesnay, Wharton, & Pamp, 2005).

There are several practical interventions in achieving a trusting and partnering relationship with culturally diverse patients. When assessing alternative health treatments, the nurse should ask clients about their health practices and assess the knowledge they have regarding the treatment being used (i.e., What plant is used? How is it used?). Efficacy and safety are two important topics to address when confronted with a client who uses alternative methods. It is important not to reduce the meaning of the client's experience by placing judgment on cultural healing methods. It is more effective to encourage the client to use complementary healing methods as supplementary treatments to conventional treatments. Safety is a concern when patients use combinations of treatments, and if the nurse does not know whether the practice is safe, she or he will have to research the treatment and discuss it with the healthcare team. While teaching, the nurse should authenticate the client's beliefs and avoid discounting the beliefs.

It is essential that the nurse document and inform the physician regarding all alternative treatments, which has the additional benefit of developing a positive relationship between the physician and the client. The nurse can advocate for the patient's needs by creating a care plan that integrates a holistic approach. By asking the cultural questions and conducting a thorough meaningful assessment of the client's perspective, the nurse fosters cultural identity, the client's sense of control, and partnership in care.

Collective Involvement

Samoans believe that every human exists in the context of an interrelated network of family and community and that the interdependence and harmony created within the relationships contribute to health and well-being (Tamasese et al., 2005). They believe each relationship is defined by specific roles and responsibilities, and if a person cannot fulfill his or her roles, disharmony occurs within the relationship. This disharmony can impair the health of the individual (Management Science for Health, n.d.). Therefore when illness affects a person, one element of healing involves reconnecting and strengthening relationships that are unbalanced. One method is through a ritual called *ho'oponopono*, which includes a method of family counseling, conflict resolution, self-reflection, and a formal session of apology and forgiveness (Management Science for Health, n.d.).

Because Samoan patients maintain an existence within a collective context, families are included in all aspects of health care, including the decision-making process. McLaughlin and Braun (1998) conducted a study on healthcare decision-making processes within Samoan families and discovered the following principles regarding the elderly and decision making. Samoans do not prefer to have a choice in major healthcare decisions because they rely on a physician's paternalistic judgment to decide the best course of action. If they must make a decision, the Samoan family collectively decides the best course of action. In addition, elderly patients often do not want physicians to inform them if they have a terminal illness because the family prefers to be informed first to protect the patient from troubling information regarding his or her health.

Contrast with Western Medicine

The Samoan value of collective involvement comes in direct conflict with values in Western health care, primarily the values of personal autonomy, self-reliance, and independence. In America there is a strong focus on protecting an individual's right to privacy, right to refuse treatment, and right to autonomous choice. Based on these values, it is unethical and illegal for a physician to perform or provide treatments to a client without informed consent, even if the client requests otherwise (Lundy & Janes, 2001). American healthcare providers do acknowledge the effects relationships have on a patient's health and claim to practice family-centered care, but always within the parameters of individualism.

Issues Contributing to Vulnerability

The difference in how decisions are made can delay treatment and create a frustrating experience for both the family and healthcare providers. If a Samoan experiences resistance from physicians in allowing the family to make the decision, he or she may choose not to participate in any treatment. Language barriers, unclear communication, and lack of knowledge of American health policy can contribute to the conflicts between Samoans and healthcare providers. Most importantly, in situations in which the client is most vulnerable, such as in an incapacitated state, his or her preference to have the family make decisions will not be honored without legal recourse. If there is no durable power of attorney, the family does not have the authority to decide what is in the best interests of the patient.

Interventions

As is highlighted in Watson's Theory of Human Care, nurses must strive to develop a capacity to problem solve with the patient and family (Erci, 2005; Mendycka, 2000). In using carative factor 6 while working with Samoans, essential tasks for the nurse are to maintain flexibility, establish a partnership, ensure clear communications, and ensure appropriate legal action. Partnership with the family is an essential aspect of providing care to elderly Samoans. Therefore it is critical to use a true family-centered approach while creating the care plan. The nurse should view the family as a positive influence and include them in the treatment strategy. Family members can help keep the patient

adherent with treatment and can increase the patient's resilience by providing support and encouragement. The nurse can provide education and information to all members of the family. To do this, however, the nurse must ensure that all information is handled with confidentiality unless permitted by the patient. Therefore it is important to determine who is legally permitted to receive the information without formal permission by the patient. Having the family elect a spokesperson can streamline the communication process.

Conflict may arise if the client is asked directly to make a decision among treatment options. The nurse should discuss all options with the family and allow adequate time for them to make a decision. If the patient does not want to know the diagnosis but wishes to receive treatment, the nurse can discuss the importance of completing an informed consent with the family. Their involvement will make the process easier for the client to cope. Before planning health teaching, the nurse must assess the need for an interpreter because this indicates to the client and family that the nurse values their involvement and wishes to make it easier for them to participate.

The most difficult conflict may arise in situations where the patient is incapacitated and the family wishes to make all decisions regarding end-of-life treatments. The nurse can assist in preventing ethical and legal conflict by providing information to the patient (while he or she is competent) and the family on advance directives. By explaining the role of a durable power of attorney, the patient has the option of legally designating a person to serve as a surrogate decision maker in end-of-life decisions. This ensures that the patient and family are prepared, and adequate preparation prevents insult to the family, who would otherwise have limited decision-making authority in what treatments their family member would receive.

Spirituality and Health

Religion and spirituality are highly valued in Samoan culture. Faith in God transcends into all areas of life, including perception on health. Samoans believe that deceased family members exist as spirits, actively influencing and participating in their lives. If unresolved conflict existed while the family member was alive, the deceased person can return as a spirit to "curse" an individual (Saau, 1996). For this reason many Samoans assert that two forms of illness exist: one that involves "Samoan spirits" and another identified as "European illnesses" (Rogers, n.d.). They base their healthcare decisions on the belief that traditional Samoan healers can treat spiritual illnesses and American doctors can treat European illnesses (Rogers, n.d.). In addition, Samoans believe that through prayer intervention, God manifests His healing powers by granting positive outcomes of medical treatment (traditional or Western) (Saau, 1996). Furthermore, medical treatment can only be effective if the family has faith that God can manifest His healing powers through the treatment. They ultimately believe that everything occurs in accordance with God's will; thus there is a strong belief in fate (Saau, 1996).

Contrast with Western Medicine

Western healthcare providers do not generally view spiritual conflicts as causative factors for disease and illness. The “superstitions” described by the client are often undervalued and ignored as the medical team focuses on finding biological and physical causes. For example, although we incorporate spirituality into nursing curricula, we do not fully explore what this means in practice and how nurses might use spiritual techniques with patients. In fact, many settings seem to have a cultural norm in which prayer and spiritual comfort are to be provided only by the chaplain. However, prayer is a recognized source of strength among many healthcare providers, and studies have been conducted in which a key finding is that prayer is associated with better patient outcomes (Bormann et al., 2005; DiJoseph & Cavendish, 2005; Flannelly et al., 2005; Meraviglia, 2006; Tracy et al., 2005; Tzeng & Yin, 2006). DiJoseph and Cavendish (2005) drew the connection of prayer to nursing theories, including Watson.

However, many nurses and physicians do not use prayer as an effective method for treatment for a variety of reasons. In some cases they have not received formal training that prepares them to provide spiritual care. They may not view spiritual care as an important aspect of nursing or medical care. They may have their own spiritual conflicts and may not be comfortable talking with others about issues of spirituality. There can be time constraints, need to focus on technology, or misdiagnosis of spiritual issues as manifestations of anxiety and depression (E. Weeg, personal communication, 2007).

Issues Contributing to Vulnerability

Many Samoans may be reluctant to use Western healthcare providers because of the lack of spiritual acknowledgment and appreciation in treatment modalities. In addition, Samoans underutilize treatment that may be beneficial if they believe they have a Samoan illness that can only be healed through traditional methods. In these cases Samoans delay seeking treatment and their illnesses are complicated by waiting to determine whether it is a Samoan or European illness.

Interventions

It is important for nurses to wait to discuss spiritual practices until after establishing rapport, because Samoan clients may view spirituality as a sensitive topic and may be reluctant to share information. The nurse should explain the purpose of gathering the information so that the patient is aware that the nurse values spiritual needs and wants to incorporate the patient’s needs into the care plan. The client will be more open to the discussion if the nurse is honest, nonjudgmental, and respectful.

The nurse should assess what the client perceives to be the cause and meaning of the illness and whether the illness is “Samoan” or “European,” followed by an assessment of the spiritual practices in which the patient participates (carative factor 10). In addition, providing clients an opportunity to disclose their spiritual journey or experience may help them reflect on the impact their spirituality has on the meaning of past and present life

experiences. Identifying and validating their spiritual practices and beliefs as strengths that promote positive coping methods conveys that the nurse is open to ideas held by the client (carative factor 5). Nurses can also assist in connecting patients with spiritual resources, such as chaplains. Christian Samoans might appreciate knowing the chaplain and visiting the chapel, but it should not be assumed that all Samoans want to see the chaplain.

At any rate, the nurse should not dismiss the importance of spiritual care, because it is a primary strength in Samoan life that provides clients with hope. Meeting the spiritual needs of patients promotes resilience. For elderly Samoans who maintain spiritual practices developed over a lifetime, it is critical to respect their need to pray in their own way (carative factor 8).

Case Study

A young Samoan woman was admitted with encephalopathy of unknown etiology to a local Seattle hospital. Although physically recognizable, her incoherent speech and violent attacks were a shock to her family and friends. The healthcare team conducted many tests to reach a diagnosis, but they could not find a cause for her behavior. Because the doctors had no physical explanation for the behavior, the Samoan family members diagnosed her with a spiritual curse: The young woman had been possessed by the spirits of several deceased family members. The woman's grandmother made a homemade lotion with native plants and oils, and in an emotional routine the family rubbed the lotion on the woman's body, surrounding her in a tight circle of prayer for over 2 hours. In several occasions they called out to the deceased family members, asking them to remove themselves from the woman's body.

This case study is an example of two cultures and perspectives meeting in a hospital setting: Samoan tradition and American health care. The situation in the case study is not uncommon, especially in regional or inner-city hospitals. The following discussion is aimed at providing the acute care nurse with practical interventions to handle the situation described in the case study with culturally competent care.

In the acute care setting, the goal for nursing personnel is to develop collaboration and partnership with the patient and family so that the health care, spiritual, and cultural needs of the patient are met. This is not to say that the nurse is only responsible for managing his or her basic nursing tasks; the nurse is the mediator and the connector between the healthcare team and the patient and family, responsible for overseeing that the patient is having his or her holistic needs met.

To begin a collaborative relationship with the patient and family, the nurse coming on shift must first establish rapport. Establishing rapport is a process of communication laced with veracity and compassion. Upon entering the room it is as simple as asking, "how are you doing?" to as complex as asking, "how do you interpret your daughter's behavior?" In the case study above, the nurse should take the time to address the family's feelings regarding the tests being performed. She or he should spend 10 to 15 minutes speaking with the family to address their frustrations and questions, keeping in mind that

it is most important to listen and not to speak. At this point if it were unknown, the nurse could find out the family's perspective on what the illness means to them and if there are any cultural beliefs that reflect their understanding on how it is caused and treated. If the nurse encounters a time constraint, he or she should tell the family they would like to come back to gather more information or would like to request a multifaith chaplain who could get more information for the healthcare team. When mentioning the request for a chaplain, the nurse should explain that a multifaith chaplain is used to provide spiritual support and to gather information that can be passed to the healthcare team so they can provide the best care for the patient in accordance with her cultural and spiritual needs.

After establishing rapport the nurse can assess the patient's holistic needs by communicating with the family, "How can we support her cultural and spiritual needs?" Nursing personnel should discuss the plan of care with the family and develop a schedule, highlighting the need for clustering care to ensure the family has privacy. In the most desired circumstance the nurse involved in this case study should have been aware of the spiritual routine before its occurrence so that maximal time and privacy is given to the patient and her family. If the routine was being performed without the nurse's knowledge and she or he happened to interrupt the routine, the nurse should then prioritize which care tasks need to be performed to interrupt as little as possible, if at all.

Conclusion

Here we focused on the nurse's pivotal role in promoting the integration of cultural diversity and holistic care into care plans for Samoans. Watson's Theory of Human Care was applied to the analysis in forming culturally competent interventions. The primary interventions include conducting thorough and meaningful assessments to evaluate the patient's perspectives, developing a trusting relationship, and collaborating with the patient and family to integrate their beliefs and practices into the care plan. In particular, spiritual practices need to be incorporated into the care plan.

There are many issues involved in providing effective care for the elderly within this population, but it is crucial to note that healthcare workers are most effective if they have an appreciation for cultural diversity and ways in which they can integrate their cultural sensitivity in practice. Although it might appear that these techniques are useful with clients who are not Samoan, it is important to stress that the specific techniques are based on what the literature says about Samoan culture and should be validated with individuals and families. The world is becoming increasingly smaller and more diverse. Our healthcare systems should reflect a caring orientation that reflects competence in nursing with diverse vulnerable populations.

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Unit 2 Chapter 8

The Ethical Experience of Caring for Vulnerable Populations: The Symphonological Approach

Gladys L. Husted and James H. Husted

As members of humankind we share with other animals the fact that our nature and relationship to the world makes us vulnerable. We are all prone to encounter, in one way or another, which blocks our efficient functioning as the kind of being we are. Our vulnerability is an inescapable part of our nature and of the influence of the world in which we live.

This is true not only of animals and humans but of everything that exists. Rocks, rose bushes, and rainbows come into and go out of existence. But to us as humans, and in fact to every animal, there is a noteworthy difference between the alternatives of staying in existence and going out of existence. This is not true of rocks, rose bushes, and rainbows. Animals act to avoid various perils to which they are vulnerable. As rational animals we (sometimes) use our powers of reason to initiate actions to oppose the loss of our well-being.

One of the ways we can do this is through ethical awareness, extending the time frame of our actions and making them more intelligible. Another is by establishing healthcare systems. The motivation for each of these is a reasoned desire to escape the consequences of various aspects of our vulnerability.

Healthcare systems are far more efficient in achieving this than are contemporary ethical systems. Ethical systems can conflict with the purposes of the healthcare setting and the rational expectations of patients. When these systems (e.g., deontology and utilitarianism) are dominant in a healthcare setting they expose patients to a virulent form of vulnerability.

Perhaps only in the court system are the benefits of an appropriate¹ ethic, insightfully applied, greater than in the healthcare system. And only in the court system are the harms of an inappropriate ethic or its inappropriate application greater. At all odds, the healthcare setting is among the most complex of ethical arenas.

Patients in the healthcare system suffer a vast multitude of disabilities through injury or illness. This makes the pursuit of a spectrum of individual values, which various

patients hold, vulnerable. “Illness creates a range of negative emotions in patients including anxiety, fear, powerlessness, and vulnerability. . . . Patients might feel vulnerable because they are aware that there is potential to be hurt both physically and emotionally. Feelings of fear and powerlessness will perhaps contribute to a general sense of feeling vulnerable: being wide open to harm” (Armstrong, 2006, pp. 110 and 112).

Agency

For bioethics, one disability defines and sets apart every patient regardless of the nature of his² affliction. This is the loss of agency—the power of an individual person to initiate and sustain action, the power to act on his purposes. Every patient suffers an impaired ability to take the actions that further his life and his flourishing. This is the overall object of the healthcare sciences. All of bioethics, properly so-called, is directed against this general disability. There cannot be an ethic for every sort of disability. The onset of disability and loss of well-being and agency sets the standard for the healthcare setting in terms of ethical awareness in relation to the disabled.

Every patient³ needs someone to take actions for him. Every patient needs someone to help him regain his lost agency. This is true even of the dying patient. The vulnerability of a patient is the central concern of bioethics, the concern that he may fail to gain a foreseeable increase in, or even to lose a part of, his agency through the actions or interactions of healthcare professionals.

The fact that patients are vulnerable is established by the fact that they are patients. As patients they remain vulnerable—more vulnerable than they were before they became patients. Healthcare professionals possess an undesirable degree of power over patients (Husted & Husted, 2007).

The more acute the potential for the loss of agency is, the greater the vulnerability. The measure of success for a practice-based bioethic is a patient’s vital objective that he shall retain or regain his power to initiate and sustain actions. To achieve this purpose, symphonology interweaves professional (therapeutic) practice and ethical interaction. By weaving them together in parsimonious temporal interactions, emphasis can easily be shifted from therapeutic to ethical concerns and back again. It is here that ethics connects and interweaves with health care and with human life and purposes. It is here that bioethics steps in to overcome the harm that can be done by the whims of healthcare personnel or reliance on the contemporary ethical systems.

The Nurse as a Second Self

According to Aristotle (McKeon, trans. 1941), a friend is, in his famous phrase, “another self” to his friend. Likewise, a nurse whose profession can be defined as consisting in acting as “the agent of a patient doing for a patient what he would do for himself if he were able” is another self to her patients (Husted & Husted, 2007). In filling the defining responsibilities of her profession, such a nurse significantly reduces the vulnerability of a patient. However, paradoxically, currently fashionable ethical beliefs imparted by her formal education may produce a

willingness to aggress against the agency of her patient. The obvious impracticality of the contemporary systems results in ethical decision-making processes constituted by a string of empty associations. The attempt to interweave utilitarianism, deontology, or subjectivism, individual or social, within the nurse–patient relationship and a nurse’s responsibility eventually instills an indifference or a blend of resentment and self-righteousness that places a patient in a subsidiary, irrelevant, or even adversarial ethical status.

At the same time, no patient ever came into the healthcare setting for the purpose of losing his right to self-determination. The great majority of patients assume that a nurse’s ethical responsibilities consist of filling her role as a nurse. However, a patient may assume a misplaced trust in a healthcare professional. This simply involves the false assumption that the stable goal of the professional is to help him regain his lost agency. Probably no patient suspects, and none would be comforted by, the knowledge that nurses consider it their ethical responsibility to

- Act on assumed duties with no concern for the nature of their consequences and whose relevance would be unconnected to him and whose nature is completely unknown to a patient (the ethic of deontology)
- Bring about, in any dilemma, the greatest good for the greatest number; a goal that becomes a nurse’s ethical fantasy, alienating a nurse from her patient, her profession, and herself (the ethic of utilitarianism)
- Follow her subjective (emotional) state of the moment, however whimsical, or the subjective sentiments of her culture or society, however irrelevant to the life and well-being of her individual patient

A patient is seldom more imperiled than when he is vulnerable to the intentional misdirected self-righteousness of a nurse (as ethic of subjectivism).

Being “a second self,” a concerned nurse does not seek to gain dominion over a vulnerable friend but accepts his right to retain his individual identity. She makes it, as far as she can, unnecessary for a patient to defend himself. When appropriate, she defends him. A concerned nurse has no interest in choosing the values or determining the fate of even the most vulnerable patient.

If a nurse were to be shorn of all her out-of-context ethical preconceptions, all that would be left are the ethical demands of her profession. If she is guided by this, her ethical concern is her relation to her patient as an independent ethical equal, deserving of her understanding and empathy.

Relationship of Nurse and Patient

A patient is one who has lost or suffered a decrease in agency; one who is unable to take the actions his survival or well-being requires (Husted & Husted, 2007). Because she is defined as the agent of her patient, it is appropriate that the center of a nurse’s professional concern should be her patient. When the center of her attention is not her patient, a nurse is practicing a perverse form of nursing. This perverseness arises through the choice of a flawed

and irrelevant standard for nursing practice. There is nothing in the theory or practice of any healthcare profession to justify the professional using preconceptions or emotional ideas as inspiration. Nothing other than the well-being of the patient can serve as an objective standard of professional judgment. No other standard will allow an intelligible interweaving of the practice of nursing and an ethic appropriate to that practice.

A patient must exercise the resources of his character that enable him to achieve greater well-being through his power to take independent action. A nurse's standard of success is met when she strengthens these resources and increases the opportunity of her patient to exercise them. For a professional ethic, one defined by a nurse's practice, this is the standard by which she measures her practice. It is the reason for being and the ethical guidepost of her profession.

Ethics of Professional Practice

The ethic of a committed nurse must be practice based. This is any ethical system in which the nature and ends of professional practice determine the nature, application, and general purposes of the profession's ethical standards. Its purpose is to enhance the benefits available to patients through the healthcare system. An ethic that is not skillfully exercised and harmoniously interwoven with practice cannot justifiably be the ethic of a healthcare professional. It is the ethic of a nurse who is merely "going through the motions." Every form of a practice-based bioethic is derived from, and is intended to be appropriate to, the self-determination of a patient, the purposes of a healthcare setting, and the role of a healthcare professional. Most nurses eventually adopt some form of a practice-based system. It is a significant benefit to them if they recognize this. It is a significant benefit to their patients if this recognition allows their system to be sufficiently complete, cohesive, and coherent to be predictable. An ethic not derived from the practice of the healthcare professions and the purposes of the healthcare setting must fail to meet the needs of a patient. Ethical decisions and actions guided by a nurse's feelings or the demands she attributes to her duty often fail. If they succeed, they succeed only by accident. To the extent that a patient is vulnerable, these decisions and actions create a greater vulnerability. The standard of a nurse's practice by which its competence is to be measured is not the nurse and the way she happens to practice. It is practice itself, as it can be and should be.

A practice-based ethical system places a nurse in harmony with the promise of the healthcare system and the trust of her patients. Such a system produces positive pride in her profession and in herself as a practitioner of this profession. And, as a corollary, it increases the confidence that each of her patients can appropriately place in her. It reduces or eliminates her patients' vulnerability, at least in their relation to her.

Nature of the Nurse–Patient Agreement

Of necessity, a practice-based system is symphonological, a term derived from *symphonia*, a Greek word meaning agreement. This is an approach to ethical interaction from pro-

professional responsibility, the responsibility encoded in a nurse's professional agreement with her patient. A practice-based bioethic aims to relate professionals and patients internally, to bring them into the same ethical context. It makes human values its focus and ensures that the healthcare setting is minimally arbitrary and maximally purposeful. This context influences directly or indirectly the way in which a nurse performs (Gastmans, 1998).

Bioethics places particular emphasis on situations where one person is extremely vulnerable, where the goals pursued are crucial, or where the dilemmas to be resolved are extraordinarily complex (Husted & Husted, 2007). A practice-based bioethic is based on interaction between a professional and a patient who relate to each other through understanding and agreement. One engages with a nurse assuming that she has agreed to act in her role as a healthcare professional. In engaging her, one agrees to be a patient, one willing for her to act for him. Logically and ethically there is an inescapable implication that the ethical interactions between nurse and patient will conform to this agreement.

Necessity of the Nurse–Patient Agreement

“How can two walk together lest they agree?” (1 *Kings* 3:16–28). The simple action of two people walking together is an interaction and is therefore, necessarily, the product of an agreement. Much more so, the complex and vital actions that take place in a healthcare system are interactions and are therefore products of a complex and vital agreement.

An agreement is a shared state of awareness established by a decision on the part of each party to the agreement. Where a patient is not able to take part in the forming of an agreement or actively participate in it, it is an implicit agreement based on a high probability that, if the patient were able, it would be formed. The agreement between nurse and patient is the foundation of the ethical interaction between them. It is structured by the expectations of each and the commitments that each makes to the other. Each agrees to satisfy these reasonable expectations and to live up to the commitment. The agreement makes their interaction intelligible. It helps each to understand what is expected and what is committed to in their interaction. Whenever a nurse fails to be guided by her professional agreement, her profession becomes, in effect, a hobby. She may believe that ethically she succeeds, but in relation to her patients and her profession she fails.

Nursing Interactions

Every action that a nurse takes is an interaction. There are no isolated actions, actions without a recipient, in the healthcare system. Isolated actions would neither be nursing nor of any consequence. A nurse's profession implies that her agreement is to interact. Even in the cases of a patient who cannot actively participate in his care, professional practice remains an interaction. A nurse interacts with the vital functions of her patients. The less a patient can participate in his care, the weaker he is in their interactions, the more vulnerable he is. A concerned nurse does, even for the most vulnerable, precisely what she

does for every patient: She acts to overcome his vulnerability, his inability to take action, his patency. Although with the more vulnerable, her actions may need to be more powerful and more precise. “The core of ethical behaviour between staff and patients may reside in the seeming minutiae of small social exchanges” (Grant and Briscoe, 2002, para. 7). In the context of a practice-based ethic, interaction begins with support for a patient’s right to self-determination

Rights

One evening, strolling across a field in a deserted park, Tom sees Dick approaching from the other side. Tom has recently lost his financial shirt. He is broke and has no bright prospects for the future. Dick is a rich recluse in ill health. He is known to carry large sums of money with him. Tom is aware of this. Tom could rob Dick, solve his financial problems, and no one would be the wiser. Dick, for his part, is unacquainted with Tom. Tom, in common with everyone in town, knows that Dick is subject to hallucinations. On this day everyone from this small town except Tom and Dick has taken a bus to the county fair. Every circumstance seems to invite Tom to rob Dick. The odds on Tom being caught are minuscule. None of this enters Tom’s mind. As they pass, Dick speaks a conventional pleasantry to him and Tom replies in kind. Tom never conceives of robbing Dick. Without thinking about it, Tom has recognized Dick’s rights. If you had seen this event, you would have seen the operation of an individual’s rights, Dick’s right not to be aggressed against.

Now what is it you have seen? You have seen the product of a spontaneous and unnoticed agreement. This agreement holds between every noncriminal member of the human species. One instance of this is the agreement existing between Tom and Dick.

*Rights*⁴ is defined as “The product of an implicit agreement among rational beings, made and held by virtue of their rationality, not to obtain actions from one another, nor to put one another in any circumstance except through voluntary consent, objectively gained” (Husted & Husted, 2007).

Imagine, if you can, a healthcare setting devoid of this agreement. Without the recognition of individual rights, this system would never have come into being. No one would conceive of something as intricate as a healthcare system. Human existence would be, in the words of philosopher Thomas Hobbes (1588–1679), “solitary, poore, nastie, brutish, and short” (Oakeshott, 1957, p. 47). To the extent that the recognition of individual rights does not guide interaction, human life must be and is right now solitary, poore, nastie, brutish, and short.

Individual rights belong to each human individual by virtue of his or her membership in the human species. In becoming a patient, an individual does not lose this membership. His rights are not increased—this is not necessary—but neither are his rights decreased—this is not permissible. He is a rational being ethically equal to all other rational beings. The nature of every interpersonal ethical system arises from the attitude

of that system toward individual rights. The nature of the ethical practice of every nurse is shaped by her attitude toward the individual rights of her patient. As there is a decrease in the recognition of human rights, there is an increase in the vulnerability of the patient and vice versa.

Ethical practice does not allow a professional to violate the rights of a patient. A dedication to human values is internal to the nature of the healthcare setting. This dedication presupposes respect for the individual rights of patients. Only when an individual has reason to be confident that he will not be the victim of aggression can he exercise his human virtues in the pursuit of his individual values.

The rights agreement is the ethical foundation for explicit agreements. It is the already established agreement that explicit agreements will be objective, voluntary, and honored. Harmony is a state wherein each person can interact without fear of aggression and betrayal. When rights encompass an agreement to nonaggression and nothing besides this, then the rights agreement creates a state of harmony among rational beings. Reliance on rights is possible and productive, even though crime is possible in the same way that reliance on health is reasonable despite the possibility of injury or illness. The practice of nursing, ideally, goes beyond respect for rights, but a professional practice-based ethic must begin with a nurse's undaunted pride in her profession and the recognition of the dignity of her patients (Hardt, 2001).

Paradox of Group Purpose

A bioethical view of rights must be concerned with individual human purposes. Nurses and patients are defined in terms of human purposes. The healthcare system is inspired by a concern for individual purposes. In the healthcare setting individual rights are manifested in the view that a patient's pursuit of his purposes should not be aggressed against. Individual purposes are the precondition and motivation of the healthcare setting and of rights. If people did not act on purposes, rights would have no relevance to ethics, and ethics would have no relevance to human life. Without the protection of rights, human individuals could not act on their purposes. Every moment of their lives would be spent defending themselves. Rights and purposes are intricately interwoven.

Much of the literature about vulnerable patients deals with vulnerable patient populations. As nurses we have to differentiate between vulnerable populations and the vulnerable patient as a unique individual requiring attention to his own specific characteristics. The concept of populations assists our understanding and communication with others; however, it does not create another entity. Populations have no purposes and no rights. No population ever occupied a hospital bed.

Nurses and patients disagree. Patients and patients disagree. Nurses disagree with each other. It is to the advantage of every individual to accept these differences in opinions and motivations as relevant to and defended by individual rights. The right to different motivations is the reason for being of ethics. Any defense of the idea that differences in motivations

as such are unjustified would involve an individual in arguing that the motivation of his individual and different point of view is justified while, at the same time, that the motivation behind individual and different points of view are unjustified.

Agreement, Bioethical Standards, and the Vulnerable Patient

Virtues are the standards of a practice-based bioethic. Whatever actions a nurse takes to defend and strengthen them are justifiable ethical actions. The nurse's virtues, to the extent that she is virtuous, sharpen her attention to her patient. The patients' virtues, to the extent that he is able to act on his virtues, sharpen his attention to his life, health, and well-being. Any actions that a nurse takes that weaken virtues are unethical and unjustifiable actions. The rights agreement is the sanction of the virtues. The nurse-patient agreement is an interaction taken in service of the virtues. The virtues, by their nature, are instruments of human purpose, and this nature structures the nature of individual purposes and human persons. Their nature is the inspiration for agreement making. The bioethical standards, the measuring rods of success, are the virtues of autonomy, freedom, objectivity, self-assertion, beneficence, and fidelity.⁵

Autonomy is the uniqueness of a person, that which makes a person the individual he or she is. It is the right to be who he or she is and act on that basis. If a nurse can strengthen and nurture her patients' autonomy, then she helps them make their purposes and actions their own. She can help them gain a better understanding and acceptance of themselves. This is her ethical means of meeting her agreement.

Freedom is the power (and right) to take long-term action based on one's own evaluation of a situation. A patient who is less able to exercise his ability to take free action is more vulnerable than one who is more able. This is because he is at a greater risk of harm, less able to know, to make known, or to defend what his free action would be. Therefore nurses or other healthcare professionals act as the agent through whom patients are able to regain their power to exercise free choice. If she can strengthen and nurture her patients' freedom, she helps them to have a clear vision of what their long-term motivations and values are and what these demand of them in their present situation. She helps them achieve the endurance to take long-term actions toward the pursuit of their values.

Objectivity is the ability to know something and interact with it as it is in itself apart from one's preconceived ideas of it. It is a patient's need to achieve and sustain the exercise of his objective awareness. A patient who is able to contribute information about himself and understand the information given to him in light of available alternatives and his own uniqueness is less vulnerable than one who cannot. All actions that involve the pursuit of benefits and the avoidance of harm occur among the physical realities in which one acts. The loss of objective awareness is a radical form of vulnerability. It makes one vulnerable to the loss of the other virtues. If the nurse can strengthen and nurture the objectivity of her patient, she enables a patient to act appropriately on his autonomous and objective awareness of his circumstances. The strength of mind necessary to maintain

objective awareness of facts outside of his mind and a stable awareness of items of knowledge that are relevant to his actions are necessary to his endurance and success.

Self-assertion is an agent's self-ownership, the power and right of an agent to control his time and effort, the right to initiate his own actions. A patient who is able to control his time and effort is less vulnerable than a patient who must rely on others to do this for him. A nurse, as the agent of a patient, assists him in regaining and exercising his power of self-assertion.

Beneficence means competence in acting to acquire what is beneficial in accordance with one's desires and values, the ability to pursue benefits and to avoid harms. A patient who is able to define benefit and harm for himself and according to his unique values is less vulnerable than one who cannot. A nurse must exert great care not to view benefit and harm for a patient according to her own idea of benefit and harm. The determination of benefit and harm is very individual. If she can strengthen and nurture his benefit seeking, she helps motivate her patient to retain his values and achieve his goals according to his long-term purposes. His courage to accept his own desires for himself, his pursuit of benefit, and his ability to avoid harm will be strengthened.

Fidelity denotes a nurse's commitment to her professional role and a patient's commitment to his life and values.⁶ All that a patient endures when he suffers through his vulnerability can be summed up by the fact that he loses his integrity and his power to be faithful to himself and the values he has chosen for his life. A nurse can exert her virtues as codified in the bioethical standards to help a patient regain and/or exert his virtues to achieve an active future. If she can strengthen and nurture his fidelity to himself, she can help him to retain a clear understanding of himself in relation to his ambitions. This will assist him in being faithful to his life and flourishing.

Justified Ethical Activity

No virtue a nurse can offer a patient is more productive to his life, health, and well-being than her knowledge of who she is both individually and as a healthcare professional. This is the virtue that enables her to feel and express empathy for her patient. It also is a virtue that enables her to intend to do good, to intend to benefit her patient.

A practice-based bioethic is an outline of the appropriate ways to interpret the healthcare professional-patient agreement. The bioethical standards, as virtues to be exercised, are preconditions of each and every agreement. The bioethical standards, as virtues to be strengthened, are the standards of ethical decision making in the healthcare system. They are standards because as virtues they are the purpose that brings a person into the healthcare setting to regain or strengthen them. His agency is constituted by these virtues.

A Patient's Agency

A nurse's most obvious standard or measure of ethical justification is the agency of her patient. According to this standard, failing to take action or acting to frustrate a patient's

rightful efforts undercuts the ability of a nurse to objectively justify her actions. The standards of a patient's success in the healthcare system are the virtues he seeks to strengthen and regain. If he succeeds in this purpose, his interactions are successful. Insofar as a nurse assists him in this, nurse and patient are equally successful. Insofar as her actions are oriented to this goal, they are justifiable. A committed nurse, through observation and communication, can come to understand how these virtues are expressed (or fail to be expressed) in the actions of her patient. She can discover whether they function and how they function in motivating him. Her understanding can guide and justify her actions.

All these virtues, by their presence or absence, form the unique character structures of a human individual. The human values that individuals pursue are made possible by these character structures exercised in successful action. They are themselves human values. The social condition necessary to this pursuit is freedom from aggression. This necessary condition of the achievement of human values is the right of every human individual that is established by the species-wide and unspoken agreement that establishes these rights. If a nurse maintains respect for her patient's rights, any action she takes is justifiable.

To the extent that rights can be violated, nothing and no one is secure. Because there are no dependable intelligible sequences to interaction, foresight and predictability are illusory. Under these circumstances a patient cannot function as a rational being, an individual who possesses purposes and rights. A patient will have a right to do and to depend on nothing. The professional will have a right, derived from coercion, to do anything, to be unpredictable. Under these conditions interactions are impossible. To the extent that events are guided by the unexpected "agreements" that are secured through deception or force, a patient's rights are violated. The recognition of a patient's rights is the only defense he has in the healthcare system.

Conclusion

"Although ethical issues in health care receive much publicity, attention is rarely given to the non-dramatic, everyday ethics of health care" (Smith, 2005, para. 1). This would include the day-to-day care of vulnerable patients who may not present an actual dilemma but whose care must be diligent because of their fragile condition. When the role of a nurse is not set by a clear and logically comprehensive definition, any action or omission on her part is allowable. This state of affairs is a violation of her profession. The professional cannot agree to act as the agent of a patient if something within the profession itself prevents this. To the extent that the definition and the nature of her role are, actually or potentially, in conflict, no agreement is possible.

Rights are not routinely violated in the healthcare system. If this were the case there would be a revolt and a reformation of the system. When rights are violated, it is usually the rights of the most vulnerable, those who have no voice and cannot defend themselves against the self-righteous irrationality of healthcare professionals.

Two factors are necessary, and almost sufficient, for a nurse's justifiable ethical interactions: her unwavering recognition of a patient's rights and her unimpeachable adherence to the essence of her profession. In a healthcare setting that is governed by a practice-based ethic, some patients are more vulnerable than others but not vulnerable in relation to a nurse. To a great extent, the degree of a patient's vulnerability is a function of a healthcare professional's character. Sometimes a patient is completely vulnerable, but the right agreement holds by virtue of his nature and her nature, and ethically, a patient's rights are always and absolutely invulnerable.

Endnotes

- ¹ "Appropriate" means according to the internal purposes of the setting.
- ² The pronouns *she* and *her* are used to designate the healthcare professional and *he* and *him* to designate the patient. This is, in part, for the reader's ease of understanding. More importantly, the singular is preferred to the plural or indeterminate because professionals and patients are individuals and a practice-based ethic is, necessarily, an individualistic ethic.
- ³ The word "patient" is derived from the Greek word *pathos* meaning experiences, suffering, or passivity. Other words with the same root are "pathos" itself (that in experience which evokes empathy or compassion), "pathetic" (evoking tenderness, pity, or sorrow), and "passive" (incapable of action).
- ⁴ "Rights" is used in this chapter as a singular concept denoting an overarching agreement.
- ⁵ "Autonomy" is not used here in its customary dictionary definition of independence. We use autonomy to denote the uniqueness of each individual person. The definition of "freedom" includes everything relevant to a person's independence.
- ⁶ All definitions are taken, from Husted and Husted (2007).

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Unit 2 Chapter 9

Giving Voice to Vulnerable Populations: Rogerian Theory

**Sarah Hall Gueldner, Geraldine R. Britton,
and Susan Terwilliger**

The human condition of vulnerability is a concept of vital concern to nurses in that a large portion of nursing practice is spent either helping individuals who find themselves in a vulnerable position or helping them avoid vulnerability. However, nursing has been slow in developing theoretical constructs of vulnerability within a nursing perspective (Spiers, 2000). Traditional definitions of vulnerability are framed within an epidemiological approach to identify individuals and groups at risk for harm. Groups most often labeled as vulnerable include the elderly, children, the poor, people with disability or chronic illness, people from minority cultures, and captive populations such as prisoners and refugees (Saunders & Valente, 1992). Labels of vulnerability are customarily applied in relation to socioeconomic, minority, or other stigmatizing status (Demi & Warren, 1995) and reflect a tendency to blame the victim rather than the prevailing social structures. The generally accepted marker for vulnerability has been the inability to function independently in accord with the values of a particular society. Fortunately, there is growing dialogue about vulnerability from the perspective of the person experiencing it, a view that is more congruent with the philosophical stance of nursing (Morse, 1997; Spiers, 2000).

The Rogerian conceptual system (Rogers, 1992), which focuses on the person as integral with and inseparable from his or her environment, holds considerable relevance as an innovative nursing framework to use in addressing the problem of vulnerability. Accordingly, the remainder of this discussion is directed toward application of the theoretical base of Rogerian nursing science to the human condition of vulnerability. Because persons who are vulnerable are at greater risk for not being heard, the last part of the chapter describes the Wellbeing Picture Scale (WPS), a 10-item innovative picture-based tool that offers a menu of paired pictures rather than words, giving people who may not be able to read English text an alternative more user-friendly way of expressing their sense of well-being.

A Rogerian Perspective of Vulnerability

According to Martha Rogers, energy fields are the fundamental unit of everything, both living and nonliving. The fields are without boundary and dynamic, changing continuously. Two energy fields are identified: the human field and the environmental field. Rogers emphasized that humans and environments do not *have* energy fields; rather, they *are* energy fields. Likewise, she insisted that the human field is unitary and cannot be reduced to a biological field, a physical field, or a psychosocial field. As postulated by Rogers, human and environmental fields flow together in a constant mutual process that is unitary rather than separate. Within this world view humans are energy fields that exist in constant mutual process with their immediate and extended environmental energy field, which includes, and cannot be separated from, other living and nonliving fields. She also postulated that both human and environmental energy patterns change continually during this process. The inseparability of the human energy field from its immediate and extended environmental energy field is perhaps the most central feature of the Rogerian conceptual system.

Phillips and Bramlett (1994) asserted that the mutual human–environmental field process can be harmonious or dissonant. Resonant with Rogers’ science, these researchers posit vulnerability as an emergent condition that arises when there is dissonance within the mutual human–environmental field process. This view is consistent with Rogerian scholar Barrett’s (1990) theory of power, which associates power with individuals’ knowing participation in change within their mutual human–environmental process for the betterment of the whole, including themselves. These authors perceive vulnerability as the opposite condition of power, a condition that may occur when an individual is unable or does not choose to participate in an informed and purposeful way in change. Persons in this situation essentially have no voice and may be intentionally or unintentionally left behind in a compromised position. Within this line of thinking, an individual’s sense of dissonance or disharmony within the mutual human–environmental field process would be viewed as a manifestation of vulnerability, placing individuals or groups at risk. Barrett developed the text-based tool, Power as Knowing Participation in Change (PKPC), to measure this concept; a subscale of the tool addresses awareness as an essential feature of knowing participation.

Lack of knowing participation may be associated with a number of scenarios. Individuals may be uninformed or misinformed about situations involving their unique human–environmental field process, or they may be unable to participate due to one or more specific circumstances such as illness (e.g., stroke or dementia) or injury (e.g., hip fracture). Common situations that may limit or prevent knowing participation include compromised vision or hearing, aphasia, difficulty with mobility, and confusion or dementia. Other circumstances that may limit knowing participation include any situation that hinders a person from engaging in sufficient communication within the community; examples might include lack of transportation or limited language facility.

Insufficient means or the inability to move about freely may diminish presence, making it more difficult, if not impossible, to be “at the table,” to achieve representation. Stigmatized individuals or groups such as single mothers, persons who are homeless, and persons perceived as unattractive or different are also at risk for a lack of information or misinformation that may lead to inappropriate participation based on misjudgment. Indeed, information may actually be withheld if participation is not welcome.

Parse’s (2003) theory of community becoming, also an extension of Rogers’ nursing science, is particularly applicable to the theoretical tenet of vulnerability. She defines community in terms of the relational experience of being “in community” and describes it as a resource, dynamic and continuously changing to represent the good of the individual to achieve the best for all. According to her definition, community is not a location or a group of people who have similar interests; rather, community is the human connectedness with the universe, including connectedness with what she terms “yet-to-be possibles.” This view represents a paradigm shift, wherein vulnerability is an emergent characteristic of the community in process that occurs when an individual or group becomes disconnected from the group and therefore from needed resources. Parse describes a nontraditional model of health service for individuals and families who have become disconnected from resources. The process involves imaging the vision of possibilities and inviting others to capture the vision, thus energizing the community to build partnerships to overcome the disconnect.

Within this conceptualization, vulnerability arises as an emergent characteristic when connectedness is compromised by a lack of communication or flawed communication that leads to exclusion from resources. Vulnerability might be seen as an unfortunate estrangement from the process of community. Within this view persons who are at particular risk for vulnerability are those who for some reason are unable to call enough attention to their needs to garner the support of their community.

Based on Parse’s (1997) “human becoming” perspective, her view of nursing practice also differs from traditional nursing practice in that the nurse does not offer standardized professional advice or opinions stemming from the nurse’s own value system. Rather, according to Parse, nursing involves a “true presence with and respect for the other” wherein the nurse dwells with the person or family to enhance their perceived “possibles.” Parse points out that it is essential to go with vulnerable persons to where they are rather than to attempt to judge, change, or control them. It is in dwelling with the individual in discussion that meanings emerge, and it is in this process of illuminating meaning that possibilities for transcendence are seen.

In Parse’s words, “The nurse in true presence with person or family is not a guide or a beacon, but rather an inspiring attentive presence that calls the other to shed light on the meaning moments of his or her life. It is the person or family in the presence of the nurse that illuminates the meaning and mobilizes the capacity to transcend and move beyond. The person is coauthor of his or her own health . . . choosing rhythmical patterns of relating while reaching for personal hopes and dreams” (Parse, 1997, p. 40). She continues,

“True presence is a special way of *being with* in which the nurse bears witness to the person’s or family’s own living of value priorities. True presence is an interpersonal art grounded in a strong knowledge base ‘reflecting the belief that each person knows *the way* somewhere within self’” (Parse, 1997, p. 40). Certainly, nowhere is it more important to respect the person as he or she is than when working with those who are vulnerable.

Parse describes a humanitarian model of nursing practice based on true presence and profound respect. Use of this model enables people to find actions that increase their ability to knowingly participate in change to improve their position, thus becoming less vulnerable. Parse refers to this process as the search for the possible beyond the now.

However, in even this overall positive system some are likely to find themselves in vulnerable circumstances. Some individuals and groups (such as young children) are placed at risk because they cannot speak for themselves and depend on others to advocate for them. Likewise, sick or frail members of the community may be too weak or impaired to participate knowingly (or sufficiently) in the change process to advance their betterment. They may not be mobile enough, think clearly enough, or be articulate enough to capture community attention and garner the resources they need.

Individuals or families at special risk for vulnerability include those who

- Have energy-draining illnesses or conditions such as stroke, heart attack, cancer, or depression
- Are not included in the dominant culture
- Have compromised language facility, making them at greater risk for being unheard
- Are out of their familiar turf (i.e., new in the community and do not know the “rules” or avenues for help)
- Are unable to comprehend information (i.e., never learned to read, have diminished vision or hearing, are unconscious or have dementia, or are unable to comprehend English)
- Have illness or injury that limits independence (i.e., broken hips that make it more difficult to stay physically connected with the community)
- Lack the ability to access services needed for everyday life (i.e., means for obtaining food, place to live, health services)
- Are in a position of diminished visibility (e.g., live in a remote area or are home-bound, becoming disconnected from community notice)

Viewed from Parse’s theory of community becoming, the approach to overcoming vulnerability is a matter of reconnecting the person or group to the community. This sometimes happens naturally through family and friends or through social institutions and/or programs such as churches and civic organizations. But it may take the focused attention and time of individuals, such as nurses, to help the person or family as they gain insight about the possibilities that are available to them.

Giving Voice: An Application of Rogerian Nursing Science

To address the lack of voice that is so intricately associated with the experience of vulnerability, this section describes a simple picture tool, the WPS, developed within the Rogerian conceptual system to amplify the voice of persons who otherwise might not be heard (Gueldner et al., 2005).

The WPS is a 10-item non-language-based pictorial scale that measures general sense of well-being as a reflection of the mutual human-environmental field process. It was originally designed as an easy-to-administer tool for use with the broadest possible range of adult populations, including persons who have limited formal education, do not speak English as their first language, may not be able to see well, or may be too sick or frail to respond to lengthier or more complex measures. Ten pairs of 1-inch drawings depicting a sense of high or low well-being are arranged at opposite ends of a seven-choice, unnumbered, semantic differential scale. The 10 items included are eyes open and closed, shoes sitting still and running, butterfly and turtle, candle lit and not lit, faucet running full and dripping, puzzle pieces together and separated, pencil sharp and dull, sun full and partially cloud covered, balloons inflated and partially deflated, and lion and mouse. Individuals are asked to view each of the 10 picture pairs and mark the point along the scale between the pictures to indicate which they feel most like, for example, a lighted candle or an unlit candle. The brief instructions for the WPS are translated and administered in Taiwanese, Japanese, Korean, Egyptian, and Spanish. Psychometric properties for the tool were established in a sample of 1,027 individuals in the United States, Taiwan, and Japan; the sample was 56% Asian, 34% white, and 10% African-American or Hispanic. The overall Cronbach's alpha was found to be 0.8795 across the three countries. Five of the 10 items were completely consistent across countries (puzzle, balloon, sun, eyes, and lion), and all others were consistent across two of the three countries.

Conceptual Formulation of Well-Being

Rogers maintained that, "the purpose of nursing is to promote health and well-being for all persons wherever they are" (1992, p. 258). According to Hills (1998), well-being is generally defined as a relative sense of harmony and satisfaction in one's life. Smith (1981) and Todaro-Franceschi (1999) defined health as movement toward self-fulfillment or realization of one's potential, a view that is congruent with Parse's (1997) theory of human becoming. Newman (1994) does not distinguish health from well-being but singularly defines it as a manifestation of expanding consciousness that may occur during, but is not separate from, the experience of illness. This view is supported by the work of Hills (1998), who demonstrated a relationship between well-being and awareness.

Conceptually, the WPS assesses the energy field in regard to four characteristics judged to be associated with well-being: frequency of movement (i.e., intensity) within the energy field, awareness of one's self as energy, action emanating from the energy field, and power as knowing participation in change within the mutual human-environmental energy field process.

Frequency

The term *frequency* denotes the intensity of motion within the energy field(s). It is postulated that higher frequency is associated with a greater sense of well-being and that it is experienced as a sense of vitality.

Awareness

Awareness refers to the sense an individual has of his or her potential for change within the mutual human–environmental field. It signals readiness for moving toward one’s potential and is postulated to be positively associated with a sense of well-being. The concept of awareness is congruent with Newman’s (1994) theory of health as expanding consciousness and Parse’s (1997) theory of human becoming (unfolding). Barrett (1990) included a subscale of awareness in her PKPC tool, and Hills (1998) discussed enlightenment as a manifestation of expanded awareness, higher level field motion, and well-being. Awareness is postulated to be a positive manifestation of the dynamics of the mutual human–environmental field process.

Action

Action is conceptualized as an emergent of the “continuous mutual human–environmental field process” (Rogers, 1992), reflecting the frequency of the human energy field. Action is viewed as an expression of field energy associated with well-being. Examples of action include activities associated with daily living, such as preparing food, eating, personal grooming, participating in social events, exercising, or doing chores, as well as actively engaging in innovative thinking or the creation of art forms.

Power

As described by Barrett (1990), power is the capacity of an individual to engage knowingly in change. Barrett defined it as the degree to which an individual is able to express energy as power to create desired change within his or her human–environmental energy field process. When power is prominent, it is postulated that one would have a sense of confidence; conversely, it would follow that powerlessness is associated with a sense of vulnerability. Power might also be conceptualized as the capacity of an individual to commute the three aforementioned conditions (energy expressed as frequency, awareness, and action) into an emergent sense of well-being.

WPS Development

The more than 10 years of developmental work and field testing of early versions of the WPS revealed a correlation with several other tools designed to measure aspects of well-being within the Rogerian framework (Gueldner, Bramlett, Johnston, & Guillory, 1996). Johnston (1994), in a sample of nursing home residents and community-dwelling elders, reported a highly significant correlation ($r = 0.6647$) between the WPS tool and her Human Field Image Metaphor Scale, which uses two- or three-word metaphors to mea-

sure image. Gueldner et al. (1996) found an even greater correlation ($r = 0.7841$) between the WPS and Barrett's (1990) PKPC tool, which measures an individual's capacity for awareness, choices, freedom to act intentionally, and involvement to bring about harmony in the human-environmental field process.

Davis (1989), in a matched sample of 30 men 19–51 years of age who had been hospitalized for traumatic injuries and 30 noninjured men, demonstrated positive significant correlations between the score on the WPS and scores on the PKPC tool ($p = 0.002$) and Rosenberg's self-esteem scale ($p = 0.02$). She also found a difference in the between-group mean scores that approached significance ($p = 0.059$), warranting further consideration in a larger sample.

Hindman (1993), in a sample of 40 nursing home residents and 40 community-dwelling older adults, demonstrated a significant correlation ($p = 0.001$) between the mean score on the WPS and humor as measured by the Situational Humor Response Questionnaire. She also found that the mean score was higher for the community-dwelling group of older adults ($p = 0.001$) than for their counterparts who lived in the nursing home and that individuals who perceived their income as adequate scored higher ($p = 0.05$) than those who perceived their income to be less than adequate. Older participants scored lower ($p = 0.05$) on the WPS.

Hills (1998), in a study of 874 mothers of 6-month-old infants, found that mothers who scored higher on the picture tool also reported higher levels of awareness ($p = 0.001$) as measured by the awareness subscale of Barrett's (1990) PKPC tool and well-being ($p < 0.001$) as measured by Cantril's Ladder for Well-Being.

Gueldner et al. (2005) administered the WPS and the Geriatric Depression Scale (GDS) to 200 older adults who were attending lunch events at six senior centers in upstate New York and reported a significant correlation ($p < 0.05$) between the WPS and the GDS. One-fifth (20%) of those who participated in the study scored above the cut-off of 5 (indicating concern for depression) on the GDS; 10% scored above 8 on the GDS, and three individuals scored an alarming 13–14 on the GDS. These findings support the ability of the more user-friendly WPS to screen for depression in community-dwelling elders.

Use of the WPS with Children

Because of their dependent status, children are at particular risk for vulnerability and their voices may not be heard; others tend to speak for them. Thus the developers of the tool believe that the WPS holds potential for giving voice to children as well as to adults. The WPS was used by two researchers to measure well-being in children.

Abbate (1990) used the early 18-item version of the tool as a pre- and posttest measure of well-being in eight school-aged children (aged 5–16 years) with cerebral palsy who participated in a 10-week therapeutic horsemanship program. The mean of the pretest scores was 82.75 and the mean of the posttest scores, 86.38. The scores of four children increased over the 10-week period, one did not change, and the scores of three decreased. All the children in the study had already been riding horses for several years, leading Abbate to

suggest that some of the children may have already achieved the most significant gain from their participation in the riding program before the onset of the study. Abbate noted that even the most impaired children seemed comfortable and confident in placing their mark along the seven-point scoring line between the picture pairs (the younger ones used crayons), supporting its utility with children. This was the first study that used the WPS tool with children, and the sample was small. However, the findings provided impetus and direction for developing a children's version of the instrument.

More recently, Terwilliger (2007) modified the format of the 10-item WPS for use with a sample of 20 fourth- and fifth-grade elementary school children. The original seven-point Likert Scale between each pair of pictures was reconfigured and abbreviated to four boxes (two boxes were placed closer to the picture on the left of the page and the other two boxes were placed closer to the picture pair on the right side of the page). For each item the investigator asked the child to point to the picture they "felt most like." Then they were each asked to place a mark in one of the two boxes to indicate whether they felt "a little bit" like the picture they had chosen or "a lot" like it. The investigator repeated each item and pointed out the designated boxes as many times as necessary if the child seemed to have difficulty understanding the scoring instructions. The scoring mechanism was adjusted so that the children's scores retained the range from 7 to 70, with higher scores indicating a higher sense of well-being. The mean scores of the children were significantly higher ($p < 0.05$) at postintervention than at preintervention. Although the sample size for this study was modest, the findings lend support for the use of the WPS with children.

In summary, work by Gueldner et al. (1996), Hills (1998), and Johnston (1994) confirmed a high correlation between scores on the WPS and other measures of well-being developed within the Rogerian conceptual system. Additionally, the work of Davis (1989), Hills (1998), and Hindman (1993) demonstrated a high correlation between the WPS tool and a number of established measures of well-being developed by other disciplines. Although both were limited in sample size, the studies of Abbate (1990) and Terwilliger (2007) demonstrated the potential usability of the tool in children. Given these findings, the WPS is offered as a general measure of well-being mediated through frequency, awareness, action, and power emanating within an individual's mutual human-environmental field process.

Conclusion

Given these findings the WPS is offered as a general index of well-being and for use with international populations who might have difficulty reading English text. The instrument is seen as having the potential to give voice to those who are too sick or weak to participate in studies that require lengthy measures of well-being and, perhaps, even to persons with mild to moderate cognitive impairment. A secondary purpose of the tool rests in its potential for use as an easy-to-administer clinical indicator of well-being across a wide sector of clinical settings. Based on the work of Abbate (1990) and Terwilliger (2007), a children's version of the tool is presently being developed and tested.

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Unit 2 Chapter 10

Application of the Barnard Parent/Caregiver–Child Interaction Model to Care of Premature Infants

Danuta Wojnar

Parent–infant interaction is the context in which most infants initially experience the world. Under normal circumstances it is within the parent–infant relationship that the infant learns about the environment. It is the parent who teaches the infant basic principles of communication while mediating the amount of sensory input the infant receives. Yet over 10% of infants are born prematurely each year and require hospitalization in the newborn intensive care unit (NICU) (Hamilton et al., 2007). Highly specialized care available in the NICU enhances preterm infants' chance for survival; however, complications of prematurity, such as acute and chronic illness (Guzzetta et al., 2006; Roy et al., 2006), developmental delays (Casey, Whiteside-Mansell, Barrett, Bradley, & Gargus, 2006; Raju, Higgins, Stark, & Leveno, 2006), and deprivation of quality parent–child interactions (Als, 1997; Barnard, 1997; Lindrea & Stainton, 2000), pose serious threats to long-term infant outcomes.

The purpose of this chapter is to discuss the Barnard (1976) Parent/Caregiver–Child Interaction Model as a framework for delivering relationship-based developmentally supportive interventions to preterm infants and their parents. Examples are provided from research and practice that demonstrate clinical applicability of the Barnard model.

Barnard Parent/Caregiver–Child Interaction Model

In the early 1970s Dr. Kathryn Barnard was contracted by the U.S. Public Health Service to study ways of measuring the health and caregiving environments of infants and young children (Barnard, 1994). Before Barnard's work, research findings of the time indicated that the primary focus of caregiving in the early months of an infant's life was to establish routines and positive patterns of interaction to support the infant's optimal growth and development (Brazelton, 1973; Sameroff & Chandler, 1975). Barnard's research with mothers and infants indicated that all dimensions of child development (physical, emotional, intellectual, and social development) interact with each other in complex ways. Deficit in one of the domains affects the others.

Another insight Barnard and her research team gained from this work was that infants and young children undergo behavioral changes and internal reorganization in response to their caregiving and environmental stimuli. This suggests that one cannot understand early child development without taking into consideration interactions between the child, caregiver, and environment (Barnard, 1994). As a result of Barnard's early work, she developed the Parent/Caregiver–Child Interaction Model to depict strengths and weaknesses in interactions between infants and parents/caregivers and to direct behavior-specific interventions to foster children's social–emotional and cognitive growth and development (Barnard, 1976).

The Parent/Caregiver–Child Interaction Model uses the language of systems and developmental theories in the introduction of ideas. She calls the elements of her model “an interactive system” (Barnard, 1994, p. 6). In contrast to reductionist theories, system theory focuses on understanding how the parts of the system are arranged, what they do, how they are related, how as a whole they interact with the environment, and how they evolve and acquire new properties (von Bertalanffy, 1968).

An influence of developmental theory is also evident in Barnard's model. According to developmental theory, learning occurs when individuals interact with their environment. The learner actively constructs understanding from processing his or her behavior and making meaning of every new experience (Rowe, 1966). Barnard asserts that it is within the interactive system with the environment that the child's emotional, intellectual, and physical needs are met or not met (Barnard, 1994, p. 6).

The model expands on existing knowledge by focusing on the parent/caregiver–child environment interactive process, reflecting the fact that infants and young children influence the parent and the environment while simultaneously depending on parents to mediate their life experiences and create learning opportunities. The central focus of Barnard's model is to assess the child's health in the context of interpersonal interaction and adaptation that occurs between the child and caregiver in any given environment.

Major Concepts and Definitions

The integral component of the Barnard Parent/Caregiver–Child Interaction Model is the interactive system consisting of the parent/caregiver, the child, and the environment (Barnard, 1994). The concepts in Barnard's model are directly observable and include the infant's behaviors, the parent/caregiver's behaviors, and the parent/caregiver's and child's environment.

Parent/Caregiver Behavior

The parent/caregiver refers to the child's mother, father, or a primary caregiver and his or her characteristics, including psychosocial skills, concern about the child, physical and mental health, expectations of the child, parenting style, and ability to adapt to new situations (Barnard, 1994).

- *Sensitivity to cues* refers to the caregiver's ability to accurately interpret and respond sensitively to the infant needs and wants.
- *Alleviation of distress* refers to the effectiveness of the parent/caregiver to respond to the infant distress, which depends on the ability to recognize that the distress has occurred and have the repertoire of soothing actions to calm the child.
- *Social-emotional growth fostering* activities refer to the ability to initiate age-appropriate affectionate play and to provide appropriate verbal and nonverbal reinforcement for desirable child behavior.

Infant or Child Behavior

- *Clarity of cues* refers to the infant's ability to communicate his or her needs and wants through changes in facial expressions, alertness, fussiness, and body posture, to name a few. Cues that are inconsistent can cause difficulties in the parent/caregiver's adaptation process (Barnard, 1994).
- The *responsiveness* to the parent/caregiver refers to the child's ability to reciprocate the caregiver's efforts, such as smiling, rocking, or soothing activities.

The lack of the child responsiveness to the caregiver's efforts is assumed to make the parental adaptation to the child difficult or even impossible (Barnard, 1994).

Environment

The *environment* refers to the environment of both the parent/caregiver and the child. The characteristics of the environment include animate (people) and inanimate (physical environment of the family including objects, sounds, and visual and tactile stimulation) elements (Barnard, 1994).

Schematic Representation

Barnard (1976) depicted the parent/caregiver-child interactive system as a diagram with the arrows moving in circular motion from the child to the parent/caregiver and from the parent/caregiver to the child. Barnard defined the break drawn in each arrow as interference in the adaptive process, which can be caused by the caregiver, the infant, or the environment. The model has been discussed widely in the nursing literature (Margolis et al., 2001; Marriner Tomey, 2006; Sumner & Spietz, 1994). The Barnard Parent/Caregiver-Child Interaction Model is based on 10 theoretical propositions:

1. In the child health assessment the goal is to identify problems at a point before they develop and when intervention would be most effective.
2. Social-environmental factors are important for determining child health outcomes.

3. The caregiver–infant interaction provides information that reflects the nature of the child’s ongoing environment.
4. Each parent brings to caregiving a basic personality and skill level that is the foundation on which caregiving skill is built. The enactment of caregiving depends on these characteristics as well as characteristics of the child and environment.
5. Through interaction, caregivers and children modify each other’s behavior. That is, the caregiver’s behavior influences the child and in turn the child influences the caregiver so that both are changed.
6. The adaptation process of the parent/caregiver and child is more modifiable than the child’s’ and the parent/caregiver’s characteristics; therefore intervention should be aimed at supporting the parent’s sensitivity and responsiveness to the infant’s needs.
7. An important way to promote learning is to respond to child-initiated behaviors and to reinforce the child’s attempts to try new things.
8. A major task for the helping professions is to promote a positive early learning environment that includes a nurturing relationship.
9. Assessing the child’s social environment, including the quality of caregiver–child interaction, is important in any comprehensive child health assessment model.
10. Assessing the child’s physical environment is equally important in any child health assessment model (Barnard, 1994).

Evaluation of the Barnard Model

According to Meleis (1997), evaluation is the cornerstone of further theory development, education, research, practice, administration, and daily decision-making process. Criteria used to evaluate Barnard’s model include clarity, consistency, simplicity/complexity, usefulness, and generalizability. Meleis states that, “precision of boundaries, a communication of a sense of orderliness, vividness, and consistency through theory” (1997, p. 262) are indicators of a theoretical model’s clarity. Although Barnard (1976) did not clearly define theoretical concepts in her model, she described them and thus implied the definitions. The concepts in the Barnard model are interconnected and form an interactive system. Because of the ongoing interaction, they influence each other and acquire new properties. The model articulates only some concepts consistent with the domain of nursing as proposed by Meleis (1997). For example, Barnard clearly addresses the concepts of environment (the physical and social environment of the child), client (parent/caregiver and the child), and the interaction (between the parent–child dyad and environment). Health is treated indirectly (interactive system provides the basis for assessing optimal child growth and development). Client transitions, nursing therapeutics, and health are not articulated and require further development.

Simplicity refers to a theory with a minimal number of concepts. On the other hand, complexity refers to the explanations and relationships among variables (Chinn & Kramer, 1991; Meleis, 1997). The appropriateness of the level of complexity within a theory depends on the nature of the concepts and relationships they are set to explain or predict (Meleis, 1997). The Barnard model at first glance is a relatively simple and elegant framework that relates to the parent–child interaction and its important elements. However, the many propositions made by Barnard about the nature of relationships between parent/caregiver, child, and environment imply high-level abstraction and complexity. According to Meleis (1997), consistency of a theoretical model depends on the level of congruency and the fit between different components of theory, for example, the fit between assumptions and concept definitions, the fit between concept definitions and their use in propositions, and the fit between concepts and exemplars (Meleis, 1997).

The theoretical basis of the Barnard model is assessed using NCAST Feeding and Teaching Scales (Barnard, 1994). The scales were developed to examine parent–infant interaction. Barnard’s team and others tested the scales for reliability. The scales were established as reliable by studies of internal consistency and test–retest procedures (Barnard, 1994). The validity of the scales to evaluate quality of parent/caregiver–child interaction has also been assessed (Barnard, 1994). Researchers, nurses, and other clinicians interested in using the scales to assess parent–child interaction are required to receive certification by NCAST programs at the University of Washington and to achieve reliability of at least 85% in using these scales.

Research Applications with Preterm Infants

Considerable amount of research has been conducted over the past 20 years to assess and test parent/caregiver–child interactions. Using prospective longitudinal designs, researchers have consistently demonstrated important links between the quality of parent/caregiver–child interaction, environmental influences, and child development outcomes (Barnard & Kelly, 1990; Diehl, 1997; Farel, Freeman, Keenan, & Huber, 1991; Lewis & Coates, 1980; Leitch, 1999; Nakamura, Stewart, & Tatarka, 2000). Few published studies tested early NICU interventions designed to prevent the development of negative parent–infant interaction trajectories or to reduce hospital length of stay. In one of the earliest intervention studies, Parker, Zahr, Cole, and Brecht (1992) tested the efficacy of maternal education, training, and support in premature infants’ behavioral and developmental functioning. Random assignment was made to intervention ($n = 26$) and control ($n = 15$) groups. Follow-up assessment took place at 4 and 8 months to determine the quality of infant stimulation in the home environment. There were no statistically significant differences either in maternal affective behavior or in infant social behavior between the groups. However, mothers in the intervention group scored significantly higher on the quality of stimulation value of the child’s home environment using the Home Observation for Measurement of the Environment Inventory.

Likewise, Harrison, Sherrod, Dunn, and Olivet (1991) reported encouraging findings from a pilot intervention study to measure effectiveness of teaching parents about preterm infants' cues. The participants were assigned to two intervention groups and one control group. Mothers in the first intervention group ($n = 10$) received demonstration and verbal and written instruction that focused on understanding preterm infants cues. The second intervention group ($n = 10$) received brief instruction about the mothers' assessment of infant behavior and was asked to rate their infants' behavior. The control group ($n = 10$) received routine NICU care and support. A feeding episode was scored approximately 6 weeks after discharge using the Barnard Feeding Scale (Barnard, 1976). The total highest parent score was reported for the mothers who received the most intense preparation.

In a subsequent study, Lawhon (1994) provided individualized interventions focused on enhancing parental and newborn competence in interaction to parents and their infants born before 32 weeks of gestation. At approximately 1 month after discharge, a trained observer rated feeding interaction using the Barnard (1976) NCAST Feeding Scale. The scores in the intervention group were comparable with scores previously reported for full-term infants, suggesting that the intervention designed for the study was quite effective.

Most recent investigations focused on two areas: (1) testing early NICU interventions with parents to prevent the development of negative parent–infant interaction trajectories to reduce hospital length of stay and (2) reducing parenting stress after preterm birth. Using a randomized controlled design, a Norwegian team (Kaaresen, Rønning, Ulvund, & Dahl, 2006) tested the effects of an early intervention program on parenting stress after a preterm birth until 1 year corrected age with a sample of 140 infants and their parents. The intervention consisted of eight sessions shortly before discharge and four home visits by specially trained nurses focusing on the infant's unique characteristics, temperament, and developmental potential and the interaction between the infant and the parents. Seventy-one infants were included in the preterm intervention group, and 69 were included in the preterm control group. Fathers and mothers in the intervention group reported consistently lower scores within the distractibility and hyperactivity behavior and higher scores on parenting competence and attachment subscales compared with the preterm control group. There were no differences in mean summary stress scores between the mothers and fathers in the two groups at 12 months, suggesting that parenting programs may reduce parents' stress among both mothers and fathers of preterm infants to a level comparable with their term peers.

Melnik et al. (2006) investigated the efficacy of an educational–behavioral intervention program called Creating Opportunities for Parent Empowerment (COPE) designed to enhance parent–infant interactions and parent mental health outcomes for the ultimate purpose of improving child developmental and behavior outcomes. A sample of 260 families participated in the intervention from 2001 to 2004 in two NICUs in the northeast United States. Parents completed self-administered instruments during hospitalization, within 7 days after infant discharge, and at 2 months' corrected age. Blinded observers rated parent–infant interactions in the NICU. All participants received four intervention

sessions of audio-taped and written materials. Parents in the COPE program received information and behavioral activities about the appearance and behavioral characteristics of preterm infants and how best to parent them. The comparison intervention contained information regarding hospital services and policies. Mothers in the COPE program reported significantly less stress in the NICU and less depression and anxiety at 2 months' corrected infant age than did comparison mothers. Blinded observers rated mothers and fathers in the COPE program as more positive in interactions with their infants. Mothers and fathers also reported stronger beliefs about their parental role and what behaviors and characteristics to expect of their infants during hospitalization. Infants in the COPE program had a 3.8-day shorter NICU length of stay (mean, 31.86 vs. 35.63 days) and 3.9-day shorter total hospital length of stay (mean, 35.29 vs. 39.19 days) than did comparison infants, suggesting that a reproducible educational-behavioral intervention program for parents that begins soon after infant's admission to NICU can improve parent mental health outcomes, enhance parent-infant interaction, and reduce hospital length of stay.

Collectively, lessons learned from the intervention studies with preterm infants and their parents indicate that relatively simple interventions can be a powerful way of improving the quality of parent-child interaction and parent and child outcomes. Findings also suggest that the parent-child interaction can be modified to meet the preterm infants' capacity to interact, and this therapeutic aim can be an integral part of everyday clinical practice in the NICU. In addition, it appears that the most effective interventions involved multiple parent teaching modalities and time points.

Barnard Model: Practice Application to Preterm Infants

The usefulness of Barnard's model has been demonstrated in research, education, and clinical practice. Barnard's (1976) original research led to the development of the NCAST Feeding and Teaching Scales, which have been standardized for use with several ethnic groups and different infant age groups. These outcome measures are now used as a standardized assessment tool of parent-infant feeding and teaching interactions in more than 10 countries by over 10,000 researchers and health professionals and are reliable at 85% or higher in using the scales. Barnard's model has an international appeal to educators and appears in maternity nursing courses at the baccalaureate, master's, and doctoral levels. It has also been used as a framework for nursing practice with childbearing families (Early Head Start Programs in Washington State and Public Health Services across the United States).

One specific case of applying Barnard's model in clinical practice is facilitating the parent-infant interaction that occurs during feeding. For example, during the past decade nurses at the IWK Health Center in Halifax, Nova Scotia, have effectively used Barnard's principles to facilitate individualized guidance for parents learning to interact with both their term and preterm newborns. In the NICU, caregivers routinely discuss the strengths and gaps in feeding interaction using the model as a framework for feedback after feeding.

Specific NCAST Feeding Scale items are used in an effort to explain and help mothers to recognize infant cues that would signal them to respond in ways that promote more effective feeding. Staff members encourage mothers to pay attention to how they sustain eye contact, their facial expressions, gentle talking and stroking, and recognizing satiation cues, such as slow-down in feeding. They are encouraged to maintain a relaxed posture and to note disengagement cues such as crying, back arching, or falling asleep as a signal to terminate the feeding. Recognizing that the preterm infant's cues are not as clear as in term infants, the teaching strategies may require focusing on one cluster of cues at a time and setting small measurable goals to promote positive parent–child relationship and positive feeding interactions in the future.

Conclusion

Barnard's Parent/Caregiver–Child Interaction Model has been used in education, research, and clinical practice for over two decades. The results of the research review and evaluation of the model suggest that it effectively describes child development within the context of the infant's interaction with the caregiver and environment.

The process of model development is consistent with the inductive form of logic in that the theorist formulates concepts and relationships based on existing theory, research, and clinical observations. Barnard provides evidence of the applicability of her model in health education, research, and clinical practice. The model has been used internationally as a theoretical framework for maternity nursing practice. The NCAST Feeding and Teaching Scales to assess parent/caregiver–child interactions in clinical practice and research have a high level of precision and reliability. The information presented in this chapter suggests that the model offers a useful framework for designing and testing clinical interventions with preterm infants and their parents. Intervention research findings suggest that timing of the clinical interventions should occur early in the parent–child relationship and be sustained over time for maximal effects.

However, Barnard's model is limited to early child development within the context of relationships with caregiver and environment. The model is applicable to all disciplines that are concerned with parent–child relationships. There has been little recent effort to test the model. In its current state the model does not fulfill criteria for theory set forth by Meleis (1997). Therefore the model should be refined and further developed. However, the model does offer an excellent framework for use in clinical practice and research with preterm infants and their parents.

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Unit 2 Chapter 11

The Utility of Leininger's Culture Care Theory with Vulnerable Populations

Rick Zoucha

In the ever-evolving healthcare environment in the United States a multitude of people have access to services that promote health and well-being and reduce the effects of illness. Similarly, there are people who are not afforded the same access to healthcare services as others based on the distinction of vulnerability. According to Campos-Outcalt et al. (1994), vulnerable populations can be defined as groups of people who experience physical disabilities, mental disabilities, cultural differences, geographical separation, limited economic resources, and, due to barriers, might be unable to integrate into the mainstream health services and delivery system. The authors include as vulnerable the urban and rural poor (especially ethnic and racial minorities), Native Americans, chronically disabled children and adults, frail elderly, people who are homeless, and undocumented immigrants. Shi and Stevens (2005) define vulnerable populations as racial and ethnic minorities, uninsured, children, elderly, poor, chronically ill, people with AIDS, alcohol or substance abusers, people who are homeless, underserved rural and urban groups, people who do not speak English or have difficulties in communicating in healthcare settings, those who are poorly educated or illiterate, those with low incomes, and members of minority groups. In addition, victims of violence are at risk of being vulnerable (Zoucha, 2006).

Leininger (1996a) contends that regardless of economic, political, and even genetic differences, everyone has a culture. This chapter discusses Leininger's Culture Care Theory and the utility of the theory in working with vulnerable populations related to cultural differences in the research and practice settings.

Leininger's Theory of Culture Care Diversity and Universality

Leininger and McFarland (2006) define cultural care as the "subjectively and objectively learned and transmitted values, beliefs, and patterned lifeways that assist, support, facilitate, or enable another individual or group to maintain health and well-being, to improve their human condition and lifeways, or to deal with illnesses, handicaps, or death." Leininger (1996b) describes culture as learned values, beliefs, rules of behavior,

and life-style practices of a particular group of people. Andrews and Boyle (2003) found culture to contain four basic characteristics: it is learned, shared, dynamic, and able to adapt to specific conditions. Culture involves all types of behavior that are socially acquired and transmitted by means such as customs, techniques, beliefs, institutions, and material objects (Locke, 1998). According to Leininger (1991b) and Andrews and Boyle (1999), humans exist within culture and culture is viewed as a universal phenomena. Leininger has taken the concept of culture and an ethical orientation of caring and developed a theory appropriate for nursing practice, research, and education (Zoucha & Husted, 2000). She also contends that individuals, families, and communities must be viewed in the context of culture (Zoucha & Husted, 2002)

Leininger and McFarland's (2006) theory of culture care diversity and universality is the product of over 50 years of research and development in which they studied over 60 cultures and identified 172 care constructs for use by nursing and other healthcare professionals. The Sunrise Model (Leininger & McFarland, 2002) depicts Leininger's theory and presents seven cultural and social structure dimensions of technological, religious and philosophical, kinship and social, political and legal, economic, and educational factors as well as cultural values beliefs and lifeways. The theory describes the diverse healthcare systems ranging from folk beliefs and practices to nursing and other health care professional systems often used by people around the world. Leininger and McFarland (2006) describe two systems of caring that exist in every culture they studied. The first system of caring is generic and is considered the oldest form of caring or nurturing. Generic caring consists of culturally derived interpersonal practices and is considered essential for health, growth, and survival of humans (Reynolds & Leininger, 1993). Generic caring is often referred to as folk practices and is defined culturally (Leininger, 1996b).

According to Leininger and McFarland (2006), the second type of caring is considered therapeutic, cognitively learned, practiced, and transmitted through formal and informal professional education such as schools of nursing, medicine, and dentistry. Professional learning can and does include concepts and techniques to enhance professional practices as well as interpersonal communication techniques and holistic aspects of care. Historically, professional care has not always included ideas about folk care because that may not have been valued by nurses and other healthcare professionals (Leininger & McFarland, 2002).

In their theory, Leininger and McFarland (2006) contend that if professional and generic care practices do not fit together, this might affect client/patient recovery, health, and well-being and result in care that is not culturally congruent with the beliefs of the person, family, or community. To provide culturally congruent care, Leininger and McFarland (2002) assert that professionals must link and synthesize generic and professional care knowledge to benefit the client. This link is a bridge, where a bridge is appropriate, between the professional and folk healthcare systems (Leininger & McFarland, 2002).

Leininger and McFarland (2006) contend that three predictive modes of care are derived and based on the use of generic (emic) care knowledge and professional (etic) care

knowledge obtained from research and experience using the sunrise model. The three modes of action are cultural care preservation/maintenance, cultural care accommodation/negotiation, and, cultural care repatterning/restructuring.

Cultural care preservation/maintenance (Leininger & McFarland, 2006) refers to assistive, supportive, facilitative, or enabling professional actions and decisions that help individuals, families, and communities from a particular culture retain and preserve care values so that they can maintain well-being, recover from illness, or face possible handicap or death. Leininger and McFarland (2002) describe cultural care accommodation/negotiation as assistive, facilitative, or enabling creative professional actions and potential decisions that can help individuals, families, and communities of a particular culture to adapt to or to negotiate with others for satisfying healthcare outcomes with professional caregivers. Cultural care repatterning/restructuring is described as the assistive, supportive, facilitative, and enabling by nurses and other healthcare professionals to promote actions and decisions that may help the person, family, and or community change or modify behaviors affecting their lifeways for a new and different health pattern. This repatterning/restructuring (Leininger, 2002b) is done while respecting the individual, family, and community cultural values and beliefs while still providing and promoting a healthier life-style than before the changes were coestablished with the person, family, and community. Leininger (2002a) asserts in her theory that the predicted three modes of action serve to guide judgments, decisions, and actions culminating in the promotion of culturally congruent care.

Leininger (2002) describes culturally congruent care as beneficial, satisfying, and meaningful to the individuals, families, and communities served by nurses. Cultural imposition occurs when nurses and other healthcare professionals impose their beliefs, practices, and values on another culture because they believe their ideas are superior to those of the other person or group (Leininger, 2002a). Leininger uses the concepts of cultural congruence and cultural imposition to focus on acceptable (caring) and unacceptable (noncaring) behavior by nurses in the practice, education, and research arena.

Utility of the Theory in Nursing Research and Practice

In addition to the development of the theory of cultural care, Leininger (1991a) developed a research method that is very useful in understanding the phenomena of culture care for vulnerable populations. As described earlier, vulnerability includes culture differences. Leininger's qualitative "ethnonursing" research method was created to work in conjunction with the theory (Sunrise Model) as a guide for research. The ethnonursing research method involves description and analysis of the lifeways of a people from the emic point of view (the viewpoint of the person being studied) with the ultimate goal of generating nursing knowledge to help those people (Leininger, 2002). Leininger (2002) suggests the method be used in conjunction with research enablers such as Leininger's observation-participation-reflection enabler, Leininger's stranger to trusted friend

enabler, Sunrise Model enabler, specific domain of inquiry enabler, and Leininger's acculturation enabler.

The enabler guides can also be used in the clinical setting in an attempt to move from stranger to trusted friend between the nurse and client. The notion of being viewed as a friend can promote culturally congruent care in many cultures (Zoucha & Reeves, 1999). This friend-like or personal relationship between the nurse and client/patient can decrease the cultural difference vulnerability of the person because the cultural care needs of the client are known to the nurse. The nurse is then able to promote care that is congruent with the person's culture and essentially promote the health and well-being needs of the person, family, and community.

The connection between the theory, research, and practice is addressed by using the identified enablers to promote a deeper understanding of the cultural phenomena of interest regardless of the context (research or clinical practice). This allows for a holistic and comprehensive view of the domain of inquiry and the particular culture being studied. As transcultural nurse researchers and clinicians seek to understand the phenomena of interest for vulnerable populations, it is possible to decrease one aspect of vulnerability described as cultural differences. If indeed transcultural nurses use the findings of studies in actual clinical practice, then an understanding of the person, family, and community can be viewed from a cultural care perspective, therefore increasing the understanding of not only the cultural care needs but exposing the vulnerability related to being culturally different.

The concern of personal, family, and community vulnerability regarding cultural difference is that if nurses pursue an understanding of culture in relation to health and well-being, then there is an ethical motivation to promote care that is culturally congruent. This motivation can possibly decrease the vulnerability for the individual, family, and community. Zoucha and Husted (2000) contend that cultural caring should consider the person, family, and community in the context of their culture and result in the promotion of ethical and culturally congruent care. In agreement with Leininger's theory, Zoucha and Husted (2000) believe that it is the ethical responsibility and duty of the nurse to promote, provide, and encourage care that is culturally based and congruent with the values, beliefs, and traditions of the individual, family, and community.

Leininger's theory does provide a holistic and emic view of factors that describe culture and those cultural values and beliefs that are meaningful to individuals, families, and communities. However, in critiquing Leininger's theory it does not explicitly state in the context of the Sunrise Model or theory the related factors of racism, poverty, and history of oppression that are common for people other than the dominant culture in the United States. Leininger does consider these issues in her writing and presentations but does not make it clear in the explication of the theory and Sunrise Model in relationship to research and clinical practice. Adding the factors of racism, poverty, and history of oppression to the Sunrise Model as part of the experience for people of different cultures (from the dominant culture) may assist nurses and other healthcare professionals in understanding the meaning of vul-

nerability. Through the use of the theory nurses and other healthcare professionals can promote health and well-being while decreasing the experience of being vulnerable.

Conclusion

Individuals, families, and communities identified as vulnerable due to cultural differences can be understood in a manner that seeks to expose the vulnerability and focus on the cultural care needs. Leininger's Theory of Culture Care Diversity and Universality promotes a deep and clear understanding of the individual, family, and community from a unique cultural perspective. Using the theory and the identified enablers for research and clinical practice allow for the nurse to view the individual, family, and community from the perspective of the seven cultural factors identified in the Sunrise Model as religion, kinship, technology, education, economic, political and legal, and cultural lifeways. In using this view, nurses and other healthcare professionals can decrease the vulnerability of the individual, family, and community by uncovering the concern of cultural difference and promoting ethical practice that is congruent with the cultural beliefs of those in the caring relationship with nurses and other healthcare professionals.

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Unit 2 Chapter 12

Positive Skills, Positive Strategies: Solution-Focused Nursing

Margaret McAllister

In my 25 years of experience in nursing and in teaching nurses for 16 years, I am frequently made aware of a need, a frustration, and a sense of powerlessness in nurses, especially when working with clients who have multilayered and enduring problems. In working with this population it is hard to know how one can be recovery oriented, empowering, and retain optimism for change. This chapter outlines a practical philosophy for being strategic, forward looking, and positive with clients. Called solution-focused nursing, it derives from critical social theory and positive psychology ideas.

The chapter begins with a client's experience with emergency health care. The narrative is analyzed, drawing from it key lessons, before moving on to a philosophical framework for nursing that helps clinicians be solution focused and strategic rather than reactive and overwhelmed.

Zara's Experience

The following narrative relates the experience of a client, Zara, who went to the emergency department for treatment:

A while ago I had an experience that I don't ever want to repeat. I had developed a headache that just wouldn't go away. The pain had become so bad that I was throwing up and beginning to have panic attacks. I'd had headaches before, but never this bad. I'd also had long-standing anxiety, treated with medications, that developed as a consequence of childhood abuse issues that I considered pretty much resolved after quite a few years of therapy.

After about 6 hours of trying to relieve the headache with paracetamol, cold compresses, and resting, the pain was just not easing. When I began vomiting, I knew I needed help. I called an ambulance and was taken to the public emergency department.

I was placed on a gurney and wheeled into a room away from the nurse's station. No one told me what was happening, whether I'd be okay, or even if they'd be watching me. Some time later a nurse came to take my temperature and blood pressure. He also asked me to rate the severity of my pain.

Then a doctor came in. She seemed kind and sympathetic at first—holding my hand, gently asking me questions, and reassuring me that the pain would subside with IV medications. She said she wanted me to stay overnight, but I told her that I felt panicky in hospitals and if the pain subsided, I'd be better off at home.

The nurse asked me why I felt panicky and I told them both that I had a lot of experience with hospitals—the last being a year ago when I was in the psychiatric unit. The doctor asked me about the reason for this stay, and I told her that it was to prevent any risks of problems that might arise after gynecological surgery. My psychiatrist had been concerned that the surgery could be triggering, because I had a history with dissociation disorder.

Revealing this information seemed to cause a sudden change in the doctor's attitude. She stopped asking me questions and just pushed up my shirt to examine my body. She saw some old scars and asked me how they were caused. Again, I was honest and told her I used to self-harm. That's when she pulled away immediately. It seemed like she was disgusted and I felt terribly ashamed.

Without a word of explanation the doctor left the room. At this point I had not been given anything for my headache and was still feeling panicky and nauseous. I looked toward the nurse. In that moment I really needed him.

Reflective Activity

Imagine you were that nurse with a client, like Zara, in pain and distress. Your colleague has acted in a way that led the person to feel ashamed. Now you must provide physical and psychological safety and minimize risks of mounting anxiety and panic.

And what of the longer term? Two issues of concern come to mind: The client's future well-being and health service utilization and promoting more effective clinician–client interactions.

Analysis of the Narrative

In generating a satisfactory complete response to these questions and in suggesting an effective care pathway for this nurse, it is helpful to reflect on what some of the significant elements within this story might mean for practice. First, the experience of ill-health can be fundamentally disempowering. Second, people who come to health services are vulnerable and need nursing support. And finally, nursing work not only frequently involves change-oriented work with clients but also with the healthcare culture.

The experience of illness is not comfortable or pleasant at the best of times, but when a client presents to a health service expecting timely quality care and they are not helped

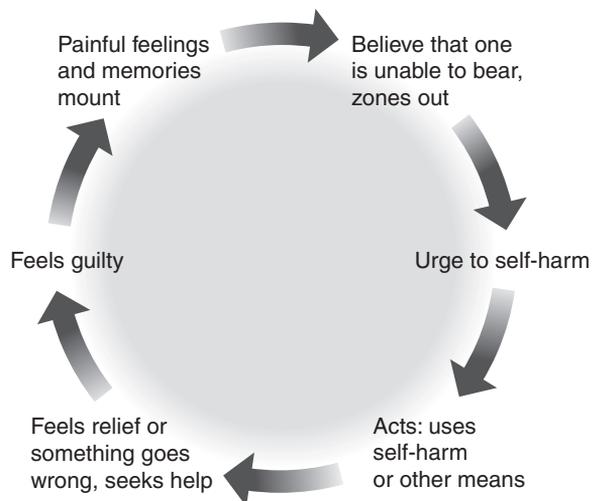
to feel safe and secure, and indeed are made to feel worse, the experience can be traumatizing (Arnold, 1994; Hartman, 1995).

Too often, clients complain of substandard care in Australian health services (SANE Australia, 2004). A significant number of clients, especially young people, who present for emergency care do not stay for treatment (Ryan, Parle, & Babidge, 1998). Additionally, when they have preexisting mental health problems, they commonly feel labeled, judged, objectified, and ashamed (Johnstone, 1997). This is a fundamentally disempowering experience that can have long-term negative health and social consequences. Many clients do not have adequate psychosocial assessments completed and are lost to follow-up (Bennowith et al., 2002). Clients may be unwilling to use the health service again, they may later act out their negative feelings on to others with hostility or violence, or they may act inwardly and allow shame and guilty feelings to spill into a vicious cycle, such as the cycle of self-harm (Figure 12-1).

Similarly, nurses required to work in such an environment frequently find that they themselves are oppressed and become disempowered (Jackson, Clare, & Mannix, 2002). Without adequate strategies to effectively intervene in situations such as these, nurses become disillusioned, disaffected, and demoralized.

In a study examining everyday conversations of nurses working with clients who self-injure (Estefan, McAllister, & Rowe, 2004), it was found that only the outward acts of injury tended to be the focus of care by nurses, so that most did not focus on events that might trigger the urge to self-harm. They did not discuss the need to empathize with the

Figure 12-1 The Cycle of Self-Harm



individual's specific and present concerns, and they did not reveal a concern for helping the clients address issues of self-injury or work with them to find safer ways to express distress and communicate their needs. The study also revealed that nurses frequently felt unprepared, lacked clear frameworks for practice, and were vulnerable to subtle tensions in practice that led to managing before caring, valuing diagnosis before understanding, and focusing on behaviors rather than personal meanings and the client. The effects for patients and for care are that alienating, unhelpful, diagnostic, and socially loaded labels are attributed to people. In the story above the fact that the client had been a past psychiatric patient led to substandard health care and a negative experience. The patient was passive and alienated. The caregiving experience was also burdensome for the doctor.

As many have argued, a model of care that is problem-centered is unlikely to offer inspiring or sustainable positive outcomes for clinicians or patients (Hall, 1996; White & Epston, 1990). This is true for virtually all healthcare contexts (Hedtke & Winslade, 2004; Wade, 1997). Yet this problem orientation remains dominant (McAllister, 2003).

A problem orientation may be useful in helping to isolate problems, target areas of change, and apply interventions dispassionately and rationally, but these actions are not always appropriate. Constantly searching for problems may prevent appreciating things that are going right for a person. It may also be that some problems may never be resolved completely, and a focus on the negative is inherently pessimistic. Problems and difficulties become the main concern rather than feats and achievements. Problems are seen as something to be overcome rather than to be tolerated and perhaps integrated.

Positive and protective client outcomes are unlikely to be developed and achieved. These include feelings of distress manageability, social supports, health-seeking behavior, optimism, and self-belief in managing feelings (Resnick et al., 1997). For nurses, there is the risk of anxiety and frustration from lack of strategies and skills, a sense of low professional self-efficacy, and feeling vicariously traumatized through dealing with these clients (Hartman, 1995; McAllister, 2003).

Yet clinicians who respond with empathy, a nonjudgmental stance, and supportive counseling skills have a positive effect on outcomes for clients (Webber, 2002). Clients are more likely to stay for treatment, to use the health service again rather than attempt to inadequately self-manage, and to accept organized follow-up care under such circumstances (Shaw, 2002). This suggests that there is much nurses can do to instill hope and to facilitate effective meaningful experiences, and, importantly, to provide supportive connections for these clients.

It is not sufficient to prepare nurses to be proficient in technical procedures in a situation such as this. What they need is a collaborative way of working with both clients and colleagues, one that is actively peace-building, so that the negative emotions generated in an encounter such as this are prevented and/or contained. It is crucial that nurses be part of the solution, as this adaptation of Bell Hooks's words (1994) reflects: "When those who know, oppress, and dominate others and continue to discriminate and attempt to disempower, then they become part of the problem."

Toward a Power-Building Practice

I believe at some level nurses who are complicit in allowing a disempowering environment to persist are unhappy and unfulfilled and that this accounts for why so many become disenchanted with their work and leave the profession. That is why it is crucial that we as nurses find a way to circumvent this situation, by inventing a way of working that gives nurses responsibility for engendering a supportive environment. In this framework of care, it is not just technical skills that are important, but the psychosocial health and well-being of all players must be paramount.

Solution-focused nursing is a philosophy of care that I developed after years of being confronted with the reality that nurses do tend to take a reactive approach with patients. There is a tendency to be concerned with problems and problem resolution rather than an approach that is preventative, strategic, and proactive. This perhaps is why the nurse in the story was very efficient in responding to the client's pain at least in the beginning. He assessed the person's physiological status and gathered some baseline data on the severity and nature of the discomfort, but he wasn't very adept at engendering a comfortable comforting environment for the person. His clinical colleague behaved in a tactless and damaging way, yet the nurse did not feel in a position to act, either in reaction or preemptively.

This is not surprising because in most health service cultures the dominant philosophy is one that favors a problem orientation and a medical model. In this world view, it is the person's presenting problems or illnesses that take priority, and the concern is to stabilize the body, be it the physical or psychological parts of that body. Further, in this model the nurse's role is primarily that of assistant to medical practitioners and to ameliorate suffering and promote restoration of health and well-being.

Consider this quotation (Harrison, 1994, p. 4) about why it is that clinicians negatively label and ostracize clients such as these: "When time and resources are limited and no one really knows how best to help, it's easier to make judgments and use labels than to spend time looking for possible causes of distress."

Yet health services will always have limited resources, and clients who present for emergency care will always have more concerns than just their physical ailment. As human service workers it is a health professional's responsibility to know how to act in compassionate yet effective ways.

Toward Empowerment

So let's take a different approach, one drawn from critical social theory and the positive psychology movement to see what other possibilities emerge for nursing practice. Critical social theory alerts us to the reality that people in society who are in submissive or marginalized positions, in this situation patients, are likely to have power removed from them, to not be free to speak their mind, and to experience further effects of being oppressed and alienated. These typically include self-directed hostility and violence, anger, and avoidance toward the disempowering other (Freire, 1972; Roberts, 1994).

Critical social theory suggests that power needs to be shifted so that it is shared between the people in positions of authority and those who are subordinate. Given that in health services there is a desire to encourage clients to take a more active role in their own health care and to be more responsible service users, such an approach makes perfect sense. Clinicians who share power with clients and who are explanatory, consultative, and collaborative are working closer to achieving their service goals. This does, by its nature, offer a proactive role for clinicians such as nurses (Hopton, 1997).

Positive psychology says that people are more likely to become healthy when their strengths and capacities are being tapped, because when there is over-focus on the person's vulnerabilities and deficiencies, then the client and the caregiver can begin to lose hope, become helpless, and give up (Peterson, Maier, & Seligman, 1995; Seligman, 1995). In such cases chronicity, depression, and a self-fulfilling prophecy of doom and gloom can set in.

Models of care are subtle and can become deeply embedded in clinicians' daily working life so that they can be reproduced unconsciously, without thought. But when they are critically reflected on, they can be challenged and replaced. I believe that nurses do feel uncomfortable with the degree of influence the medical model has over their professional practice. Yet because the medical model is the most familiar world view in health services, it is also the one that people tend to resort to when they lack an alternative. But critical social theory would also urge that the alternative world view needs to be brought in from the margins and consciously used so that it does begin to compete with that which has been taken for granted.

One effective way that we can challenge ourselves to not unconsciously reproduce the medical model in our day-to-day interactions with clients is to exercise our abstract creative brain and rethink practice. This process has been coined "conscientization" (Freire, 1972; Martin & Younger, 2000). Harden (1996) argues that such a process is crucial for all groups seeking emancipation. She states that only when oppression in nursing has been recognized and a critical consciousness achieved can true humanistic care be given. Try this consciousness-raising activity as an example:

Go to a collection of paintings by Frida Kahlo (Herrera, 1991) and find the picture entitled, "The little deer." Complete a surface level reading of this picture by writing down all of the elements you see within the frame.

Now try to look more deeply and make an attempt to answer these questions: Imagine this "person" is the client in the story just recounted. How might she be feeling? What factors are contributing to this feeling state?

Where is the light coming from in this painting? What might this signify? If the role of the nurse is to take the person from a position of darkness and fear to a position of light and comfort, what could a nurse do if she or he was painted into this frame?

Frida Kahlo, the Mexican artist, provides many vivid evocative expressions, many of them autobiographical, of the experience of pain and vulnerability. But also in this and other

paintings of hers one gets a sense of strength, endurance, and resilience. Through all this pain and loneliness, there's a power to her spirit. Recently at a conference on nursing practice development, I showed this image to try to promote thought on reframing care by thinking about the lived experience of being a patient and being in pain. I asked participants to tell me what they saw in this image, what it meant to them.

The following insights, drawn from the audience, remain with me and perhaps they resonate for you: that people can be wounded, in pain, dehumanized, lost, vulnerable, and at risk, but that good nursing care and good health care comes when clinicians are able to be with clients and perhaps reorient them. Just by turning around and facing a new direction we can help to show people ways out of their dilemmas. To me good health care is about finding ways to turn crises into turning points.

To think about this image and the role of nursing whenever nurses find themselves in a difficult position with clients or colleagues I believe is illuminating. It suggests a way forward and that way emphasizes shared humanity and noticing people's inherent strengths that can be enduring even within hardships and challenges.

Solution-Focused Nursing

Many nursing scholars argue for a model of practice that is antioppressive but do not clearly show how that may be done (Harden, 1996; Hopton, 1997; Martin & Younger, 2000). Solution-focused nursing attempts to fill this gap by stating a simple philosophy and clarifying practices nurses can use in a range of different healthcare situations. Solution-focused nursing comprises six principles:

1. The person, not the problem, is at the center of inquiry.
2. Problems and strengths may be present at all times. Looking for and then developing inner strengths and resources will be affirming and will assist in coping and adaptation. By working with what's going right with a client, one can be enhancing their hope, optimism, and self-belief, thus maximizing their health capacity.
3. Resilience is as important as vulnerability.
4. The nurse's role moves beyond illness care toward adaptation and recovery.
5. The goal is to create change at three levels: in the client, nursing, and society.
6. The way of being with clients is proactive rather than reactive.

This model of care is very much focused on achieving empowerment for clients and emancipation for nursing. Where clients may have been overlooked, patronized, and marginalized in the healthcare relationship, nurses have similarly had their power constrained and their potential reduced. In addition to principles and phases of the working relationship, several concepts inherent to empowerment need close analysis and perhaps reframing: power, skill, awareness, and language (Table 12-1).

TABLE 12-1 Elements of Empowerment

Element	Characteristics
Power	Rather than avoid power, nurses can see power as having positive influence, as a resource to be shared, and as a tool to use “softly.”
Nursing skill	The skill of nursing is neither just about technical proficiency nor is it something that remains within the individual nurse’s sphere of ownership. Skill also refers to being with a patient supportively, knowing what not to say as well as how best to communicate. Skill is something to be shared with clients and with colleagues. It is in the sharing where sustainable development and advancements are made.
Awareness	Awareness is a state of being as well as a goal within the nurse–client relationship. Being aware means not being unconscious to the practices that keep groups disempowered. Achieving awareness as a goal refers to the sharing of knowledge, skills, and understanding.
Language	Language provides the codes through which we talk about and understand the world in which we live. Language transmits powerful messages. Unconscious use of language can lead to oppression and ongoing marginalization. Conscious usage can be the tool by which nurses move toward an alternative to dominating practices.

It is not uncommon for clinicians working in a deficit model to feel disempowered, out of their depth, and directionless. Bowles, Mackintosh, and Torn (2001) conducted a pretest–posttest study to evaluate the impact of solution-focused communication training. Before training they found that nurses commonly believed they were inadequate, illustrated in the comment, “I really didn’t feel like I was offering anything in terms of solutions.” Nurses also believed they had no direction with patients. One nurse, for example, said that there was, “Lots of waffling going on, I let people waffle. . . . I was a good listener, I can listen for weeks with no solution in sight.”

Yet after training nurses said they had new tools to work with. Participants said things like, “I know where I’m going now with something. I mean, the listening’s still there, but it’s different now. . . . I feel as if I’m listening more intently.” Also, the quality of interactions that nurses had with patients changed. One nurse said, “I think it’s empowered me. It’s released me from this awful feeling that as the nurse I have to put a plaster on and sort of send them away.” Significantly, nurses were also able to transfer the skills learned in one context to other situations, and these interactions used optimism and change-based strategies.

Solution-focused nursing involves three phases: joining, building, and extending.

Joining

In the joining phase effort is made to get to know who the person is, what their strengths and vulnerabilities are, and what the nature of their condition is, physically as well as psychosocially. It is important to notice and develop areas in the person that are healthy and adaptive because this leads to appropriate behavior.

In Zara's case the nurse could have used the time when he was measuring her vital signs to spend just a few moments engaging Zara. This requires a conscious stance wherein you move away from the position of detached dispassionate expert to one who is, to put it simply, human. In this way a connection is made based on what is shared between a client and a clinician rather than what keeps them separate. Note the following example:

Zara, my name is Paul. I'm your nurse. You must be feeling awful (wait and listen), being in pain, being here alone. You have made a good decision getting help now. I need to tell you that there will be a wait ahead as the team is really busy here.

By trying to relax, you may help to contain the pain. Have you found, in the past, effective ways to be calm? How would you feel about using those strategies or some that I could suggest?

Even if answers are not forthcoming, the nurse has made an effort to show his or her concern and opened up a pathway to collaborate. It sets a respectful tone and invites the person to become active in his or her own health care.

Building

In the building phase the aim is to be educative and supportive. Empowerment is all about giving the skills to clients so they can better understand health and well-being and better self-manage. It aims to develop in the client a sense of capability and inner strength and motivation to get through the present health challenge.

Solution-focused nursing is not about a forced optimism. It is not about being solution forced, because it involves appreciation for the fact that people have vulnerabilities and strengths. Thus in a respectful empowering relationship, the person feels supported and also motivated. Skill deficits (such as ways to relax and relieve head tension) and excesses (such as the mechanism of self-injury, which can be very effective in managing pent-up distress) can be discussed.

In emergency health care, such as in Zara's case, the building phase may be brief, perhaps taking only a couple of minutes, but it is nonetheless the heart of the nurse-client relationship. Without the building phase nursing work has no purpose. It may be as simple as conveying the value of optimism in change or as complex as showing a client ways to self-manage a chronic debilitating disease. The following example illustrates this point:

Zara, this kind of headache is something that, with effort, you could minimize and even prevent. Would you like to learn more about factors that influence headaches?

Together, the nurse and client might work on building a repertoire of coping skills to deal with the immediate situation, talking through issues such as relationships, tension management, and being both capable and strong at the same time as sometimes feeling vulnerable and emotional. This may help to build up in the client feelings of optimism, so that the client can adapt, recover, and get stronger in the longer term.

In this phase too the work may not be exclusively focused on the nurse–client relationship. Indeed, nurses may find that the change that is needed rests within their own workplace culture and not within the client. Solution-focused nursing sees that the possibilities for change rest equally within the cultural and social sphere as they do within the client relationship. This notion is quite a departure from the medical model, and even from other nursing models that emphasize and centralize concern for the individual client (Gordon, 1994; Roper, Logan, & Tierney, 1980). The implication is that the profession of nursing plays no part in creating and sustaining ill health when what we so often see is that it patently does.

Zara’s experience emphasizes this notion clearly. The nurse in this story, by failing to intervene tactfully and assertively with the doctor, is being complicit in harmful care. On the other hand, in being ethical and empowering nurses have a duty and a moral obligation to protect the person’s dignity. But how does one act in a delicate situation such as this? Again, the answers rest in simply being human, thinking of a way to be empathic and respectful yet advocating for better care for clients:

Sue, got a few minutes? I noticed back there with Zara that you looked uncomfortable and you didn’t speak much to her. (Waits and listens) . . . It’s a challenge sometimes to be nonjudgmental. Yet it’s so important. Want to talk some more about this?

Therefore the solution-focused nursing model values moving beyond individual-focused care to valuing the role of social and cultural care. It involves noticing discourses, practices, actions, and inactions that constrain, obscure, or mislead our aim to be empowering and enabling, and it requires nurses to suggest more enabling ways of thinking about and practicing nursing and health care.

Extending

In the extending phase the emphasis is on encouraging the person to transfer the skills learned in the nurse–patient relationship so they can be used in other contexts such as when they are faced with social situations that are upsetting. It also involves setting the client up with social supports that can be used in place of the clinician–client relationship and therefore be more enduring and sustainable.

Again, in Zara’s case this phase would be brief, perhaps a matter of seconds. Time and duration are not important but conveying the belief that change has been made and that the way ahead is positive are

If you need help again, Zara, you know what to do and you know more about ways to self-manage, right? (Waits for confirmation.)

Note that all these examples of being solution focused are not unidirectional, which is often the case in expert-care models, but rather this model emphasizes working alongside the client and negotiating care with them. The nurse relies on the client giving feedback that the message has been received. The nurse makes an effort to engage in conversation and real dialogue. The belief is that in a partnership model, the person is more likely to feel understood, cared for, and motivated to resume self-caring work.

Conclusion

Positive nursing strategies are about taking action, knowing that small steps in the right direction can have a huge impact. It is about nurturing the things you want to grow—in clients, in the relationship, and in the health service culture. It is about encouraging innovation, creativity, and bright ideas. It is about moving beyond the routine and mechanical in the knowledge that technical competence is only half the story to nursing practice. It is about making a commitment to collaborate, to question, to practice humanism in the everyday and having the courage to do things differently.

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