Nursing Theories & Nursing Practice
SECOND EDITION

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This book offers the perspective that nursing theory is essential to practice, research, education, and development. Nursing theories, as abstractions, reflect nursing and are used by nurses to frame their practice. As guides for nursing endeavors, nursing theories provide communication with those being nursed as well as with colleagues in related health and illness services. At the same time, they are tools for developing and evolving nursing theory. It is hoped that the relations of nursing theory and various nursing endeavors of the future will thus be advanced.

This very special book is intended to honor the work of these theorists in their day-to-day nursing care, by reflecting the contributions of eminent nursing thinkers and doers of our lifetime. Their work has been described as a guide and a product of the theorist's work and who have a deep respect for the work of other scholars. Indeed, to the extent possible, contributing authors have written about their theoretical work. The pattern for each chapter, or team of authors according to their individual thinking about scientific perspectives of the chapter. This freedom of format honors the best thinking of contributing authors; several authors have written a chapter for this book, or their work has been described for this book or their work has been described for this book.

This book is intended to assist nursing students in understanding the development of nursing programs to explore and appreciate nursing theories, nursing practice, and scholarship. In addition to the development and response to calls for use by those who desire to enrich their practice of nursing, and through references to nursing practice and scholarship. This overview of nursing theory and a focus for thinking about theory for use in nursing practice. An outline at the beginning of the chapter, the selected points are highlighted in each chapter prepared for this book; it reflects the experiences of many who have had such a good time teaching and learning nursing and nursing programs.

The design of this book highlights work of nurses who writing up to 50 years ago or more. Building then, as now, on the work of these nurse scholars have provided essential influences for the field, these influences can be seen in the theory presentations in the selected nursing theories that are most in use today. The last section describes development processes and perspectives on views for the future as we move into the twenty-first century, both descriptions of a particular theory and the use of the theory in education, and administration.
Kristen M. Swanson: A Program of Research on Caring

Kristen M. Swanson

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In this chapter, I provide answers to questions posed by students and practitioners who have wanted to know more about the origins and progress of my research and theorizing on caring. I have situated myself as a nurse and as a woman so that the context of my scholarship, particularly as it pertains to caring, may be understood. I consider myself to be a second-generation nursing scholar. I was taught by first-generation nurse scientists (that is, nurses who received their doctoral education in fields other than nursing). My struggles for identity as a woman and as an academician were, like many women of my era (the baby boomers), a somewhat organic and reflective process of self-discovery during a rapidly changing social scene (witness the women's movement, civil rights, etc.). Third-generation nursing scholars (those taught by nurses whose doctoral preparation is in nursing) may find my "yearning" somewhat odd. To those who might offer critique about the egocentricity of my pondering, I offer the defense of having been brought up during an era in which nurses dealt with such struggles as, "Are we a profession? Have we a unique body of knowledge? Are we entitled to a space in the full (i.e., PhD-granting) academy?" I fully appreciate that questions of uniqueness and entitlement have not completely disappeared. Rather, they have faded as a backdrop to the weightier concerns of making a significant contribution to the health of all, working collaboratively with others and challenging other scientists and practitioners, embracing pluralism, and acknowledging the socially constructed power differentials associated with gender, race, poverty, and class.

Turning Point

In September 1982 I had no intention of studying caring: my goal was to study what it was like for women to miscarry. It was my dissertation chair, Dr. Jean Watson, who guided me toward the need to examine caring in the context of miscarriage. I am forever grateful for her foresight and wisdom. I believe that the key to my program of research is that I have studied human responses to a specific health problem (miscarriage) in a framework (caring) that assumed from the start that a clinical therapeutic had to be defined. So, hand in glove, the research has constantly gone back and forth between "what's wrong and what can be done about it," "what's right and how can it be strengthened," and "what's real to women (and most recently their mates) who miscarry and how might care be customized to that reality." The back-and-forth nature of this line of inquiry has resulted in insights about the nature of miscarrying and caring that might otherwise have remained elusive.

Predoctoral Experiences

My preparation for studying caring-based therapeutics from a psychosocial perspective began, ironically, in a cardiac critical care unit. After receiving my BSN at the University of Rhode Island, I was wisely coached by Dean Barbara Tate to pursue a job at the brand-new University of Massachusetts Medical Center (U. Mass.) in Worcester, Massachusetts. I was drawn to that institution because of the nursing administration's clear articulation of how nursing could and should be. It was so exciting to be there from day one. We were all part of shaping the institutional vision for practice. It was phenomenal witnessing myself and my friends (nurses, physicians, respiratory therapists, and housekeepers) make a profound difference in the lives of those we served. However, what I learned most from that experience came from the patients and their families. I realized that there was a powerful force that people could call upon to get themselves through incredibly difficult times. Watching patients move into a space of total dependency and come out the other side restored was like witnessing a miracle unfold. Sitting with spouses in the waiting room while they entrusted the heart (and lives) of their partner to the surgical team was awe-inspiring. It was encouraging to observe the inner reserves family members could call upon in order to hand over that which they could not control. I felt so privileged, humbled, and grateful to be invited into the spaces that patients and families created in order to endure their transitions through illness, recovery, and, in some instances, death.

After a year and a half at U. Mass., I was still a fairly new nurse and was very unclear about what all of these emotions, I saw all of it. My spiritual beliefs are not relevant. At that point, what was my emerging passion for studying complex processes in conveying that sensitive place? Hence, I applied with the intention of focusing on the acutely ill adult in completing my PhD at the University of Pennsylvania.

While at Penn, dedicated to the graduate program as such, was involved in revising the master's curriculum, listening to Dr. Betty Sharpe and was amazed at how I was surrounded by extraordinary faculty who comprised nursing's top researchers and were able to give voice to the needs of the newly emerging Massachusetts Medical Center in Worcester. Shortly after witnessing the closed system, I was hired as a research assistant, and immediately enrolled in Fawcett's new PhD program in nursing. It provided me with the resources had ever made me. I was certain I finally knew what I wanted to study; a discipline that I was passionate about. It was experiential, phenomenological, and was more suited for the patients who were more interested in holistic wellness. I had also begun to study and understand the diagnosis of illness, a key to ability to understand the transitions through transdisciplinary care.

Doctoral Experiences

Such insights were critical for doctoral study and I applied them to the area of study...
All of these emotional insights had to do with nursing. I saw all of it as more of something about my spiritual beliefs and me than about my profession. At that point, what mattered most to me as a nurse was my emerging technological savvy, understanding complex pathophysiological processes, and conveying that same information to other nurses. Hence, I applied to graduate schools with the intention of focusing on teaching and on the care of the acutely ill adult. Approximately two years after completing my baccalaureate degree, I enrolled in the Adult Health and Illness Nursing program at the University of Pennsylvania.

While at Penn, I served as the student representative to the graduate curriculum committee and, as such, was invited to attend a two-day retreat to revise the master’s program. I distinctly remember listening to Dr. Jacqueline Fawcett and being amazed at hearing her talk about health, environments, persons, and nursing and claiming that these four concepts were the “stuff” that really comprised nursing. It was like hearing someone give voice to the inner stirrings I had kept to myself. It was so clear to me that I was now starting to understand from an undergraduate medical-surgical nursing. I immediately enrolled as a postmaster’s student in Dr. Fawcett’s new course on the conceptual basis of nursing. It proved to be one of the best decisions I had ever made, primarily because it helped me to figure out an answer to that constant question, “Why doesn’t a smart girl like you enter medicine?” I finally knew that it was because nursing, a discipline that I was now starting to understand from an experiential, personal and academic point of view, was more suited to my beliefs about serving people who were moving through the transitions of illness and wellness. I suppose it is safe to say that I was beginning to understand that my “gifts” lie not in the diagnosis and treatment of illness but in the ability to understand and work with people going through transitions of health, illness, and healing.

Doctoral Studies

Such insights made me want more; hence, I applied for doctoral studies and was accepted into the graduate program at the University of Colorado. My area of study, psychosocial nursing, emphasized such concepts as loss, stress, coping, caring, transactions, and person-environment fit. Having been supported by a National Institute of Mental Health (NIMH) traineeship, one requirement of our program was a hands-on experience with the process of undergoing a health promotion activity. Our faculty offered us the opportunity to carry out the requirement by enrolling ourselves in some type of support or behavior-change program of our own choosing. Four weeks into the same semester in which I was required to complete that exercise, my first son was born. I decided to enroll in a cesarean birth support group as a way to deal with the class assignment and the unexpected circumstances surrounding his birth. It so happened that an obstetrician had been invited to speak to the group about miscarriage at the first meeting I ever attended. I found his lecture informative with regard to the incidence, diagnosis, prognosis, and medical management of spontaneous abortion. However, when the physician sat down and the women began to talk about their personal experiences with miscarriage and other forms of pregnancy loss, I was suddenly overwhelmed with the realization that there had been a one-in-six chance that I could have miscarried my son. Up until that point, it had never occurred to me that anything could have gone wrong with something so central to my life. I was 29 years old and believed, quite naively, that anything was possible if you were only willing to work hard at it.

Two profound insights came to me from that meeting. First, I was acutely aware of the American Nurses’ Association social policy statement, namely, “Nursing is the diagnosis and treatment of human responses to actual and potential health problems” (1980, p. 9). It was so clear to me that whereas the physician had talked about the health problem of spontaneously aborting, the women were living the human response to miscarrying. Second, being in my last semester of course work, I was desperately in need of a dissertation topic. From that point on it became clear to me that I wanted to understand what it was like to miscarry. The problem, of course, was that I was a critical care nurse and knew very little about anything having to do with childbearing. An additional concern was that during the early 1980s, although there was a very strong emphasis on epistemology, ontology, and the methodologies to support multiple ways of understanding nursing as a human science, our methods courses were very traditionally
quantitative. Luckily, two mentors came my way. Dr. Iody Glittenberg, a nurse anthropologist, agreed to guide me through a predissertation pilot study of five women's experiences with miscarriage in order that I might learn about interpretive methods. Dr. Colleen Conway-Welch, a midwife, agreed to supervise my trek up the psychology-of-pregnancy learning curve.

DISSERTATION: CARING AND MISCARRIAGE

Twenty women who had miscarried within 16 weeks of being interviewed agreed to participate in my phenomenological study of miscarriage and caring. These results have been published in greater depth elsewhere (Swanson-Kauffman, 1985, 1986b, Swanson, 1991). Through that investigation, I proposed that caring consisted of five basic processes:

Caring consisted of five basic processes: knowing, being with, doing for, enabling, and maintaining belief.

knowing, being with, doing for, enabling, and maintaining belief. At that time, the definitions were fairly awkward and definitely tied to the context of miscarriage. In addition to naming those five categories, I also learned some important things about studying caring: (1) if you directly ask people to describe what caring means to them, you force them to speak so abstractly that it is hard to find any substance; (2) if you ask people to list behaviors or words that indicate that others care, you end up with a laundry list of "niceties"; (3) if you ask people for detailed descriptions of what it was like for them to go through an event (i.e., miscarrying) and probe for their feelings and what the responses of others meant to them, it is much easier to unearth instances of people's caring and noncaring responses; and finally, (4) I learned that although my intentions were to gather data, many of my informants thanked me for what I did for them. As it turned out, a side effect of gathering detailed accounts of the informants' experiences was that women felt, heard, understood, and attended to in a nonjudgmental fashion. In later years, this insight would actually become the grist for a series of caring-based intervention studies.

I have often been asked if my research was an application of Jean Watson's Theory of Human Caring (Watson, 1979/1985, 1985/1988). Neither Dr. Watson nor I have ever seen my research program as an application of her work per se, but we do agree that the compatibility of our scholarship lends credence to both of our claims about the nature of caring. I have come to view her work as having provided a research tradition that other scientists and I have followed. Watson's research tradition asserts that caring (1) is a central concept in nursing, (2) values multiple methodologies for inquiry, and (3) honors the importance of nurses (and others) studying caring so that it may be better understood, consciously claimed, and intentionally acted upon to promote, maintain, and restore health and healing.

Postdoctoral Study

POSTDOCTORAL STUDY #1: PROVIDING CARE IN THE NICU

Approximately nine months after I completed the dissertation, my second son was born. This child had a difficult start in life and spent a few days in the newborn intensive care unit (NICU). Through this event, I became aware that caring (i.e., miscarriage-bearing loss (having a not-well child at birth), I, too, wished to receive the kinds of caring responses that my miscarriage informants had described. Hence, my next study, an individually awarded National Research Service Award postdoctoral fellowship (1989 to 1990), was inspired. Dr. Kathryn Barnard, at the University of Washington, agreed to sponsor this investigation and ended up opening doors for me that still continue to open. With her guidance, I spent over a year "hanging out" in the NICU at the University of Washington Medical Center (the staff gave me permission to acknowledge them and their practice site when discussing these findings). The question I answered through the NICU phenomenological investigation was, "What is it like to be a provider of care to vulnerable infants?" In addition to my observational data, I did in-depth interviews with some of the mothers, fathers, physicians, nurses, and other health-care professionals who were responsible for the care of five infants. The results of this investigation are published elsewhere (Swanson, 1990). With respect to understanding caring, there were three main findings:

1. Although I was primarily interested in the NICU setting, the findings seemed applicable in other settings as well.
2. It was evident to me that caring (i.e., "caring for"") and helping (i.e., "helping others") are two activities so closely connected that they are often confused. In effect,尼克松, are strongly need to be understood.
3. The NICU setting provided a research tradition that other scientists and I have followed.
1. Although the names of the caring categories were retained, they were grammatically edited and somewhat refined so as to be more generic.
2. It was evident that care in a complex context called upon providers to simultaneously balance caring (for self and other), attaching (to people and roles), managing responsibilities (self-, other-, and society-assigned), and avoiding bad outcomes (for self, other, and society).
3. What complicated everything was that each NICU provider (parent or professional) knew only a portion of the whole story surrounding the care of any one infant. Hence, there existed a strong potential for conflict stemming from misunderstanding others and second-guessing another’s motives.

While I was presenting the findings of the NICU study to a group of neonatologists, I received a very interesting comment. One young physician told me that it was the caring and attaching parts of his vocation that brought him into medicine, yet he was primarily evaluated on and made accountable for the aspects of his job that dealt with managing responsibilities and avoiding bad outcomes. Such a schism in his role-performance expectations and evaluations had forced him to hold the caring and attaching parts of doing his job inside. Unfortunately, it was his experience that those more person-centered aspects of his role could not be “stuffed” for too long and that they oftentimes came hauntingly into his consciousness at about A.M. His remarks left me to wonder if the true origin of burnout is the failure of professions and care delivery systems to adequately value, monitor, and reward practitioners whose comprehensive care embraces caring, attaching, managing responsibilities, and avoiding bad outcomes.

POSTDOCTORAL STUDY #2: CARING FOR SOCIALLY AT-RISK MOTHERS

While I was still a postdoctoral scholar, Dr. Barnard invited me to present my research on caring to a group of five master’s-prepared public health nurses. They became quite excited and claimed that other mothers, fathers, and advanced practice nurses had participated in Dr. Barnard’s Clinical Nursing Models Project (Barnard et al., 1988). They had provided care to 68 socially at-risk expectant mothers for approximately 18 months (from shortly after conception until their babies were 12 months old). The purpose of the intervention had been to help the mothers take control of themselves and their lives so that they could ultimately take care of their babies. As I listened to these nurses endorsing the relevance of the caring model to their practice, I began to wonder what the mothers would have to say about the nurses. Would the mothers (1) remember the nurses, and (2) describe the nurses as caring?

I was able to locate 8 of the original 68 mothers (a group of women with highly transient lifestyles). They agreed to participate in a study of what it had been like to receive an intensive long-term advanced practice nursing intervention. The result of this phenomenological inquiry was that the caring categories were further refined and a definition of caring was finally derived.

Hence, as a result of the miscarriage, NICU, and high-risk mothers studies, I began to call the caring model a middle-range theory of caring. I define caring as a “nurturing way of relating to a valued ‘other’ toward whom one feels a personal sense of commitment and responsibility.”
supporting, allowing and validating feelings, generating alternatives, thinking things through, and giving feedback. The last caring category is "maintaining belief," which means sustaining faith in the other's capacity to get through an event or transition and face a future with meaning. This means believing in the other and holding him or her in esteem, maintaining a hope-filled attitude, offering realistic optimism, helping find meaning, and going the distance or standing by the one cared for, no matter how his or her situation may unfold (Swanson, 1991, 1993, 1999a, 1999b).

The Miscarriage Caring Project

As my postdoctoral studies were coming to an end, Dr. Barnard challenged me and claimed, "I think you've described caring long enough. It's time you did something with it!" We discussed how data-gathering interviews were so often perceived by study participants as caring. Together we realized that, at the very least, open-ended interviews involved aspects of knowing, being with, and maintaining belief. We suspected that if doing-for and enabling interventions specifically focused on common human responses to health conditions were added, it would be possible to transform the techniques of phenomenological data gathering into a caring intervention. That conversation ultimately led to my design of a caring-based counseling intervention for women who miscarried.

The next thing I knew, I was writing a proposal for a Solomon four-group randomized experimental design (Swanson, 1999a, 1999b). It was funded by the National Institute of Nursing Research and the University of Washington Center for Women's Health Research. The primary purpose of the study was to examine the effects of three one-hour-long, caring-based counseling sessions on the integration of loss (miscarriage impact) and women's emotional well-being (moods and self-esteem) in the first year after miscarriage. Additional aims of the study were to (1) examine the effects of early versus delayed measurement and the passage of time on women's healing in the first year after loss, and (2) develop strategies to monitor caring as the intervention/process variable.

An assumption of the caring theory was that the recipient's well-being should be enhanced by receipt of caring from a provider who is informed about common human responses to a designated health problem (Swanson, 1993). Specifically, it was proposed that if women were guided through in-depth discussion of their experience and felt understood, informed, provided for, validated, and believed in, they would be better prepared to integrate miscarriage into their lives. Content for the three counseling sessions was derived from the miscarriage model—a phenomenologically derived model that summarized the common human responses to miscarriage (Swanson, 1999b; Swanson-Kauffman, 1983, 1985, 1986a, 1986b, 1988).

Women were randomly assigned to two levels of treatment (caring-based counseling and controls) and two levels of measurement ("early"—completion of outcome measures immediately, six weeks, four months, and one year postloss; or "delayed"—completion of outcome measures at four months and one year only). Counseling took place at one, five, and eleven weeks postloss. ANOVA was used to analyze treatment effects. Outcome measures included self-esteem (Rosenberg, 1965); overall emotional disturbance, anger, depression, anxiety, and confusion (McNair, Lorr, & Droppelman, 1981); and overall miscarriage impact, personal significance, devastating event, lost baby, and feeling of isolation (investigator-developed Impact of Miscarriage Scale).

A more detailed report of these findings is published elsewhere (Swanson, 1999a). There were 242 women enrolled, 185 of whom completed. Participants were within five weeks of loss at enrollment; 89 percent were partnered, 77 percent were employed, and 94 percent were Caucasian. Over one year, main effects included the following: (1) caring was effective in reducing overall emotional disturbance, anger, and depression; and (2) with the passage of time, women attributed less personal significance to miscarrying and realized increased self-esteem and decreased anxiety, depression, anger, and confusion.

In summary, the Miscarriage Caring Project provided evidence that, although time had a healing effect on women after miscarrying, caring did make a difference in the amount of anger, depression, and overall disturbed moods that women experienced after miscarriage. This study was unique in that it employed a clinical research model to determine whether or not caring made a difference.
I believe that its greatest strength lies in the fact that the intervention was based both on an empirically derived understanding of what it is like to miscarriage and on a conscientious attempt to enact caring in counseling women through their loss. Of course, the greatest limitation of that study is that I derived the caring theory (developed from the intervention) and conducted most of the counseling sessions. Hence, it is unknown whether similar results would be derived under different circumstances. My work is further limited by the lack of diversity in my research participants. Over the years, I have predominantly worked with middle-class, married, educated Caucasian women. I am currently making a concerted effort to rectify this situation and to examine what it is like for diverse groups of women to experience both miscarriage and caring.

Monitoring caring as an intervention variable was the second specific aim of the Miscarriage Caring Project. Three strategies were employed to document that, as claimed, caring had indeed occurred. First, approximately 10 percent of the intervention sessions were transcribed. Analysis was done by research associate Katherine Klaich, RN, PhD, having also been one of the counselors in the study, found she could not approach analysis of the transcripts naively—that is, with no preconceived notions, as would be expected in the conduct of phenomenologic analysis. Hence, she employed both deductive and inductive content analytic techniques to render the transcribed counseling sessions meaningful. She began with the broad question, "Is there evidence of caring as defined by Swanson [1991] on the part of the nurse counselors?" The unit of analysis was each emic phrase that was used by the nurse counselor. Phrases were coded for which (if any) of the five caring processes were represented by the emic utterances. Each counselor statement was then further coded for which subcategory of the five processes was represented by the phrase. Twenty-nine subcategories of the five major processes were defined. With few exceptions (social chit-chat), every therapeutic utterance of the nurse counselor could be accounted for by one of the subcategories.

The second way in which caring was monitored was through the completion of paper-and-pencil measures. Before each session, the counselor completed a Profile of Mood States (McNair, Lorr, & Droppleman, 1981) in order to document her presession moods (thus enabling examination of the association between counselor presession mood and self or client postsession ratings of caring). After each session, women were asked to complete the Caring Professional Scale (investigator-developed). Women, having been left alone to complete the measure, were asked to place the evaluations in a sealed envelope. In the meantime, in another room, the counselor wrote out her counseling notes and completed the Counselor Rating Scale, a brief five-item rating of how well the session went.

The Caring Professional Scale (2002) originally consisted of 18 items on a five-point Likert-type scale. It was developed through the Miscarriage Caring Project and was completed by participants in order to rate the nurse counselors who conducted the intervention and to evaluate the nurses, physicians, or midwives who took care of the women at the time of their miscarriage. The items included: "Was the health-care provider that just took care of you understanding, informative, aware of your feelings, centered on you, etc." The response set ranged from 1 ("not at all") to 5 ("not at all"). The items were derived from the caring theory. Three negatively worded items (abrupt, emotionally distant, and insulting) were dropped due to minimal variability across all of the data sets. For the counselors at one, five, and eleven weeks postloss, Cronbach alphas were .80, .95, and .90 (sample sizes for the counselor reliability estimates were 80, 87, and 76). The lower reliability estimates were because the counselors' caring professional scores were consistently high and lacked variability (mean item scores ranged from 4.52 to 5.0).

Noteworthy findings include the following:

1. Each counselor had a full range of presession feelings, and those feelings/moods were, as might be expected, highly intercorrelated.
2. For the most part, counselor presession mood was not associated with postsession evaluations.
3. The caring professional scores were extremely high for both counselors, indicating that, overall, the clients were pleased with what they got and, as claimed, caring was "delivered" and "received."
4. One of the counselors was a psychiatric nurse by background. She knew very little about miscarriage prior to participating in this study and had
recently experienced a death in her family. The only time her precession moods (in this case, depression and confusion) were significantly associated (p \leq .05) with any of the postsession ratings (both client caring professional score and counselor self-rating) was in Session I. During Session I, women discussed in-depth what the actual events of miscarrying felt like. It is possible that the counselor was so touched by and caught up in the sadness of the stories that her own vulnerabilities were a bit less veiled.

5. Session II, in which the two topics addressed were relationship oriented (who the woman could share her loss with and what it felt like to go out in public as a woman who had miscarried), was the only session in which the other counselor's vulnerabilities came through. This counselor, having just gone through a divorce, was probably least able to hide her precession moods (depression, (p \leq .05) and low vigor, confusion, fatigue, and tension (all at p \leq .01), as was evident in the significant associations with her own postsession self-ratings. Also, most notably, there was an association between this counselor's precession tension and the client's caring professional rating (p \leq .05).

A Literary Meta-Analysis of Caring

Another recent project was an in-depth review of the literature. This literary meta-analysis is published elsewhere (Swanson, 1999). Approximately 130 data-based publications on caring were reviewed for this state-of-the-science paper. Developed was a framework for discourse about caring knowledge in nursing. Proposed were five domains (or levels) of knowledge about caring in nursing. I believe that these domains are hierarchical and that studies conducted at any one domain (e.g., Level III) assumes the presence of all previous domains (e.g., Levels I and II). The first domain includes descriptions of the capacities or characteristics of caring persons. Level II deals with the concerns and/or commitments that lead to caring actions. These are the values nurses hold that lead them to practice in a caring manner. Level III describes the conditions (nurse, patient, and organizational factors) that enhance or diminish the likelihood of caring occurring. Level IV summarizes caring actions. This summary consisted of two parts. In the first part, a meta-analysis of 18 quantitative studies of caring actions was performed. It was demonstrated that the top five caring behaviors valued by patients were that the nurse (1) helps the patient to feel confident that adequate care was provided; (2) knows how to give shots and manage equipment; (3) gets to know the patient as a person; (4) treats the patient with respect; and (5) puts the patient first, no matter what. By contrast, the top five caring behaviors valued by nurses were: (1) listens to the patient, (2) allows expression of feelings, (3) touches when comforting is needed, (4) is perceptive of the patient's needs, and (5) realizes the patient knows himself/herself best. The second part of the caring actions summary was a review of 67 interpretive studies of how caring is expressed (the total number of participants was 2,314). These qualitative studies were classified under Swanson's caring processes, thus lending credibility to caring theory. The last domain was labeled "consequences." These are the intentional and unintentional outcomes of caring and noncaring for patient and provider. In summary, this literary meta-analysis clarified what "caring" means, as the term is used in nursing, and validated the generalizability or transferability of Swanson's caring theory beyond the perinatal contexts from which it was originally derived.

Couples Miscarriage Healing Project

I am currently principal investigator on an NIH-, NINR-funded randomized trial of three caring-based interventions against control to see if we can make a difference in men and women's healing after miscarriage. The purpose of this randomized trial is to compare the effects of nurse caring (three nurse counseling sessions), self-caring (three home-delivered videotapes and journals), combined caring (one nurse counseling plus three videotapes and journals), and no intervention (control) on the emotional healing, integration of loss, and couple well-being of women and their partners (husbands or male mates) in the first year after miscarrying. All intervention materials have been developed based on the Miscarriage Model and the Caring Theory. Our goal is to enroll 340 couples. This study is ongoing.
Much work lies ahead. The profession has a long way to go to make a case for the education needed to support caring practices; the importance of nurses practicing in a caring manner; the essential contributions of caring to the well-being of all; and the costs of caring in terms of time, money, and personal energy expended. The discipline also has much work left to do. It is essential that nurse investigators frame nursing interventions under the framework of caring in order to tie together the essential contributions of the profession to the health of society. Finally, caring, in order to be effective, must be sensitive to those involved in caring transactions (nurses and clients), to the cultural contexts in which it is performed, and to the common responses that individuals, families, groups, and communities experience when living with conditions of wellness and illness.

References


