MEASURING CARING
INTERNATIONAL RESEARCH ON CARITAS AS HEALING

JOHN NELSON
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Editors
Measuring Caring

*International Research on Caritas as Healing*
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John Nelson, RN, MS, PhDc
Jean Watson, PhD, RN, AHN-BC, FAAN

Editors
This book is dedicated to all the practitioners, educators, and scholars in caring science around the world who are interested in and committed to pursuing research and innovative approaches to assess and measure Caritas (caring and love), as well as theory validation.

To those who paved the way for this research and ventured into new models of experimentation and collaboration to make this happen.

Finally, to Springer Publishing for its support and encouragement in pursuing the publication of this international research.
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Foreword

Caritas Consciousness Through an Integral Lens

This book is the first collection of research that tests the construct of Caritas (caring and love) within the context of caring science and the theory of human caring assembled over the last 30 years by Dr. Jean Watson and her colleagues. This book represents the efforts of a community of practice—a group of people who share a passion for something they know how to do and who interact regularly in order to learn how to do it better (Wegner, 2005).

The collection of chapters in this volume supports and extends the evidence of measuring the impact of caring consciousness and the role Caritas plays in healing and value-driven philosophy health. The fact that this book is bringing Caritas consciousness to other nurses and health care professionals around the world illustrates the wisdom and power of a value-driven philosophy—theory and the importance of good science. Reading this book is likely to support personal and professional transformation and to support development of nurses’ collective consciousness.

I think Dr. Jean Watson and her colleagues are integral philosopher-scientists. The word integral means “to include, to bring together, to join, to link, to embrace.” Ken Wilber (2007) has advanced an integral theory based on internal-external, inside-outside, individual and collective perspectives related to experience in the world. Integral philosophy attempts to include and coordinate the many faces of the Good (the “we”), the True (the “it”), and the Beautiful (the “I”), as all of them evolve across a spectrum, from sensory forms (seen with the eye of flesh) to mental forms (seen with the eye of mind), to spiritual forms (seen with the eye of contemplation).

To be integral involves adoption of three integrative principles (Wilber, 2007): nonexclusion (acceptance of truth claims that pass the validity tests for their own paradigms in respective fields), enfoldment (sets of practices that are more inclusive, holistic, and comprehensive than others), and enactment (various types of inquiry that disclose different
phenomena, depending on the quadrants—self, relationship, body–mind, systems—levels, lines, states, and types of the inquiry).

Within integral theory there are lines of development. Predictably, people develop from preconventional to conventional to postconventional ways of thinking, being, and doing. I believe Caritas consciousness is a cognitive-ethical-moral-spiritual line of development enhanced through practice and verified through multiple forms of inquiry and evidence. The works described in this book are establishing the foundations of good science in the discipline.

Good science from an integral perspective involves instrumental injunctions, direct apprehensions, communal confirmations, or rejections. As explained by Sean Esbjorn-Hargens and Ken Wilber (2006):

Instrumental injunction refers to an actual practice, an exemplar, a paradigm, an experiment or an ordinance. It is always of the form “If you want to know this, do this.” Direct apprehension refers to an immediate experience of the domain brought forth by the injunction: that is, a direct experience or apprehension of data (even if those data are mediated, at the moment of experience they are immediately apprehended). Communal confirmation or rejection is a checking of the results, the data, the evidence with others who have completed the injunction and apprehensive strands adequately. Thus all kinds of science are in fact empirical in the broadest sense of experiential. This is a much broader definition of science than the narrow definition of sensory experience usually associated with it. (p. 534)

This text contains many examples about the application and use of pluralistic inquiry methods. Integral Methodological Pluralism (IMP) proposes that different types of inquiry have their own methods and validity claims (Esbjorn-Hargens, 2006). For example, phenomenological inquiry includes mindful practices such as reflection, journaling, prayer, and shadow work. The validity claims associated with these inquiry methods include truthfulness, honesty, sincerity, integrity, and the identification and acknowledgment of bias and assumptions. Hermeneutical interpretive methods include storytelling, collective reflection, and textual analysis. Validity claims for these methods include issues of intersubjective justness. Empirical inquiries include surveys, field observations, the development of measures and metrics and include validity claims of propositional objective truth through repeatable, controlled, empirical, logical conditions. Finally, when inquiry is focused on systems, direct experience with the system(s) through mapping, statistical analysis, and study can gain validity claims of functional fit as data and evidence from multiple and reputable sources converge. Examples of phenomenological, hermeneutic, empirical, and systems inquiry are represented in the chapters contained in this volume. Each study examines self, relation-
ships, body, mind, and systems in the context of caring theory and practices.

This book brings the theory, practice, and evidence of Caritas consciousness to other nurses and health care professionals around the world. The efforts of the community of practice involved in this work illustrate the purpose and power of a value-driven philosophy—theory with the influence of good science to enable the appreciation of the wisdom of caring and love in health and healing. A careful read of this book will support personal and professional transformation through the development and evolution of our collective consciousness. Personal and professional transformation is hard work that takes time and intention.

Robert Kegan (1994) notes that personal and professional transformation takes place when we develop fifth-order consciousness. Kegan describes the development of consciousness this way: As we grow and develop we realize differences between self and other—the “me” and “not me.” We evolve from self-consciousness to “self-other” consciousness. We then progress to a second level of consciousness that he calls the “we” or “socialized mind.” Most people's growth and development become arrested at this conventional level of consciousness. With critical experiences and time, some of us master the hidden curriculum of daily life. We transcend our third level of consciousness and develop a fourth-order consciousness that Kegan calls “self-authoring mind.” Self-authoring individuals view work, school, parenting, therapy, intimate relationships, and citizenship differently than those who operate at the level of socialized mind. At work, fourth-order consciousness manifests itself in the following ways. A person is:

- the inventor or owner of one’s own work and distinguishes work from job.
- self-initiating, self-correcting, self-evaluating rather than being dependent on others to frame the problems, initiate adjustments, or determine whether things are going acceptably well.
- guided by one’s own visions at work rather than being without vision or being captive of the authority’s agenda.
- responsible for what happens to oneself at work externally and internally (rather than seeing present internal circumstances and future external possibilities as caused by someone else).
- an accomplished master of one’s particular work roles, jobs, or careers (rather than having an apprentice or imitating relationship to what one does).
- conceiving the organization from “outside in” as a whole, seeing one’s relation to the whole and seeing the relation of the parts to the whole, rather than seeing the rest of the organization and its parts
only from the perspective of one's own part, from the “inside out” (Kegan, 1994, p. 302).

In educational settings, those with a “self-authoring mind”

- exercise critical, creative, and systems thinking.
- examine self, culture, and milieu in order to understand what we feel from what we should feel, what we value from what we should value, and what we want from what we should want.
- are self-directed learners (they take initiative, set their own goals and standards, use experts, institutions, and other resources to pursue these goals, take responsibility for their own direction and productivity in learning).
- see themselves as cocreators of the culture (rather than shaped by the culture).
- read actively (rather than receptively) with a purpose in mind.
- write to themselves and bring their teachers into their self-reflection (rather than write mainly to the teachers or for the teachers).
- take charge of the concepts, theories of a course or discipline and marshal on behalf of themselves an independently chosen topic and its internal procedures for formulating and validating knowledge (Kegan, 1994, p. 303).

Kegan argues that continual, professional growth and development in a postmodern society may require a “fifth order of consciousness, or the growth and creation of a ‘self-transforming mind.’” At this level people integrate polarities and contradictions in their own behavior as they develop and appreciate complexity thinking and engage in the really hard work of psychological and spiritual integration. I believe this book challenges all nurses to aspire to fifth-order consciousness of a self-transforming mind.

As you read this book, I hope you appreciate and value the integral nature of the work and the evidence gathered. May your exploration and analysis of these ideas and methods stimulate the development of your own personal and professional Caritas consciousness in support of your own healing work and the healing care of others.

REFERENCES


_Daniel J. Pesut, PhD, RN, PMHCNS-BC, FAAN_
Preface

The intent of this book is to build a scientific–theoretical argument that Caritas (caring and love) is an intervention for healing. There is much evidence that pharmacotherapy and technology heal, but we lack evidence on the healing power of caring and love.

Skeptics will state, “You can't measure the impact of caring and love.” If that is true, then we must negate the science regarding stress, quality of life, coping, and all the other abstract dimensions of the human experience. The body of science relating to the power of love follows the same trajectory as these other abstract/latent dimensions of life and human experiences associated with all the vicissitudes of living and dying. As such, this book is the first collection of research that tests the construct of Caritas (caring and love) within the context of Caring Science and the Theory of Human Caring assembled over the last 30 years by Dr. Jean Watson.

Here our focus is for nurses engaged in the theory-guided practices of the Caritas processes within the context of health provision as well as for all health providers. The book focuses on nurses because nursing and health care are in need of new methods of human caring and healing that are low cost, can be used by all, and can influence outcomes. Simply, we propose that Caritas interventions will influence practitioner/patient, organizational, and financial outcomes in a positive direction.

Caring interventions begin with self. Research within this book reveals that caring for self relates to caring for others, specifically, coworkers and patients. Caring, according to Watson, includes 10 Caritas processes. When applied within the appropriate time, using the appropriate method, caring and love will be perceived and healing will follow. Behaviors include treating oneself with loving kindness, taking time for relationships, tending to one's basic needs of life, embracing both positive and negative aspects of oneself, honoring spiritual aspects of life, taking time to acquire knowledge, having belief and hope, allowing oneself to believe in the impossible, creative problem solving, and creating a healing environment. Theoretically, if these behaviors are enacted toward self, there will be greater access to one's inner healing processes for wholeness.
This book has initiated a mass collaboration of researchers worldwide who are testing these theories. There is already enough research, prompted by the completion of this book, to write a second volume on how we have built the scientific argument, including how we are correlating nurse and patient reports of caring with their respective biophysical, physiological markers. Once we are able to show how caring behaviors toward self and others decrease the prevalence and incidence of illness, we may be able to initiate training and reimbursement for effective caring. Thus, this work has practical and empirical implications as well as theoretical validation for Caring Science as a growing field.

This book has several applications, including those for educators who teach nursing theories, for research professors who are building the scientific argument, and for teachers who focus on professional leadership and clinical scholar roles. The book is organized in sections, with several chapters relating to that topic or dimension of caring. The first section reviews the theory of caring and possibilities for the use of Watson’s concept of Caritas. The second section reviews research that connects caring to the care provider who, in this case, is the nurse. The third section provides exemplars of interventions aimed at the enhancement of Caritas toward self and others. The fourth section presents international perspectives from cross-sectional studies across the globe. Finally, the fifth section, along with the appendices, includes several studies that examine caring in specific contexts such as addiction, electroconvulsive therapy (ECT), and other particular populations. All the tools described within this book that are derived from the Caring Factor Survey (CFS), the primary tool used for the majority of the studies in this book, can be downloaded at the Springer Publishing website at www.springerpub.com/nelsoncaring.

The authors of this book readily participated in what could be called a mass collaboration. The networking occurred mostly through the Caring International Research Collaborative (CIRC) and Watson’s Caring Science Institute (WCSI). The CIRC group is a research community within Sigma Theta Tau International and WCSI is a nonprofit foundation created by Dr. Jean Watson. Together, participants are all learning from each other, and thus this work furthers that goal of clinical scholarship.

John Nelson
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I thank John for his leadership and vision for this book and all the intense international communication and follow-up required for this research. I appreciate the many researchers who were willing to take chances and engage in further developing and validating concepts of caring, love, and Caritas as empirical variables worthy of researching. My continuing appreciation goes to the collaborating organizations, the contributing authors, and colleagues who participated in the birthing of this work, and to Allan Graubard at Springer for his support, encouragement, and guidance for this book. I am grateful also for his creation of Springer Publishing’s Watson Caring Science Library in conjunction with Watson Caring Science Institute (WCSI).

As founder of the WCSI, I am pleased and delighted to endorse this work as part of the Watson Caring Science Library. It is an exemplar of the nature of caring-science research and the assessment and measurement of caring and healing, the foundations of authentic nursing care and caring in our world. May it serve as a foundation for further research in Caritas—Caring and Love, the ultimate source of healing and true health.

Jean Watson

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John Nelson
SECTION I

Theoretical Background of Caritas
Contemporary nursing practice focuses on creating caring environments for nurses, patients, and families within today's complex health care organizations. With the emergence of the American Nurses Credentialing Center's (ANCC) Magnet Recognition Program® (Magnet), nursing theory has moved from its central place in academia and research to practice. The majority of Magnet hospitals have implemented a theoretical framework grounded in caring science. Indeed, the theme for the 2010 ANCC National Magnet Conference, “Magnet: A Culture of Caring,” was characteristic here with Jean Watson giving the keynote address on caring and caring science to an audience of nearly 6,000 nurses (October 2010). Watson’s (1979, 1985, 2005, 2008, 2011) theory of human caring has become the theory of choice as direct care registered nurses (RNs) return to caring values. Theory-guided practice advances both the discipline and profession of nursing. Practice outcomes demonstrate the creation of a caring-healing environment at all levels and facilitate both human and environmental well-being (DiNapoli, Nelson, Turkel, & Watson, 2010; Turkel & Ray, 2004; Watson, 2008).

Theories are part of the knowledge structure of any discipline (Parker & Smith, 2010). According to Parker and Smith (2010), the major reason for structuring and advancing nursing knowledge through nursing theory is clear: to develop, understand, and transform nursing practice. Nursing is a professional discipline, and nursing theory guides and informs practice. As the work of nursing scholars and theorists has transformed professional nursing practice, so has the everyday practice of nursing enriched and advanced nursing theory. According to Parker (2006), “creative nursing practice is the direct result of ongoing theory-based thinking, decision making, and action of nurses” (p. 15).
I. THEORETICAL BACKGROUND OF CARITAS

Various definitions of theory exist. According to Parson (1949), theories tell us what we already know and what we need to know. Dickoff and James (1968) defined theory as a “conceptual system or framework invented for some purpose” (p. 198), whereas Ellis (1968) termed it “a coherent set of hypothetical, conceptual and pragmatic principles for forming a general frame of reference for a field of inquiry” (p. 217). Watson (1985) defined theory as “an imaginative grouping of knowledge, ideas, and experience that are represented symbolically and seek to illuminate a given phenomenon” (p. 1). Watson (2005, 2008, 2011) further related theory to the Latin origin *Theoria*, which means “to see”—acknowledging theory as another way to see phenomena that are right in front of us. Although definitions vary, they meet in one purpose: to give meaning and explanation to, and understanding of, nursing practice. Theory represents the intellectual life of nursing (Levine, 1995).

The conceptual-theoretical-empirical (CTE) system of nursing practice as described in Fawcett (2000) is the purposeful way that nurses can apply the hierarchy of nursing knowledge to predict quality patient outcomes. The structural components of the CTE are a conceptual model, or theory, that is made up of concepts and propositions. Although not tangible entities, scholars propose them to help clinicians better understand a phenomenon. These conceptual definitions can then be formalized through empirical research methods designed to test and confirm the linkages between the concepts in a theory. It is this knowledge—of the linkages between concepts in a theory—that practitioners can use to help predict quality patient outcomes (Fawcett, 1999). Examination of caring theory through the lens of the CTE clarifies for practitioners how to demonstrate that caring practices and professional models of care, grounded in the tenets of caring theory, make a difference in nursing, patient, or organizational outcomes.

Implementing the CTE system to understand caring theory must begin with clarification of the concept as it relates to the metaparadigm concepts of nursing. Let us recall that a paradigm, as defined by Kuhn (1970, 1977), serves as a basis for understanding nursing knowledge (Parker, 2001). According to Kuhn, a paradigm is a framework or worldview consisting of assumptions held by members of the discipline considered as essential in the development of the discipline. Traditionally, the metaparadigm of nursing includes these concepts: nursing, person, health, and environment (Fawcett, 1984). Nursing scholars continue to advance knowledge within the discipline, which has in turn generated new ideas—also from nursing scholars—that have shifted the focus of the traditional metaparadigm. “Caring is considered by many as one central feature within the meta-paradigm of nursing knowledge and practices” (p. 456). The notion of replacing the concept “nursing” with “caring” within the disciplinary metaparadigm was advanced by Watson (1979) and by a group of scholars at the Wingspread Conference (1989) on

Caring, as the essence of nursing practice, has evolved over time since Watson's conception in Nursing: The Philosophy and Science of Caring (Watson, 1979), and later in Nursing: Human Science and Human Care (1985). These original theory books developed the concepts of transpersonal caring relationships between the nurse and the patient, the caring occasion, phenomenal field, and caring moment, advancing the notion that caring should be considered a metaparadigm concept of nursing and not simply something that nurses do. Watson and Smith (2002) also have fostered an understanding of the concept of caring from a theoretical perspective of caring science, which seeks to unify and connect as an “evolving philosophical-ethical-epistemic field of study that is grounded in the discipline of nursing and informed by related fields” (p. 456).

Indeed, Jean Watson's seminal work offers justification for the conceptual-theoretical link between the essential aspects of caring in nursing and the core of professional nursing by identifying 10 Carative Factors that can be measured empirically. Nursing-sensitive quality patient outcomes guided by the Carative Factors and grounded in a humanistic value system are what differentiate professional nursing practice and nursing practice focused solely on mechanics or tasks. Watson's original work has continued to evolve and grow—the Carative Factors were redefined as the Caritas Processes, reflecting a deeper connection among nursing praxis, caring science, and the universal concept of love. In Latin, caritas means “Christian love” and has been further defined as love for humanity. Caritas nursing practice involves the integration of transpersonal caring and love within the context of the nurse-patient relationship and interactions, resulting in a caring, healing relationship (Watson, 2005, 2008).

NURSING THEORY: ADVANCING THE DISCIPLINE AND TRANSFORMING PRACTICE

Watson’s (1979, 1985, 2005, 2008, 2011) philosophy brought to light caring science as the essence of nursing and as the foundational core of the discipline. Caring is a dynamic, transpersonal relationship between the nurse and the patient that involves ethical choice and action within the present moment (past, future, and present all at once), which manifests the potential for harmony of body, mind, and soul (spirit) (Watson, 1985, 2005, 2008). Thus, the process of caring is a moral ideal committed to a specific end, “the protection, enhancement, and preservation of the person’s humanity which helps to restore inner harmony and potential healing” (Watson, 1985, p. 58).

To further advance the discipline of nursing and transform nursing practice it is necessary to empirically measure caring. This opens another
debate essential to the development of psychometrically sound instruments: how to articulate the place caring has within an increasingly pharmacologic and mechanistic health care environment. As such, is caring a single concept that can be measured or a construct requiring the creation of a series of subscales to measure the identity and nature of a human phenomenon? Clearly, this debate must include scholars and practitioners.

A careful examination of the concept of caring—through the theory of caring science as proposed by Watson—might suggest that to measure Caritas is to view the concept of caring as a construct (Caritas), which implies a composite of elements that, when taken together, creates a single structure/construct. This conceptualization assists with examining Caritas as a paradigm of healing while allowing flexibility in testing individual processes (as interventions of healing). The composite elements of the construct are individual concepts that, when taken separately, have their own definitions and empirical indicators. Conceptualizing each of the Caritas Processes separately allows for the classification of each as a middle-range theory.

**CONCEPT ANALYSIS**

Concepts represent meaning, experience, or ideas of the human experience (Chinn & Kramer, 1995). Concept analysis is used to determine the state of the science of the concept in relation to science. In order for a concept to progress from analysis to scientific analysis of relevance within the lived experience, the concept must be validated within the context in which it is being examined (Hupcey & Penrod, 2005). Thus each concept within Watson's theory is proposed to be valid as a part of the construct of Caritas within the contexts being studied. When the concept is challenged within contexts being examined, further concept analysis may need to be conducted as it relates to the use of the concept within the construct of Caritas. It is important to examine the concept within the consideration of the entire construct within which it is embedded. Isolation of the concept without consideration of the entire construct limits the application of the concept to the human experience (Hupcey & Penrod, 2005).

In the case of the Caritas Processes, it must be considered, when examining a concept separately, how it relates to healing within the construct of Caritas. For example, how does loving kindness as a concept relate, and potentially contribute, to healing within the construct of Caritas? How does nurses' teaching in a way patients can learn contribute to healing within the construct of Caritas? Without considering how each concept contributes to the construct of interest (Caritas), the concepts lose scientific meaning. How they each contribute to healing from a theoretical and empirical point of view grows opaque, which, in turn, inhibits our ability to interpret findings of science (Hupcey & Penrod, 2005).
Wilson's classic work (1963) provides a framework to examine a concept within various contexts, including social context, similar concepts, practical application, and language (Hupcey & Penrod, 2005). Because constructs are prone to evolve, their concepts are temporal entities as well (Walker & Avant, 1995). Thus concept analysis is not a one-time event but a recurring aspect of construct validation within various contexts and points of time. Notably, Rodgers (2000) also viewed concepts as dynamic within context and time.

The three primary types of concept analysis previously referred to include Wilsonian-derived, evolutionary, and pragmatic utility. In fact, Wilson (1963) proposed 11 techniques to isolate a concept for useful dialogue in science. This method was contemporized by Walker and Avant in 1983 by reducing the 11 techniques to 8 (Weaver & Mitcham, 2008). Although other revisions of the Wilsonian approach were conducted by Chinn and Jacobs (1983) and Schwartz-Barcott and Kim (2000), the Walker-Avant approach is the most widely used in graduate schools (Weaver & Mitcham, 2008). Rodgers's (2000) evolutionary method also considers context and time as well as application within practice (Weaver & Mitcham, 2008). The final method, the pragmatic utility approach developed by Morse (2000), advises researchers to consider concept within the critical appraisal, specifically as it relates to research perspective, questions, assumptions, and methods (Weaver & Mitcham, 2008).

In terms of developing middle-range theories, some authors proposed that concept analysis can be used in that regard (Bu & Jezewski, 2007). Once the concepts’ defining attributes, antecedents, consequences, and context of concepts are defined, the concept is potentially ready for examination as a middle-range theory to test within practice. The authors provide a walkthrough of the process they used to examine the concept of patient advocacy and possible future work as a middle-range (Bu & Jezewski, 2007).

THE FUTURE OF NURSING KNOWLEDGE: CARITAS PROCESSES AS MIDDLE-RANGE THEORY CONCEPTS

The development of nursing knowledge is an ongoing process. Middle-range theory, whose development has increased over time, focuses on specific aspects of nursing practice and is often viewed as more relevant and applicable to nursing practice than grand theories. Middle-range theories present concepts and propositions at a lower level of abstraction and are useful for increasing theory-based research and evidence-based nursing practice initiatives (Smith & Leiher, 2008). Certainly, future advances in nursing knowledge can be made by considering the development of middle-range theories based on caring science.
A place to start may be examination of each of the Caritas Processes as a specific phenomenon in middle-range theory. The conceptual analysis of several of the Caritas Processes has already been completed by Watson and others. Following are the 10 Caritas Processes and concept analyses found in the literature to address each concept.

**Caritas Process 1: Cultivating the Practice of Loving Kindness and Equanimity Toward Self and Others** (layman’s terms: loving kindness, compassion, and forgiveness for self and others). This process involves listening and respecting others, honoring human dignity, treating self and others with loving kindness, recognizing vulnerabilities in self and others, and accepting self and others as they are. Upon examination of the literature, no concept analyses were found that were specific to loving kindness. However, the literature did reveal that this concept is being considered. Carson et al. (2005) tested a century-old practice of meditation of loving kindness practiced by the Buddhist tradition \((n = 43)\). It was their desire to understand if meditation on loving kindness would decrease perception of pain for patients suffering from chronic low back pain. The 8-week study revealed a statistically significant decline in perception of pain for the loving kindness group, whereas no change occurred for the control group. Deeper examination of the loving kindness group revealed that the pain was lowest on the days that loving kindness meditation was practiced (Carson et al., 2005). Another study in meditation on loving kindness showed that only a few minutes of loving kindness increased perception of social connection (Hutcherson, Seppala, & Gross, 2008). Meanwhile, the control group showed no increase in perception of social connection (Hutcherson et al., 2008). These two studies suggest that loving kindness has potential to be examined further as a concept of healing physically, mentally, and/or spiritually.

**Caritas Process 2: Being Authentically Present: Enabling, Sustaining, and Honoring Faith and Hope** (layman’s terms: faith and hope). The concept analysis of authenticity addressed self-discovery, which may include faith and hope (Starr, 2008). Search strategies to identify the concept of faith and hope revealed that they were analyzed as separate concepts. Benzein and Saveman (1998) used the Walker and Avant (1995) method of concept analysis to examine hope. Hope is future oriented, includes positive expectations, requires intentionality and action, involves interconnectedness, and includes a realistic goal (Benzein & Saveman, 1998). Others have conducted concept analysis in specific populations, including in the pediatric oncology population (Hendricks-Ferguson, 1997). The concept of hope as a subconcept of caring is reviewed in much more detail in Chapter 3 by Giuliana Masera and Karen Gutierrez of this book as an example of how health care professionals, academicians, and/or researchers can examine hope at a more extensive level.

One challenge in the identification of literature related to a specific concept is the verbiage used to label concepts that use different words but hold very similar, if not the same, meaning. According to Dyess
(2008), faith is related to spiritual belief rather than a more broad examination as a concept of believing in or for an outcome. Further discussion in supporting one's belief and hope as a process of healing is warranted.

**Caritas Process 3: Cultivation of One’s Own Spiritual Practices and Transpersonal Self, Going Beyond Ego-Self** (layman’s terms: spiritual support, growth and development, and evolution of higher consciousness). It is important to identify that the concept of spirituality, like other concepts in the construct of Caritas, uses different terms to identify the same or very similar concepts. For the concept of spirituality, there is some overlap in the terms religiosity and spirituality. These are not the same, but the concepts and overlap must be addressed within this discussion.

Bjarnason (2007) used the concept-analysis method espoused by Rodgers to examine religiosity, which has to do with traditions, practices, and affiliation. According to Bjarnason (2007), religiosity includes external behaviors such as attending a place of worship like a temple, mosque, church, or other formal gathering place for people of similar religiosity. It can also include internal behaviors such as reading religious text or private prayer (Bjarnason, 2007). The terms spirituality, coping, belief, and hope serve as surrogates for this concept in some literature (Bjarnason, 2007). Religiosity has been shown to have protective qualities for patients from conditions such as depression, hypertension, suicide, and drug involvement (Bjarnason, 2007). It also has been reported to aid in coping for stressful life events and chronic joint pain (Bjarnason, 2007).

Spirituality, as a concept, was analyzed by McBrien (2006) using the method of Walker and Avant (1995). Spirituality goes beyond the traditions and practices of religiosity to an individual's search for meaning and connection (McBrien, 2006). Spirituality includes the attributes of belief in God or a higher power; inner strength and peace derived from acceptance of one's situation; and connectedness to self, others, and God, which leads to deeper meaning in life (McBrien, 2006). Spirituality then may or may not include religiosity, per se, but allows the exploration of the individual in to deeper connectedness and meaning.

**Caritas Process 4: Developing and Sustaining a Helping-Trustig Caring Relationship** (layman’s terms: helping–trusting relationship). Search terms used to identify concept analysis included helping, help, trusting, trust, and helping-trusting. Using the databases CINAHL and Medline, 31 articles were identified and three were selected to review for this chapter: Bell and Duffy (2009) analyzed the concept of nurse-patient trust; Hams (1997) conducted a concept analysis of trust from the perspective of coronary care; and Johns (1996) also conducted a concept analysis of trust. No concept analysis was found that examined helping-trusting or helping. However, within the concept of trust, help was reported to be an important attribute of trust (Bell & Duffy, 2009). Johns (1996) stated that trust includes the reliance on another to meet an unmet need. This could be referred to as being “helped” by another.
Caritas Process 5: Being Present to, and Supportive of, the Expression of Positive and Negative Feelings (layman’s terms: promote feelings, both positive and negative). Concept analysis of listening was the closest concept found to “promotion of feelings, both positive and negative.” According to Shiley (2010), listening is a skill and concept that has not received warranted attention as it relates to outcomes in health care. Attributes of listening include use of empathy and silence while maintaining a nonjudgmental and accepting attitude of what is being said both verbally and nonverbally (Shiley, 2010). No tools were found by Shiley to measure the patient’s perception of listening skills of nurses. Therefore, the empirical data regarding the impact of listening as perceived by the patient and associated outcomes were also missing. This provides a future opportunity to examine the skill of listening as it relates to healing.

Caritas Process 6: Creative Use of Self and All Ways of Knowing as Part of the Caring Process; Engage in the Artistry of Caritas (layman’s terms: creative problem solving). When looking for a concept analysis for creative problem solving or use of all ways of knowing, the closest terms found were problem solving and intuition. Zander (2007) examined the concept of ways of knowing from an historical perspective and how it has evolved as a concept over time. Rodgers’s (2000) process of concept analysis was used because it includes the dynamics of a concept over time and possible evolution. Epistemology (Carper, 1978) and ontology (Jacobs-Kramer & Chinn, 1988), as resources for making decisions, were reviewed (Zander, 2007). Intuition was also identified as one “other” way of knowing (Zander, 2007).

Based on the historical review of Zander (2007), it is plausible that creative problem solving as a Caritas Process could be broken down and examined as a number of concepts, including aesthetic knowing, empirical knowing, ethical knowing, and personal knowing. Zander (2007) also identified other aspects of knowledge, including experience (Benner, Tanner, & Chesla, 1992; Burnard, 1987) and intuition (Agan, 1987; Rew & Barrow, 1987; Young, 1987). Simmons (2010) conducted a concept analysis of intuition as an aspect of knowing. It is proposed that knowing contains several concepts in itself as a separate construct. Further inquiry is needed to understand which aspects of knowing relate most strongly to problem solving as a Caritas Process that in turn relates to healing.

Caritas Process 7: Engage in Genuine Teaching-Learning Experience That Attends to Unity of Being and Subjective Meaning—Attempting to Stay Within Others’ Frame of Reference (layman’s terms: effective teaching). Two concept analyses were found that are central to teaching patients: health literacy (Speros, 2004) and information needs (Timmins, 2006).

Health literacy relates to the patients’ ability to comprehend the necessary information to promote their own health (Speros, 2004). Speros used the Walker and Avant method to examine health literacy. Attributes
of health literacy included both cognitive and social skills (Speros, 2004). Cognitive skills included the patients’ ability to read and use numbers as well as comprehend either or both (Speros, 2004). Social aspects included the patients’ ability to function as health care consumers and past experiences in health care (Speros, 2004). Speros did identify health outcomes of health literacy, including perceived health status and lower health care costs. Lower costs included decreased length of stay, less frequent use of health care services, and better health-promotion knowledge that resulted in better health status (Speros, 2004).

Timmins (2006) used Rodgers’s (2000) evolutionary approach to examine the concept of information needs. Timmins identified that humans have individual learning needs and motivations. This fact requires health care professionals to understand the concept of information needs to be successful in teaching patients what they need to know (Timmins, 2006). Information-needs attributes include individual coping, problem-solving approach, perception of illness or health, and perception of health care professionals’ competence in educating them (Timmins, 2006). The dynamics of measuring the impact of teaching are complicated by the constant change of demographics of society, advancement of technology, and increased access by consumers to electronic information (Timmins, 2006). These challenges prevent patients’ information needs from being met, despite multiple methods and instruments to measure patient information needs (Timmins, 2006). No matter what method or instrument is used, each patient must be asked specifically what his or her information needs are, rather than assuming that each individual’s information needs match those of the population that shares the individual’s respective diagnosis (Timmins, 2006).

Qualitative research conducted by Turkel (1997) revealed that both patients and registered nurses valued patient education or patient teaching as a caring behavior or caring practice. An outcome of this caring was enchantment of learning when the teaching was done by a caring nurse. Patient participants talked about being able to ask questions and wanting to learn when they had a caring nurse. They believed they “could remember better” with a caring nurse. In terms of economic outcomes caring makes a difference. If patients are readmitted within 30 days after discharge with the same diagnosis because they do not understand how to care for themselves the hospital will not be reimbursed. Recidivism is costly to patients and hospitals: costly to patients in terms of increased time required for healing and recovery and costly to hospitals that will not be reimbursed for treatment.

*Caritas Process 8: Creating a Healing Environment at All Levels* (layman’s terms: creates healing environment). No concept analysis was found for Caritas Process 8. Terms used to search for this concept analysis included *healing environment, optimal healing environment,* and *environment*. Articles related to each of these terms were identified, but
no concept analysis. Although no specific content analysis was found in the nursing literature related to a healing environment, components of this Caritas Process have been found in the nursing literature from both a theoretical and research perspective. Nightingale (1859), in the seminal work *Notes on Nursing*, wrote that “unnecessary noise is the cruelest absence of care.” Watson (2008) described noise reduction as a comfort measure that facilitates creation of a healing environment. As part of integration in practice, RNs have implemented quiet times in acute care settings where noise levels are intentionally reduced, lights are dimmed, and the patient is allowed to rest. Findings from Press Ganey indicated that patients complained about noise two times more often than about anything else in a hospital, including the food (Mazer, 2010). A recent study by Lawson et al. (2010) validated that high levels of sound in critical care result in poor sleep quality, which leads to slower healing, poorer immune response, and decreased cognitive function.

Additional healing modalities, including massage therapy, therapeutic touch, guided imagery, music, aromatherapy, and art therapy, are being used by RNs in practice to facilitate creation of a healing environment at all levels. Each of these modalities has empirical research validating its positive effect on healing. A few studies are presented. Therapeutic touch (TT) is an intervention that involves the intentional direction of energy for the purpose of healing. In an intervention study of 21 postoperative surgical patients, findings showed that participants who received TT had significantly lower level of pain, lower cortisol level, and higher natural killer cells (NKC) level.

The purpose of a study by Locsin, McCaffrey, and Purnell (2009) was to describe RN experiences of being cared for in a hospital healing-arts space in a southeast Florida hospital. Written narratives from 16 respondents to the question “What was your experience like, using the healing arts space?” were transcribed and analyzed following Colaizzi’s (1978) phenomenological approach. Three themes were found to describe the nurses’ experience of being cared for: freely appreciating oneness with the environment; “caring for self” as centering, relaxing, and knowing; and being physically present is living in a calm and gentle space all at once.

Twiss, Seaver, and McCaffrey (2006) studied the effect of music on anxiety and length of intubation time for 60 patients undergoing coronary artery bypass surgery. The researchers found that patients who listened to music had lower scores on anxiety measures and were able to be removed from the ventilator 3 hours earlier. McCaffrey (2008) reviewed numerous research articles, providing evidence that listening to music is a way to create and provide a healing environment for older adults and that music improves the healing environment from a physiologic and psychologic perspective.
Numerous research studies show the efficacy of aromatherapy and massage. One particular study (Lemon, 2004) examined the effect of massage with essential oils in 32 patients with psychiatric illness in an acute care setting. Findings indicated that the patients receiving massage with essential oils showed significantly more improvement in scores on depression, anxiety, and severity of emotional symptoms.

**Caritas Process 9: Administering Sacred Acts of Caring-Healing by Tending to Basic Needs** (layman’s terms: holistic care). No concept analysis was found for holistic care. Although no specific concept analysis was found in the nursing literature, Watson (2008) invited RNs to assist with basic human needs with an intentional caring consciousness. An example of this is the evidence-based practice work of Sauer (2010) reducing bloodstream infections in the neonatal intensive care unit (NICU). The purpose of this evidence-based practice initiative was to change nursing practice in the NICU from clean to sterile technique for the tubing change of central venous catheters (CVCs). Bloodstream infections in the NICU patient population have the potential to be life threatening. Premature infants have a weakened immune system, and an infection compromises reserves and impacts the body system as a whole. Creating a healing environment by attending to safety and sterility potentiated comfort and healing. Changing CVC tubing is a sacred nursing act when the nurse practices with intentionality, will, and commitment. Realizing that it is a privilege to care for this patient population in all their vulnerability allows the “task” to become a caring interaction. The change from nursing task to Caritas practice has resulted in zero bloodstream infections in the past nine months.

From a theoretical perspective, Hektor and Touhy (1997) reflected, “Have we not thrown out the ‘baby with the bath water’ when we reduce bathing to a task to be accomplished, often without the expertise and involvement of the professional nurse?” Rather than being a healing and positive experience for older persons, bathing in institutions becomes routine, depersonalized, and often harmful. According to Hektor and Touhy, attention to the aesthetics of the bath could return bathing to its prior status as therapeutic healing intervention. From their perspective, examining the art of nursing as it was historically practiced helps us to rediscover the meaning of the skillful and artful therapeutic bath.

Disruptive behaviors, including physical and verbal aggression, often occur during bathing and are especially common among nursing home residents who are cognitively impaired. Research facilitated by Hoeffer, Rader, McKenzie, Lavelle, and Stewart (1997) aimed at changing the psychosocial environment in which bathing occurred and addressed the function, frequency, and form of bathing as well. Nursing practice emphasizing an individualized person-focused, rather than task-focused, approach reduced aggressive behavior during bathing and made it a more positive experience for nursing assistants and less stressful for residents.
Caritas Process 10: Opening and Attending to Spiritual/Mysterious and Existential Unknowns of Life-Death (layman’s terms: allows belief in miracles). No concept analysis was found for miracles. However, the topic of miracles is described in many professional books and journals. For example, a book titled *Daily Miracles* (Briskin & Boller, 2006) captures stories and the practice of humanity, caring, and excellence in health care. Physicians and RNs from various practice settings reflected on and then shared stories of the human experience of caring and compassion.

CARING IN THE METAPARADIGM OF NURSING

Nightingale never explicitly defined caring in her seminal work, *Notes on Nursing* (1859, 1992); however, her professional and personal life exemplified an ethos of caring (Dunphy, 2006). In this regard, Watson (1992) has written: “Although Nightingale’s feminine based caring healing model has transcended time and is prophetic for this century’s healthcare reform, the model is yet to truly come of age in nursing or the healthcare system.” Watson’s (1979) work advanced the concept of caring within the discipline of nursing and, at that time, Watson called for caring to be included within the metaparadigm of nursing.

Numerous other scholars of caring have continued to advance it as a substantive area of study (Benner et al., 1992; Boykin & Schoenhofer, 1993; Duffy, 2005, 2007; Leininger, 1981; Ray, 1989, 2006, 2008, 2011; Roach, 1987; Smith, 1999, 2010; Sumner, 2010; Sumner & Fisher, 2008; Swanson, 1991, 1999). As concept, caring is broad enough to encompass the discipline of nursing and capture the nature of nursing (Ray, 2006). This transtheoretical identification recognizes the commonality of caring among the various theories, philosophies, and conceptual frameworks of the discipline. Nurses in practice are able to articulate caring as a philosophical and theoretical foundation for practice.

Qualitative research continues to advance the reflective, human nature of caring and captures the meaning and experience of giving and receiving caring. Quantitative research continues to show that caring can be measured and that it influences patient and nurse satisfaction and facilitates healing. Over 25 instruments with demonstrated reliability and validity have been developed to empirically assess and measure caring mindfully and intentionally (Watson, 2008).

Given this in-depth development of scholarly knowledge, and the ongoing advancement of caring in professional practice, the authors acknowledge caring as the unifying focus of the discipline. With respect to its historical development, and the influence of scholars who contributed to the original metaparadigm of nursing, the time has come to embrace caring as part of that same metaparadigm. Thus this book helps to explore
the evolution of the concepts of caring within the construct of Caritas as emerging middle-range theories worthy of empirical validation and measurement.

REFERENCES


I. THEORETICAL BACKGROUND OF CARITAS


1. CONCEPTS OF CARING AS CONSTRUCT OF CARITAS HIERARCHY


