

A theory of holistic comfort for nursing

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Although the construct of comfort has been analysed, diagrammed in a two-dimensional content map, and operationalized as a holistic outcome, it has not been conceptualized within the context of a broader theory for the discipline of nursing. The theoretical work presented here utilizes an intra-actional perspective to develop a theory of comfort as a positive outcome of nursing care. A model of human press is the framework within which comfort is related to (a) interventions that enhance the state of comfort and (b) desirable subsequent outcomes of nursing care. The paper concludes with a discussion about the theory of comfort as a significant one for the discipline of nursing.

INTRODUCTION

The construct of comfort recently has been analysed, diagrammed in a two-dimensional conceptual map, and operationalized as a holistic outcome (Kolcaba 1992). Comfort is defined for nursing as the satisfaction (actively, passively or co-operatively) of the basic human needs for relief, ease or transcendence arising from health care situations that are stressful. Nursing care is designed to meet or continue meeting needs that fall under the domain of the discipline.

The purpose of this paper is to postulate relationships between patients' needs, nursing interventions, comfort, and subsequent outcomes, from these relationships a theory of comfort is derived. It concludes with a discussion about the significance of the theory of comfort for nursing.

Holistic outcomes and nursing

Nurse scientists are beginning to explore the effectiveness of broadly targeted interventions such as progressive muscle relaxation, imagery and therapeutic touch.

These interventions and others are intended to elicit positive whole person responses and thus would be measured most accurately by whole person outcomes. Whole person outcomes entail positive or negative carry-over effects between aspects of the person's response. Whole person responses have been difficult to operationalize because of their complicated content domains, possible carry-over effects between components of the outcome, and the theoretical difficulties of interpreting a total score. However, comfort is a holistic outcome that accounts for whole person responses and it has been previously operationalized (Kolcaba 1992).

The basic assumptions of the theory of comfort are that (a) human beings have holistic responses to complex stimuli, (b) comfort is a desirable holistic outcome that is germane to the discipline of nursing, and (c) human beings strive to meet, or to have met, their basic comfort needs. These assumptions underpin the theory of comfort and are in concert with an intra-actional perspective in which the components of a whole person response are related and assessed comprehensively (Kolcaba 1992). ('Intra' designates within, comfort is an outcome that consists of many aspects that are related within the domain of the construct.)

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COMFORT AS A HOLISTIC OUTCOME

Comfort is a holistic outcome because it designates a dynamic and multifaceted state of persons. Thinking about the outcome of comfort requires an intra-actional perspective because interventions that are intended to enhance one or more aspects of comfort indirectly enhance other aspects. Consistent with an intra-actional perspective, the magnitude of the total direct and indirect effects is expected to be greater than the magnitude of effects achieved by addressing single aspects separately. The extent to which comfort is holistic is based on the perception of all the aspects taken together at one time, because the effects in one have carry-over effects on other aspects.

Aspects of comfort have been arrayed in a two-dimensional grid (Kolcaba 1992). They were derived from a review of archaic, historical and contemporary nursing literature as well as a review of literature from other disciplines (medicine, psychiatry, ergonomics, psychology) (Kolcaba & Kolcaba 1991, Kolcaba 1992). A review of the previous work follows.

Dimension one

The first dimension of comfort consists of three states, called relief, ease and transcendence. Relief is defined as the experience of having had a specific need met (Kolcaba 1991). Relief from needs is necessary for return to former function or a peaceful death. Ease is defined as a state of calm or contentment (Kolcaba 1991). Ease is the state of comfort that is a necessary condition for efficient performance. Transcendence is defined as the state in which ordinary powers are enhanced (Paterson & Zderad 1976). The characteristic that differentiates transcendence from the other two states, relief and ease, is that the former designates the patient's potential for extraordinary performance as an end.

Because each of the three states of comfort entail positive relationships to performance, theoretically they also imply a strengthening component. This feature of comfort provides the central rationale for promoting the patient's comfort. Comfort is a desirable outcome for nursing care because it facilitates gains in physical and/or psychological performance, comfort also is essential for a peaceful death because a dying person requires psychic strength for acceptance and release. The states of comfort are often continuous, overlapping and interdependent.

Dimension two

The second dimension of comfort is the contexts in which comfort occurs. The contexts are derived from the

nursing literature about holism (Kolcaba 1992). The first context is physical, pertaining to bodily sensations. The second context is psychospiritual, pertaining to the internal awareness of self, including esteem, sexuality, meaning in one's life, and relationship to a higher order or being. The third context is social, pertaining to interpersonal, family and cultural relationships. Also included under social comfort are the financial and informational aspects of social life. The fourth context in which comfort is experienced is environmental, pertaining to light, noise, ambience, colour, temperature and natural versus synthetic elements (Kolcaba 1991).

When the two dimensions (three states and four contexts) of comfort are juxtaposed, the result is a two-dimensional grid with 12 facets of comfort. Items for comfort questionnaires can be generated from each facet that is relevant to a specific research question. In a pilot project, 48 items were constructed using the comfort grid as a conceptual map (Kolcaba 1992). In the instrumentation study that followed, the three states of comfort (relief, ease and transcendence) occurred as factors in each of the four contexts (physical, psychospiritual, environmental and social), as revealed by factor analysis of 256 completed comfort questionnaires (Kolcaba 1992). The emergence of three factors, semantically corresponding to the three states, occurred in each of the separately analysed contexts as well as in total comfort.

For convenience in analysing and discussing responses, the four contexts were thought of as subscales of comfort, each containing items from the three states or factors. A total comfort score was achieved by adding the scores for each subscale. Total comfort scores were useful for differentiating between known groups and for hypothesis testing (Kolcaba 1992). (Factor analysis of individual subscales that comprise a multidimensional construct is an adaptation of traditional factor analysis that was previously applied with unidimensional scales.)

CONCEPTUAL FRAMEWORK

Constructs gain significance when they are related to other concepts. An organizing framework for comfort had to meet the following criteria: the framework had to be based on (a) needs arising from the environment of (b) whole persons for whom nurses could intervene. The effectiveness of (c) the interventions had to (d) be perceived by the persons and (e) lead to subsequent outcomes. The efforts of Murray (1938) and colleagues to synthesize major elements of personality theories into a coherent model led to a theory of human press that is consistent with the above criteria for a framework for

comfort Murray called his model 'organismic' (holistic) and stated, 'Since the parts of a person cannot be dissected physically from each other, and since they act together, ideally they should all be estimated simultaneously' (Murray 1983)

In the model of human press, a stimulus situation is that part of the total environment to which people attend and react during a given episode in their life. Human development, whether positive or negative, is determined by the accumulated impressions about one's success or failure that are formulated during encounters with the situation. For nursing, a stimulus situation can be regarded as any health care situation.

The stimulus situation consists of alpha press and beta press. Alpha press is the sum of negative (obstructing) forces, positive (facilitating) forces, and interacting forces. Beta press is the person's perception of the total effect of the forces in alpha press. For nursing, obstructing forces are the total negative stimuli arising from the health care situation including side-effects of illness or treatments, noxious or threatening environmental and social experiences, and emotional sensations such as fear, anxiety, powerlessness or aloneness. The facilitating forces are nursing interventions designed to meet the needs that remain after the person's own reserves are depleted by obstructing forces.

Events also are interpreted by the person in terms of the many interacting forces that influence the outcome of perception (Murray 1938). The interacting forces consist of the person's past experiences, age, attitude, emotional state, support system, and the totality of elements in the present experience. Murray states that, because these parts of persons cannot be dissected physically from each other and because they act together, ideally they all should be estimated simultaneously (Murray 1938). (With modern statistical methods, interacting forces can be operationalized as covariates in analyses of variance or beta weights in regression models.)

Needs

Needs are defined as hypothetical drives or tensions induced by obstructing forces that promote activities designed to satisfy the drives (Murray 1938). The result is an outcome that is opposite to the arousing drives. If needs are met successfully by appropriate interventions, the immediate outcome is perceived by the person as being relatively positive (Murray 1938).

As stated above, beta press is the person's perception of the total effect of the phenomena in the stimulus situation. The events in the situation are interpreted as a temporal gestalt of stimuli which can be either threaten-

ing or promising (Murray 1938). Beta press involves the appraisal of how well the needs that arise from the obstructing alpha forces are met by facilitating alpha forces in the stimulus situation. If the outcome is positive, evaluations accumulate and provide the expectation that other situations will end positively, contributing to a unitary trend (Murray 1938). Unitary trend is defined as behavioural co-ordination of activity towards the achievement of a desired effect.

For nursing, beta press is the person's perception of how well the nursing interventions (facilitating forces) meet the needs arising from the health care situation (obstructing forces) for which the patient requires assistance in satisfying. Perceptions of comfort imply that negative tensions have been reduced. The person's perception of an increase in total comfort leads to the reinforcement of habits and goals that were successful in reducing tensions. Patterns of successful habits and goals lead to an orienting theme that provides direction for future action. A desirable theme that nursing seeks to promote is a health theme defined as a general orientation to health-seeking behaviours (Schlotfeldt 1975). A reciprocal relationship exists between health-seeking behaviours and comfort because health-seeking behaviours also can enhance comfort.

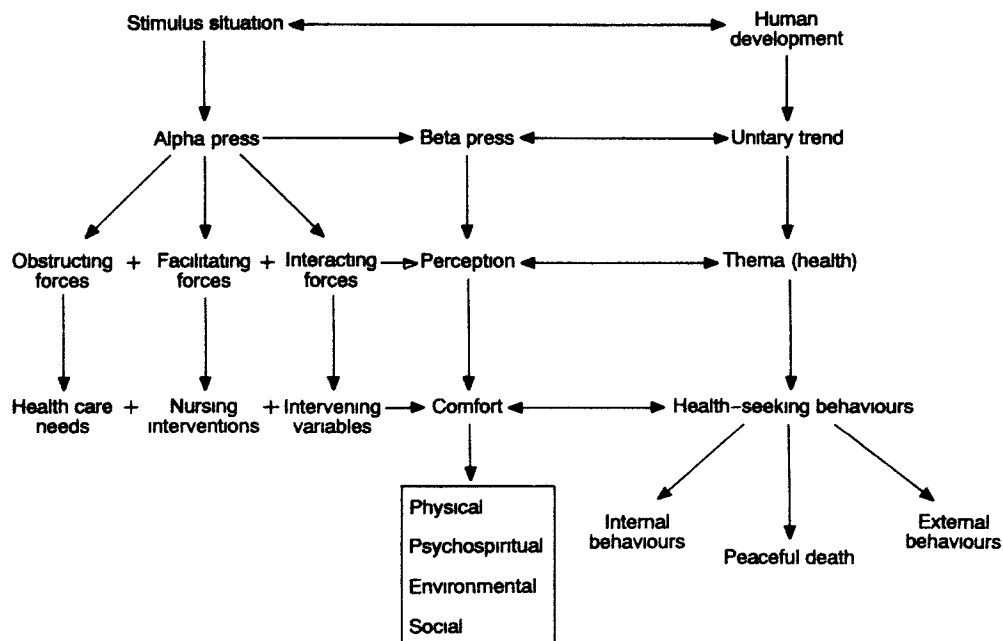
Health-seeking behaviours are conceptualized as internal or external in this theory of comfort. Internal behaviours happen at the cellular or organ level, such as healing or immune function. External behaviours are related to the outer world, such as self-care activities, functional status and health maintenance programmes. The external behaviours named self-care, function, health maintenance programmes, and lengths of hospitalization are explicit in Schlotfeldt's model (1975), while internal behaviours are implicit under the categories of survival and fertility. Schlotfeldt also includes dignified death in her model under the category of health. Consistent with holism, conscious thought and subconscious frame of mind influence health-seeking behaviours. If the person is incapable of conscious thought, the nurse can look for external signs of comfort/discomfort, and promote greater comfort when possible to enhance healing or a peaceful death.

The relationships between the concepts of human press and nursing concepts are depicted in Figure 1. Note the reciprocal relationships between the stimulus situation and human development.

THEORY OF COMFORT

The theory of holistic comfort is a component of a normative and descriptive theory for nursing care. The

Figure 1 The conceptual framework for a theory of comfort



theory is that outstanding needs arise from the stimulus situation and cause negative tension. Negative tension represents an imbalance that exists when obstructing forces outweigh the facilitating forces at hand. The needs for comfort, in any aspect of the content domain, are identified and interventions are targeted towards those specific needs, moving tension in a positive direction. The patient perceives whether the tensions are changed by the intervention(s), the nurse judges the extent to which the desirable outcome of comfort has been met by assessing the patient's perception of comfort objectively or subjectively.

An increase in comfort indicates that negative tensions are reduced and positive tensions are engaged. Positive tensions lead to a unitary trend of constructive behaviours. Constructive behaviours of interest to nursing are health-seeking behaviours and these behaviours stem directly from the health thema. The nurse facilitates the outcome of comfort because theoretically it is related to internal/external health-seeking behaviours or a peaceful death. When practised, health-seeking behaviours can cause greater comfort.

Evidence for the relationship between comfort and health-seeking behaviours

Contemporary nurse thinkers continue to explore the significance of the construct comfort for nursing. Schlotfeldt (1981) states that a focus of nursing is to assist clients to achieve optimal health, function, comfort and self-fulfilment. The American Nurses' Association's

position statement on promotion of comfort in dying patients states that the main goal in the nursing care of dying patients should be maximizing comfort as is consistent with the desires of the patient (Hockenberger 1992).

Richeson & Huch (1988) claim that comfort is nursing's unique contribution to health care, and Morse (1992) states that the ultimate purpose of nursing is to promote comfort. Gropper (1992) adds that, by promoting comfort, nurses are promoting health. The last assertion, though not supported in her paper by empirical testing, provides the theoretical rationale for nurses to assist patients in achieving or enhancing comfort.

Empirical evidence for a link between internal and external health-seeking behaviours and comfort is scant at the present time. The reason for the present state of knowledge about comfort is that the construct has only been recently operationalized (Kolcaba 1992) and the theoretical linkages to health-seeking behaviours are proposed here for the first time. However, empirical research supports the external consistency between comfort and some health-seeking behaviours. The research that is available for this purpose is presented briefly in the following paragraph.

In the field of psychoneuroimmunology, positive correlations have been shown between comfort achieved by relaxation and imagery to enhanced immune parameters (Jasnoski & Kugler 1987, McClelland 1988, Zacharzewa *et al* 1990, Groer 1991). Similarly, comfort achieved by relaxation and imagery have desirable effects on blood pressure (Pender 1985), pulse (Guzzetta 1980) and

respirations (Alexander *et al* 1979). In a study of abortion, patients had increased comfort after participating in pleasant imagery (Wells 1989). In efforts to increase athletic performance and endurance, comfort achieved by imagery was related positively to basketball skills (Kendall *et al* 1990), muscular endurance irrespective of mood state (Lee 1990) and strength (Murphy *et al* 1988). Functional outcomes were enhanced by the comforting effects of relaxation in adults with traumatic head injuries (Lysaght & Bodenhamer 1990), while coping strategies were enhanced by effects of a similar intervention in children (LaMontagne *et al* 1985), students with test anxiety (Sunn 1972), and in adults with multiple sclerosis (Foley *et al* 1987). The interventions cited above are holistic and the outcomes are congruent with internal or external health-seeking behaviours. These studies and others lend encouragement to nurse researchers who ask the question, 'Why comfort?'

The significance of a theory of comfort

Comfort has been called a distinguishing characteristic of the nursing profession (Ferrell & Ferrell 1990), yet heretofore it has not been conceptualized within a theory for nursing. For this reason, comfort is of interest. Secondly, a theory of comfort can be used to explain and predict phenomena of interest to nursing. Thirdly, comfort as a psychological phenomenon is of interest in its own right.

The philosopher of science, Popper (1959), delineated characteristics of significant theories. Ellis (1968) presented these characteristics to nurse researchers as guides to developing theories, stating that nursing theories should be about phenomena observed in their own practice. These characteristics of significant theories are presented here so that the adequacy of the theory of comfort can be judged. In assessing the theory of comfort, contrasts will be drawn between the outcome of comfort and the less holistic outcomes of pain and anxiety.

The first characteristic of a significant theory is its scope (Popper 1959, Ellis 1968). A theory of comfort is of broader scope than a theory of pain or fatigue because comfort subsumes statistical generalizations from the study of pain and fatigue and helps explain them. The extensions of theoretical terms within the theory of comfort designate pain and anxiety phenomena as they interact with other realities such as psychological transcendence. In this way, a theory of comfort has positive components that theories of pain, etc., do not have, thus, its explanatory powers are greater than for the other

theories. A good theory of comfort, therefore, promises to have greater explanatory power than theories of pain and anxiety.

A second measure of the adequacy of scientific theories is their predictive success (Popper 1959, Ellis 1968). We will only know if the theory of comfort has more predictive success than competing theories by testing it. But the theory provides clear direction for testability. First, the theory generates hypotheses about interventions that enhance holistic comfort and, second, the theory generates hypotheses about the relationships between comfort and health-seeking behaviours. The theory is eminently testable and its degree of predictive success readily determinable.

The usefulness of a theory for clinical practice is the third characteristic of significant theories (Ellis 1968). Some phenomena occur rarely or require exotic conditions to bring them about. Comfort phenomena, by contrast, are observable and ever present in the therapeutic context apart from experimentation. It is a small step to bring these phenomena under experimental control.

A fourth characteristic of significant theories is complexity, meaning that multiple relationships among single variables or the complexity of a single variable are addressed (Ellis 1968). The theory of comfort meets both of these criteria, while including a minimum of unobservables. Causation of comfort is more complex than for relief of pain or anxiety, so more complex interventions or sets of interventions are required for enhancing comfort. Because such interventions are targeted broadly, they approximate therapeutic completeness, whereas interventions for pain alone would require adjunct interventions to achieve completeness.

A fifth attribute of significant nursing theories is that they utilize terminology that is meaningful and relevant for nursing. Comfort is a familiar term to nurses, yet a schema for understanding the complexity of the term and its relationship to interventions and subsequent outcomes has not been previously set forth. With the present schema and theory, nurses can design interventions to enhance comfort and measure the effectiveness of their interventions upon the outcome of comfort. Moreover, patients also use comfort to describe their responses and conditions, and other health care personnel use the term to describe patients' conditions. The term is generally understood to be broad, important, positive and related to subsequent desirable behaviours.

Lastly, a measure of the adequacy of scientific theories is their unifiability with other established theories (Nagel 1979, Popper 1968). Because the theory of comfort is unifiable with theories of pain and anxiety, it is desirable

for nursing research because it is an inclusive yet succinct outcome. Comfort takes the place of many separate measurements of more narrow outcomes, yet it is richer than many separate measurements because it accounts for the intra-action between aspects of comfort. The outcome of comfort is nurse-sensitive because it is influenced by nursing interventions. And the theory of comfort is potentially unifiable with theories of health and well-being that are yet to be developed.

CONCLUSION

The understanding of comfort directly guides nursing care that is inclusive of physical, psychospiritual, social and environmental interventions. A series of interventions that target holistic comfort, such as taking the patient to the bathroom, reassuring him about a treatment, giving him information, and cleaning up his room, can be rendered during one nurse-patient encounter after a brief assessment of comfort states in each context. An actual or potential deficit in any context triggers a comfort measure. Thus, an unhappy, unhealthy or unwell patient can be made more comfortable, or a patient's discomfort that is not described as pain can be discerned and targeted. In this example, comfort is inversely related to a host of discomforts and thus it is a 'missing piece' in a theory of nursing practice.

The theory of comfort provides direction for nursing practice and research because it entails an outcome that is measurable, holistic, positive and nurse-sensitive. Clinicians have the capability and disciplinary interest to effect comfort, and patients look to nurses for help in achieving comfort. Because the construct represents an intra-active phenomenon, an operational definition linked to theory is significant for explaining and predicting the rich relationships among the realities of comfort.

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