Empirical Development Of a Middle Range Theory of Caring

KRISTEN M. SWANSON

A middle-range theory of caring was inductively derived and validated through phenomenological investigations in three separate perinatal contexts. Caring was described in Study I by 20 women who had recently miscarried, in Study II by 19 careproviders in the newborn intensive care unit, and in Study III by 8 young mothers who had been the recipients of a long-term public health nursing intervention. The empirical development and refinement of the theory is discussed. The five caring processes and an overall definition of caring are presented. Finally, study findings are compared and contrasted with Cobb's (1976) definition of social support, Watson's (1979, 1985) "curative" factors, and Benner's (1984) description of the helping role of the nurse.

As evidenced by our history, practice, and scholarship, caring has long been recognized as central to nursing. Nursing's service to humanity is to care for the client experiencing actual or potential health deviations until such time as the client (individual or aggregate) is able to independently care for the self. Whether caring is self or other directed, the meaning of caring and the essential components of caring remain unclear.

Noddings (1984) analyzed caring from a philosophical standpoint and noted that the one caring is motivated to resolve or ameliorate the discomfort of the other as a result of having let the self become engrossed in the other's plight. Noddings' use of the term engrossment incorporates being able and willing to perceive the other's reality in an "as if" fashion, as if the other's reality were one's own. Benner and Wrubel (1989), like Noddings, propose that caring is central to assessing and intervening on behalf of another. They claim that the focus of a nurse's caring actually defines the areas in which attention is paid to a client's stress and coping needs.

Gilligan (1982) and Ray (1967) place caring in an ethical framework. Gilligan (1982), in her examination of women's development, noted that caring and connectedness are central to a woman's sense of morality and ethics. Ray (1987), in a phenomenological investigation of eight critical care nurses' expressions of caring, identified five caring themes: maturational, technical competence, transpersonal caring, communication, and judgment/ethics. The pervasiveness of an ethic of caring led Ray (1987) to conclude that "the ability of these critical care nurses to apply ethics and morality in distinguishing right from wrong in the attitudes and behaviors associated with the use of technology was the common denominator of their experiences as a whole" (pp. 167-8).

Several nurse investigators have focused on identifying caring acts. Leininger's (1988) ethnoscienctific studies in 52 different cultures led her to conclude that "cultural care has more diverse than similar meanings, and the patterns of care expression have major implications for building an extensive body of nursing knowledge" (pp. 158-9). Brown (1986), Rienie (1986), and Larson (1984) have examined nurse caring behaviors and descriptions from the perspective of those cared for. Clients perceive as caring those nursing ministrations that are person-centered, protective, anticipatory, physically comforting, and that go beyond routine care. Larson (1984) noted a difference between nurses' and clients' perceptions of which caring behaviors were the most important. Whereas clients tended to value physical nursing ministrations, nurses believed they were most valued for their psychosocial supportive interventions.

Watson (1988), who views caring as a moral ideal, suggested that both nursing and medicine are moving out of an era in which cure is dominant into one in which care takes precedence. She noted, however, that more is known about treatment and cure than about healing and caring processes. Watson (1985) claims that nurses practicing, researching, and educating from a stance of caring will ultimately lead to "the promise of human preservation in society" (p. 29).

A universal definition or conceptualization of caring does not exist. Controversy exists within and outside of nursing as to the role of caring in personal and professional relationships. Is caring a process observable only in the context of two or more persons relating? Is it an intent embedded in the behavior of a caregiver? Or is it a perception identifiable only through the eyes of a care recipient? Can caring be taught? Is it a moral ideal? Or is it a way of being in the world? Caring has been discussed and described from each of these perspectives; yet little inquiry exists from a phenomenological inductive stance whereby caregivers, care receivers, and care observers are queried for their perceptions of caring.

The purpose of this study is to describe the inductive development and refinement of a factor-naming theory of the middle range, an empirically derived descriptive theory pertaining to the characteristics of a specified phenomenon.
Table 1. Definitions of the Five Caring Processes

<table>
<thead>
<tr>
<th>Study I</th>
<th>Study II</th>
<th>Study III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women Who Miscarried</td>
<td>NICU Caregivers</td>
<td>At-Risk Mothers</td>
</tr>
</tbody>
</table>

**Knowing**
- Identifies the woman’s desire to be understood for her experience.
- Striving to understand an event as it has meaning in the life of the other.
- Striving to understand an event as it has meaning in the life of the other.

**Being With**
- Illustrates the woman’s need to have others feel with her—not necessarily as her, but with her.
- Being With emotionally present to the other.
- Being With emotionally present to the other.

**Doing For**
- Describes the need to have others do for her (i.e., physical care).
- Doing For doing for the other as he/she would do for the self if it were at all possible.
- Doing For doing for the other as he/she would do for the self if it were at all possible.

**Enabling**
- Depends the need to have her grieving facilitated.
- Facilitating the other’s passage through life transitions and unfamiliar events.
- Facilitating the other’s passage through life transitions and unfamiliar events.

**Maintaining Belief**
- Focuses on the need to have others maintain belief in her capacity to get through the loss and to eventually give birth.
- Sustaining faith in the other’s capacity to get through an event or transition and face a future of fulfillment.
- Sustaining faith in the other’s capacity to get through an event or transition and face a future with meaning.

**Caring**
- Is a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility.

Note: Underlined = Proposed; Normal = Refined; Bold = Confirmed.

n = 20, 40 interviews.

n = 18, 35 interviews

n = 8, 8 interviews

Protection of human subjects was granted for each project, confidentiality was assured, and informed consent of participants was obtained.

Method: Phenomenology involves four basic steps: bracketing, intuiting, analyzing, and describing (Swanson-Kaufman & Schonwald, 1988; Ornery, 1983; Oiler, 1986). Bracketing is a conscious attempt by the investigator to remain critical and aware of the potential for personal bias and a priori assumptions that may skew the meanings intended by study participants. Intuiting is the result of the investigator’s remaining open to the meanings attributed to a phenomenon by those who have lived the phenomenon. The investigator need not have experienced the phenomenon personally; however, having solicited many personal accounts of the phenomenon’s existence, the investigator experiences the meanings as if the informants’ reality were his/her own. Intuiting engages the investigator’s self with the existence of those being investigated. Analysis involves the methods by which empirical accounts of a phenomenon are elicited (interviews and/or observations), documented (transcribed tape recordings and field notes), coded (sorted by topics addressed), and categorized into essential meaning components or processes (Swanson-Kaufman, 1986b). In the final phase of phenomenology, the phenomenon is described as the investigator has come to understand it. The description includes definitions of the essential meaning components (processes) and presentation of sufficient data to support the investigator’s conclusions. The findings are internally validated through the quotes of the study participants and externally validated through comparison to the literature. The ultimate test of validity of phenomenological inquiry is concept recognition on the part of research consumers. The validity of the investigation is supported if those who have experienced the phenomenon can recognize their own reality in the phenomenological description.

Study I: Caring and Miscarriage: Study I (Swanson-Kaufman, 1986a, 1988b) began with the question “What are the caring behaviors of others that are identified as helpful by women who have miscarried?” Twenty women who had recently miscarried were interviewed on two occasions. About two thirds of the way through data collection and phenomenological analysis, however, it became apparent that focusing on acts and behaviors was not only premature to understanding the conceptual processes of caring, but also a naive application of the phenomenological method—a method meant to interpret the meaning of lived experiences. Therefore, the research question that ultimately guided analysis was “What constitutes caring in the instance of miscarriage?” As summarized in Table 1 (first column), the outcome of the miscarriage study was the identification of the five caring processes and their preliminary definitions. These definitions were substantively tied to the clinical context of miscarriage and were awkwardly worded from the perspective of the ones cared for.

Study II: Caring in the Newborn Intensive Care Unit: In Study II (Swanson, 1990), the question posed was “What is it like to be a provider of care in the Newborn Intensive Care Unit (NICU)?” Data were gathered over the course of one year through participant observation of care provision, attendance at biweekly ethical rounds, and a total of 33 interviews with 19 care providers. Care providers interviewed included one nurse administrator, one biomedical ethicist, one social worker, five mothers, two fathers, four continuity physicians, and five primary nurses. Each of these informants was either a parent or professional caregiver to at least one of.
six very low birthweight infants. One of the outcomes of this NICU-based investigation was confirmation of the five caring processes and refinement of their definitions to more generalizable, less context-connected meanings that were worded from the perspective of the one caring. The refined definitions are listed in Table 1.

**Study III: Caring and the Clinical Nursing Models Project**

Interviewed in Study III (Swanson-Kauffman, 1988a) were eight of the 68 young mothers initially enrolled in the Mental Health Intervention Group in conjunction with Barnard’s Clinical Nursing Models Project (Barnard, Magary, Sumner, Booth, Mitchell, & Spieker, 1988). The purpose of the 18-month-long public health nursing intervention was to enable pregnant women who were at high social risk to take control of their lives and ultimately care of their infants. Despite the highly transient lifestyle of many of these young women, four years after their participation in the intervention protocol, it was possible to contact and interview eight of the mothers. The research question posed was “How do recipients of a long-term intensive nursing intervention recall and describe the nurse-patient relationship four years post intervention?” Through this study the five caring processes were confirmed, or in one category (maintaining belief), slightly refined; subdimensions of each process were identified; and ultimately an empirically derived definition of the overall concept of caring was proposed. The processes and overall definition are summarized in Table 1 (third column). The subdimensions of the caring processes are listed in Table 2.

**The Theory of Caring**

In the theory’s most recent form, caring consists of five categories or processes. They are: (a) knowing, (b) being with, (c) doing for, (d) enabling, and (e) maintaining belief. Although each of these categories is presented separately, the categories are not mutually exclusive.

**Knowing:** Knowing is striving to understand an event as it has meaning in the life of the other. When one is operating from a basis of knowing, the care provider works to avoid a priori assumptions about the meaning of an event; centers on the one cared for; and conducts a thorough, ongoing cue-seeking assessment of the experience of the one cared for. The provider begins with the premise that the desire is to understand the personal reality of the one cared for. Integral to knowing is the provider’s philosophy of personhood and the willingness to recognize the other as a significant being. When knowing occurs, the selves of both provider and recipient are engaged.

One of the mothers from the Clinical Nursing Models Project described how the nurse worked with her to get to her true feelings:

> When things weren’t right, I could say that things were fine and it was only a matter of time. I mean the nurse would ask certain questions and there would be no way that I could be consistent without telling the truth. And then we would talk, and pretty soon instead of saying it was fine, I would start out with what was really wrong.

In the NICU study, one group of parents described how much they wanted to be recognized for their experience and needs in the NICU. With the birth of their twin sons, the mother and father were in the unit for the third time. On two previous occasions, in the same hospital, they had experienced the deaths of children born prematurely. In the following quote, the father describes how the staff’s knowing their experience was essential to meeting their needs:

> They thought at first that we were being like resistive to learning...and it wasn’t until they found out that this was the third time in three years we’ve been here...[that] they started to figure out that the most important thing we wanted to find out immediately was the major things. We weren’t so concerned about movement and that kind of stuff, the major things we were concerned with was the oxygen, the respirators, and how they were doing feeling...I was going in there daily. We’d wash up, she’d reach in and touch them first and I’d go right to the charts and start reading.

External validity for the inductively derived category of knowing is found in the philosophical work of Noddings (1984) who examines caring in the contexts of teaching and parenting. In her book, Caring: A Feminine Approach to Ethics and Moral Education, she states: “Apprehending the other’s reality, feeling what he feels as nearly as possible, is the essential part of caring from the view of the one-caring” (p. 16).

**Being With:** The second caring process, being with, is being emotionally present to the other. It involves simply “being there,” conveying ongoing availability, and sharing feelings, whether joyful or painful. Yet, the presence and sharing are responsibly monitored so that the one caring does not ultimately burden the one cared for. Being with goes one small step beyond knowing. It is more than understanding another’s plight; it is becoming emotionally open to the other’s reality. The message conveyed through being with is that the other’s experience matters to the one caring.

A woman from the miscarriage study described how the nurse who cared for her during her dilatation and curettage was able to be with her:

> The male nurse—I think he helped me quite a bit because he
tried to comfort me as much as possible...he tried to be as gentle as possible...he even cried a little bit. He made me feel more like he cared. When they were using the vacuum cleaner, the little suction thing—that hurt quite a bit. I was gritting my teeth, waiting for it to be over, and he tried to comfort me and tell me that it was just about finished...He didn’t break down and not be able to do his job...He just kept saying, “It’s a matter of time.” You know, he was so sorry (Swanson-Kaufman, 1986a, p. 42).

In the NICU study, one nurse described how important it was to be with the infants she cared for:

Barrett was a chronic baby who died recently. I was one of his consistent people. I loved him and I really liked his parents. He went through everything, a terrible lung disease, he was blind, and then he died of SIDS...Some of these kids have such a short time and it isn’t appropriate to say, “Well, if they make it to two years old, we’ll start loving them.” They need it now...At least before that baby died he knew what it was like to be loved.

Noddings (1984) also provides validation of the being with category. She states that presence can occur even in physical absence. Engrossment in the other, regard, and desire for the other’s well-being are signs of presence (p.19).

**Doing For:** The third caring category is doing for. This entails doing for the other what he or she would do for the self if it were at all possible. Care that is doing for is comforting, anticipatory, protective of the other’s needs, and performed competently and skillfully. As Larson (1984) and Riemen (1986) have described, clients will oftentimes identify nurses’ doing for as those acts which are most appreciated. When a person is in a state of being that requires another to do for them, it can be very embarrassing. Consequently, the caregiver must consciously act to preserve the dignity of the other. As Gadow (1984) states, “Dependence upon another for care of the body constitutes an indignity only when the person cared for becomes an object for the caregiver” (p. 67).

Oftentimes, this type of dignity-preserving doing for must be delivered in an unobtrusive, easily forgotten manner. Bowers (1987) beautifully illustrated the dignity preservation inherent in doing for in her discussion of family caregivers’ well-thought-through schemes to maximize their aging parents’ capacity to practice self-care. Similar to the subdimensions of doing for, Bowers has identified five categories of caregiving: anticipatory, preventive, supervisory, instrumental, and protective.

The following quote is a description of doing for on the part of a husband whose wife just miscarried. She stated:

Tim went to the store and got me some sanitary napkins, which I hadn’t used in years...and he came home with every style that there is out there, it was like every kind in the world. I still have some! I was so hungry. And he was just real sweet...fixed me poached eggs, brought them to me in bed. We didn’t even really talk about it. We were both thankful I was O.K. He said, “All I really care about is that you’re all right” (Swanson-Kaufman, 1986a, p. 43).

Once again, support for doing for as a caring category may be found in Noddings (1984) work: “When we see the other’s reality as a possibility for us, we must act to eliminate the intolerable, to reduce the pain, to fill the need, to actualize the dream” (p. 14).

**Enabling:** The fourth caring category, enabling, means facilitating the other’s passage through life transitions and unfamiliar events. An enabling caregiver is one who uses his or her expert knowledge to the betterment of the other. The purpose of enabling is to facilitate the other’s capacity to grow, heal, and/or practice self-care. Enabling involves providing information and explanations as well as offering emotional support in the form of allowing and validating the other’s feelings. Enabling often includes assisting the ones cared for to focus on their concerns, generate alternatives, and think through ways to look at or act on a situation.

One mother from the Clinical Nursing Models Project described how the nurse validated her unsure beliefs about parenting:

Like I said I was really nervous after Tracy was born. So, I called the nurse up several times. My mother did not believe in breast-feeding. We had many heated arguments over it. My husband, he was like, “Nothing’s too good for my baby and doctors say that the breast is best.” So my mom and husband got into a few fights. But the nurse, she was always agreeable with everything that I felt and she could always back it up with her research.
Mayeroff (1971) supports the importance of enabling another's passage through transition times. He states: "To care for another, in the most significant sense, is to help him grow and actualize himself" (p. 1).

Maintaining Belief: The final caring process, maintaining belief, is sustaining faith in the other's capacity to get through an event or transition and face a future with meaning. This definition used to conclude with the words "of fulfillment." In Study III (Swanson-Kaufman, 1988a), however, interviews with women whose lives were riddled with challenges to merely survive revealed that fulfillment may be one step beyond reality for some human experiences. Caring that is maintaining belief, involves holding the other in esteem and believing in them. The one caring maintains a hope-filled (as opposed to hopeless) attitude and offers realistic optimism as they "go the whole distance with the other person." In nursing, maintaining belief is a pervasive part of our profession; nurses approach human responses as meaningful aspects of their clients' realities. Nurses seek to assist clients to attain, maintain, or regain meaning in their experiences of health and illness.

A young mother from the Clinical Nursing Models Project described how the nurse was there with her all the way:

I was not only pregnant, I felt very unattractive and I had the boyfriend or the partner to prove to you that he wanted nothing to do with me, and I got a lot of negative feedback from him. All the while I’m trying to keep real positive and yet feeling I’m failing and then Cindy would put me back up and I would keep going. And I did, I kept going.

In maintaining belief, the goal is not to give the other’s life meaning. Rather the one caring strives to know, be with, do for, and enable the other so that within the demands, constraints, and resources of the other’s life, a path filled with meaning will be chosen. According to Noddings (1984), although we cannot define others’ perfection, we must be “exquisitely sensitive” to their ideal of perfection and must act to promote that ideal (p. 102).

Caring: Definition and Discussion

Through three phenomenological studies, the five caring processes: knowing, being with, doing for, enabling, and maintaining belief were empirically identified and described. Ultimately, the following definition of caring was inductively derived: Caring is a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility.

Caring as defined through these three perinatal studies is very compatible with Gauth's philosophical analysis of caring. Gauth (1983) has stated that caring, at its very least, involves individual attention to and concern for another, individual responsibility for or providing for at some level, and individual regard, fondness or attachment.

Although caring is most likely an aspect of all socially supportive relationships, not all caring relationships are experienced as social support. The proposed definition of caring may be contrasted with Cobb's (1976) definition of social support: "Information that one is cared for and loved; that one is valued and esteemed; and that one belongs to a network of mutual obligation" (pp. 300–1). The caveat between caring, as defined through these investigations, and social support, as defined by Cobb, is at the point of mutual obligation. For example, mutually obligating, socially supportive relationships might include new mothers exchanging babysitting, neighbors borrowing sugar, classmates taking notes for each other, or co-workers sharing rides. In each of these instances, although a sense of caring might motivate the willingness to assist another, the assistance is offered with the implicit or tacit agreement that "you would do the same for me if I needed it." In contrast, if one considers the primary caring relationship—the parent-child relationship—the parent gives to the child from a sense of responsibility and love, not from the expectation that the child will pay back in kind for services rendered. The child may love back; however, the parent does not care with the expectation that the child will reciprocate. Similarly in nurse-client relationships, the nurse cares without obligating the client to reciprocate. As Norbeck (1984) has proposed, it is possible that the reason patients generally do not list health care providers as members of their social support networks is that patients do not (and hopefully should not) feel a sense of mutual obligation when professional caring is provided.

Leininger (1981) claims that "Caring is the central and unifying domain for the body of knowledge and practices in nursing" (p. 3). Yet, caring is not uniquely a nursing phenomenon. There may, however, be characteristic behavior patterns that are universal expressions of nurse caring. For example, Watson (1985, 1979) has identified 10 clarative factors and Benner (1984) has delineated eight dimensions of the helping role of the nurse. The factors and role dimensions are nursing acts that universally cut across client health conditions and developmental levels. The theory of caring, clarative factors, and helping role provide cross-validation for each other. Table 3 facilitates comparison and contrast among the caring processes, clarative factors, and helping role. Because the clarative factors and helping role are conceptually grounded in the caring processes, the theory of caring provides a meaningful base for why the clarative factors and helping role may be perceived as nurturing or helpful by nursing clients. The convergence of the caring processes with Watson's factors and Benner's helping role supports the claim that caring is a central and unifying nursing phenomenon; it does not, however, render the concept of caring as unique to nursing knowledge or practice.

Future Directions

A theory of caring has been derived through studies in three perinatal situations; it now needs to be examined for its applicability in other nursing and nonnursing contexts. The congruence of the caring processes with Watson's clarative factors and Benner's description of the helping role of the nurse provide evidence that the proposed theory of caring may have validity in nursing beyond the perinatal contexts from which it was derived. Furthermore, the data derived from other health professionals and parents in the NICU study and the congruence of the theory with some of the nonnursing literature (Mayeroff, 1971; Gilligan, 1982; Noddings, 1984) suggest that the proposed theory of caring may generalize to relationships other than those occurring just in nursing.

At present, a caring-based nurse counseling program for women who miscarry is being developed and tested (National Center for Nursing Research, R29 NR01899-04). Hopefully, this deductive application of the theory of caring will demonstrate the effectiveness of a caring-based intervention on women's health and, ultimately, document the capacity for caring to enhance healing and the potential to find meaning in human experiences of health and illness.
CALLS FOR PAPERS

Abstracts are invited for papers and poster sessions for the Fifth Annual NIMH International Research Conference on the Classification, Recognition, and Treatment of Mental Disorders in General Medical Settings sponsored by the Primary Care Research Program of the Services Research Branch, Division of Applied Services Research of the National Institute of Mental Health. The conference will be held on September 23–24, 1991 in Washington, DC. Deadline for submission is May 30, 1991. For further information contact: Junius Gonzales, MD or Kathryn Magruder, MPH, PhD, Fifth Annual Primary Care Research Conference, National Institute of Mental Health, Division of Applied and Services Research, Services Research Branch, Room 16Cl4, 5000 Fisherdes Lane, Rockville, MD 20857; 301/46/3303 or 3364.

Abstracts are requested for the 6th Annual Nursing Research Symposium: "Clinical Decision Making," sponsored by the University of Chicago Hospitals, Department of Nursing. The conference will be held on November 8, 1991 in Chicago, IL. Deadline for submission is June 1, 1991. For further information contact: Susan Nick, PhD, RN, Department of Nursing, Box 416, University of Chicago Hospitals, 5841 South Maryland, Chicago, IL 60637; 312/703-5497.

Abstracts are requested for the 18th Annual Research Conference presented by Saint Louis University School of Nursing and Delta Lambda Chapter of Sigma Theta Tau. The conference will be held in St. Louis, MO on October 4, 1991. Deadline for submission is July 1, 1991. For more information contact: Doris M. Edwards, RN, MSN, Saint Louis University School of Nursing, 3325 Caroline St, St. Louis, MO 63104-1093.

Abstracts are invited for the Sixth Annual Research Conference of the Southern Nursing Research Society. The conference will be held February 6–8, 1992 in Nashville, TN. Deadline for submission is July 1, 1991. For more information contact: Barbara J. Holzclaw, PhD, RN, Center for Nursing Research, Vanderbilt University School of Nursing, Nashville, TN 37240; 615/343-4370.

Abstracts for poster sessions are requested for the Sixth National MNC Convention, sponsored by MNC, The American Journal of Maternal/Child Nursing to be held March 1-4, 1992 in Atlanta, GA. Deadline for submission is July 31, 1991. For more information contact: Susan Sloan, The MNC Convention, George Little Management, Inc., 2 Park Avenue, Suite 1100, New York, NY 10016; 212/696-6070, ext. 218 or 212/340-9218.


Abstracts are invited for the 17th Annual Conference of the American Academy of Ambulatory Nursing Administration/AAANA Research Forum to be held on March 5–8, 1992 in San Antonio, TX. Deadline for submission is September 15, 1991. For further information contact: AAANA National Office, North Woodbury Road, Box 56, Pittman, NJ 07501; 905/692-9617.

Abstracts are invited for "Research-Based Nursing Education," a conference sponsored by St. Louis University School of Nursing to be held in St. Louis, MO on May 18–19, 1992. Deadline for submission is December 2, 1991. For further information contact: Irene Kahns, RN, EdD, Director, Nursing Continuing Education, St. Louis University School of Nursing, 3525 Caroline Avenue, St. Louis, MO 63104.
Nursing as Informed Caring for the Well-Being of Others

Kristen M. Swanson

Assumptions about four main phenomena of concern to nursing (persons/clients, health/well-being, environments and nursing) are presented and an elaboration is made of the structure of a theory of caring. The issues that arise when nursing is viewed as “informed caring for the well-being of others is also examined.”

(Keywords: caring; theory construction/model building; nursing process; nurse-patient relationship)

Caring is the roar that lies on the other side of silence. When the mist lifts, nurses can find new images of caring (Watson, 1987, p. 16).

Nursing is informed caring for the well-being of others. As Carper (1978) has noted, nurse caring is informed by empirical knowledge from nursing and the related sciences, as well as ethical, personal and aesthetic knowledge derived from the humanities, clinical experience and personal and societal values and expectations.

Assumptions Underlying Caring

Persons/Clients

Watson (1985) proposed that how nurses view persons and define personhood sets the stage for who the clients of nursing are, and what constitutes the practices, environments and goals of nursing care. Persons are unique beings who are in the midst of becoming and whose wholeness is made manifest in thoughts, feelings and behaviors. The experienced life of each person is influenced by a genetic heritage, spiritual endowment and the capacity to exercise free will. Persons in their wholeness are not stagnant; rather, as Travelbee (1971) has noted, they are becoming, growing, self-reflecting and seeking to connect with others. Persons both mold and are molded by the environment in which they exist. The genetic heritage serves as a blueprint for each person’s unique human characteristics. The spiritual endowment connects each being to an eternal and universal source of goodness, mystery, life, creativity and serenity. The spiritual endowment may be a soul, higher power/Holy Spirit, positive energy, or, simply grace. Free will equates with choice and the capacity to decide how to act when confronted with a range of possibilities. While acknowledging free will does mandate that nurses honor individuality, it may also delude us into believing that the “range of possibilities” are equally available, acceptable and desirable to all persons. Practice based on such parochial ego-centric assumptions have historically lead health care providers to label wrongfully clients as irresponsible and non-compliant, set up health care delivery systems that are convenient to providers versus accessible to consumers and sacrifice client centered care at the altars of technology, economics and provider egos.

Schultz (1987) has identified that the “other” whose personhood nurses attend to may be individuals or aggregates (i.e., families, groups or societies). Most often, the “other” will be a specified individual or aggregate, however, it may also be a generalized other. For example, the generalized other may be future generations or social issues such as freedom of speech, human rights or access to health care. One last additional class of other/person/client to whom nurses attend is actually an awkward use of the word other and refers to

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care of self. Self-as-other refers to the well-being of each nurses' self and her/his nursing and the well-being of all nurses and their nursing.

Environment
Environment is defined situationally. For nursing, it is any context that influences or is influenced by the designated client. Realms of influence are multiple, including the cultural, political, economic, social, biophysical, psychological and spiritual realms. When examining the influence of environments on persons, it is helpful to consider the demands, constraints and resources brought to the situation by the participant(s) and the surrounding environment (Klausner, 1971). What is considered client in some situations, may serve as context or environment in other circumstances. For example, in some nursing care situations the community may be the client (i.e., nurses acting politically about the need for safe play areas for inner-city children), at other times it may be the environment (i.e., nurse assessment of how the school system accommodates the needs of a specific child with a chronic health condition.) For heuristic purposes the lens on environment/designated client may actually be further specified to the intra-individual level, wherein the “client” may be at the cellular level and the environment may be the organs, tissues or body of which the cell is a component.

Health/Well-being
Smith (1981) has delineated four views of health that include health as: absence of illness; ability to perform one’s roles; capacity to adapt; and as the pursuit of eudemonistic well-being. Nurses focus on how clients are living with whatever illness or wellness condition they may be in. As nurses our focus is not so much on disease amelioration, per se, as it is on assisting clients to attain, maintain or regain the optimal level of living or well-being they choose given their personal and environmental demands, constraints and resources. Well-being is living in such a state that one feels integrated and engaged with living and dying. When nurses focus on health as well-being, our care must take into account what it means to be whole persons who are becoming, growing, self-reflecting and seeking to connect with others.

To experience well-being is to live the subjective, meaning-filled, experience of wholeness. Wholeness involves a sense of integration and becoming wherein all facets of being are free to be expressed. Facets of being include the many selves that make us human: our spirituality, thoughts, feelings, intelligence, creativity, relatedness, femininity, masculinity and sexuality, to name just a few. Healing, the process of reestablishing well-being, includes releasing inner pain, establishing new meanings, restoring integration and emerging into a sense of renewed wholeness.

Health, illness, deviance and pathology are socially defined phenomena. As so defined, they are influenced by societal values, political ideations, cultural norms and economic conditions. Socially defined phenomena frequently wreak havoc with the becoming and healing necessary to the realization of well-being. For example, when a woman miscarry a desired pregnancy her spiritual, maternal, feminine and sexual selves are challenged to reestablish meanings that allow her to experience a renewed sense of integration wherein her personal biography includes the experience of having miscarried a longed-for child. The seeking and becoming of well-being requires a safe space for acquiring information, releasing the pain of sadness and fear and expressing longing for the lost loved one. When no such arena exists and the woman is given socially defined dictums of what is normal (i.e., “At your age, it was a blessing;” “It’s been two months, aren’t you over that yet?”), her attempts at reestablishing well-being are thwarted. Her many selves are left disintegrated and a feeling of wholeness is replaced with one of inadequacy.

Nurses and Informed Caring
Nurses “diagnose and treat human responses to actual or potential health problems” (American Nurses Association Social Policy Statement, 1980). This description clarifies our functional role to the publics we serve and underscores the importance of nurses providing care to clients (individuals or aggregates) who are currently dealing with or potentially facing health deviations. But this language does not, capture the essence of nursing’s values, history, expertise, knowledge, universality and passion. Those whom we serve, how we serve and why we continue to serve mandate an impassioned integration of science, self, concern for humanity and caring. Consummated in transactions among nursing and society and each nurse and client are the profession’s commitments to caring, the preservation of human dignity and enhancement of well-being for all.

Informed nurse caring ranges from having novice to expert capacity in practice. As Benner (1984) has noted, novice nurses may care very deeply about the well-being of others, yet their repertoire of caring therapeutics may be somewhat constricted. For example, in order to proceed safely, novice nurses may need to restrict their definition of other to “this patient’s wound,” and their definition of well-being to “infection and pain avoidance.” In contrast, the informed expert nurse would view the other as an individual who is ultimately capable of managing her own wound. The expert would modulate care between what she/he needs do to assure safety and what the client must do to learn self-care. An expert nurse has a deeper understanding of what constitutes well-being, a broader scope of caring practices, and a wider view of who or what constitutes “the other.”

The techniques and knowledge embedded in nurse caring often are so subtle as to remain virtually undisclosed to the uninformed observer. For example, when a newborn intensive care unit nurse places a pacifier in a preterm infant’s mouth a minute or two prior to diapering (for the compromised infant an energy draining activity), unless one appreciates the importance of non-nutritive sucking as a self-soothing, oxygen conserving infant self-care behavior, the rationale for the nursing therapeutic of pacifier placement would be glanced over. When, in fact, the nursing act was based on esthetics, a sense of the whole of what works for this infant’s overall well-being; caring ethics, which raised the child from the
moral status of object to one of a person whose self-soothing abilities mattered; empirical evidence, which demonstrates that non-nutritive sucking can lessen neurobehavioral disorganization in the face of manipulative interventions; and self-knowledge, or the nurses’ sense of how she/he would wish to be treated were she/he in the infant’s position.

As Reverby (1987) has noted, just as nursing knowledge is hidden in caring acts, the acts themselves are likewise frequently hidden, undervalued and under rewarded. Some of the reasons that nurses, their knowledge and their nursing are so little appreciated and greatly concealed include: The fact that nursing is frequently dismissed as “women’s work;” caregiving tasks often are viewed as coming from the heart and not from the brain; nursing is perceived by many as an extension of medicine involving technical skills and a willingness to obey; and our society values curing disease and circumventing death over preventing health problems, enhancing life quality and preserving personal dignity.

It takes a person schooled in “nursing appreciation” to fully see the beauty in expert nursing practice. For some, the appreciation comes from having been the recipient of expert nursing. In those instances, the appreciative audience has a non-indexical way of defining care and resorts to superlatives (Great! Wonderful! So caring!) to capture the beauty of their experience. For others, nurses, appreciation comes from formal education and clinical practice wherein we know good nursing when we see it; yet we, too, may be without words if good nursing is what we routinely practice. In other words, good nursing is the cultural norm and as such is difficult to describe from within the culture. Disseminated nursing appreciation must come from those (nurses and non-nurses) who deliberately observe and in the words of their own disciplines say back to nurses and their care recipients just what is precious about nursing. Some of the products of “nursing aficionados” have included Notes on Nursing, (Nightingle, 1859); Ordered to Care (Reverby, 1987); The Cancer Unit: An Ethnography (Germain, 1979); Intensive Care (Heron, 1987); Midwife and Other Poems on Nursing (Krysl, 1989); From Novice to Expert (Benner, 1984); A Family Caregiving Model for Public Health Nursing (Zerwekh, 1991) and Providing Care in the NICU: Sometimes an Act of Love (Swanson, 1990). Not all of these “nursing appreciation majors” are nurses, thus suggesting that nursing (informed caring for the well-being of others) may be observed, understood and interpreted by those who are willing to thoughtfully observe and inductively describe nurses and their practice.

Making the claim that nursing is informed caring for the well-being of others does not mean that only nurses are caring, and that all nursing practice situations may be characterized as caring. It also does not suggest that nursing is the only profession whose practice involves informed caring. What it does claim is that the therapeutic practices of nurses are grounded in knowledge of nursing, related sciences, and the humanities, as well personal insight and experiential understanding and that the goal of nurse caring is to enhance the well-being of its recipients. It is the blend of knowledge/information and the goal of practice that distinguishes nursing from others whose practices includes caring.

The Structure of Caring

In 1991, I described a middle range theory of caring that was empirically derived through phenomenological inquiry in three perinatal nursing contexts. Citing corroborative nursing and non-nursing literature, it was postulated that the theory may have generalizability beyond the perinatal contexts studied and beyond the practice of nurses only. Since publishing the theory of caring, it has become apparent that a limitation is a lack of structure to the theory as to how the five proposed caring processes relate to each other. In this section, in addition to reviewing the major components of the theory of caring, a structure is proposed and justified for my theory of caring.

The five caring processes and sub-dimensions are not suggested to be unique to nursing, they are proposed as common features of caring relationships. Caring is defined as “a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility” (1991). Key words in this definition include: nurturing (growth and health producing); way of relating (occurs in relationships); to a valued other (the one cared-for matters); toward whom one feels a personal (individualized and intimate); sense of commitment (bond, pledge, or passion); and responsibility (accountability and duty). Whereas this definition applies to all caring relationships, relationships of central concern for nursing include nurse to client, nurse to nurse, and nurse to self. In keeping with the overall purpose of this manuscript (to deal with the claim that nursing is informed caring for the well-being of others) the remaining discussion of the caring theory is restricted to its applicability to nursing.

Maintaining Belief

An orientation to caring begins with a fundamental belief in persons and their capacity to make it through events and transitions and face a future with meaning. As illustrated in Figure 1, maintaining belief in persons is at the base of caring, it is from this stance that nurses define what matters and where to address care. Whether nurses articulate it, clients are approached with a conviction that there is personal meaning to be found in whatever health condition or developmental challenge the person is facing.

Maintaining belief is a foundation to the practice of nurse caring. It is sustaining faith in the capacity of others to get through events or transitions and face a future with meaning that initiates and sustains nurse caring. Such an orientation fuels nursing and nurses to a commitment to serve humanity (in general) and each client (in specific). On the societal level, it is belief in the rights of all people to get through events and face a meaningful future that motivates nurses to political activism around such matters as access to care and the need for health care reform. On the interpersonal level, maintaining belief is evident in the case of a nurse who cares for a couple laboring to birth their stillborn daughter. In this example, the nurse’s care centers on monitoring the mother’s...
physical and emotional safety while assuring the couple’s long-term healing. The nurse sustains faith that the couple, with her guidance, will safely and humanely get through the immediate birth and death. Fundamentally, the nurse believes in the family’s capacity to create both a dignified passage for their child and a meaning-filled future for themselves: a future wherein their daughter and her birth and death will have a peaceful, permanent meaning in their family’s day to day existence.

Knowing

If maintaining belief is at the base of nurse caring, knowing is the anchor that moors the beliefs of nurses/nursing to the lived realities of those served. Knowing is striving to understand events as they have meaning in the life of the other. Knowing translates the idealism of belief maintenance into the realism of the human condition. It involves avoiding assumptions, centering on the one(s) cared for, thoroughly assessing all aspects of the client’s condition and reality, and ultimately engaging the self or personhood of the nurse and client in a caring transaction. In effect, nurse knowing sets the potential for the nursing therapeutics of being with, doing for and enabling to be perceived as relevant and, ultimately, effective in promoting client well-being.

The efficiency and efficacy of knowing as a caring therapeutic is enhanced by empirical, ethical and aesthetic knowledge of the range of responses humans have to actual and potential health problems. Formal nursing education that includes content on physical, cultural, spiritual, and emotional responses to conditions of wellness and illness prepare nurses to throw a wide net when casting for any one client’s lived reality. Experience with clients with similar conditions, or a given client under differing conditions, hones a nurse’s capacity to know the meaning of an event in a given client’s life. A nurse’s knowledge of self sets the stage for how willing a nurse is to truly know another’s reality and just how capable she/he is to contain her/his needs and center on the client’s lived reality. On a disciplinary level, nurses’ clarity on our own perspectives and contributions, sets the agenda for nursing scholarship and promotes the potential for truly knowing and serving the health needs of society.

Being With

Being with, being emotionally present to other, is the caring category that conveys to clients that they and their experiences matter to the nurse. Emotional presence is a way of sharing in the meanings, feelings and lived experience of the one-cared for. Being with assures clients that their reality is appreciated and that the nurse is ready and willing to be there for them. Being there includes not just the side-by-side physical presence but also the clearly conveyed message of availability and ability to endure with the other. For inpatient nursing, the call bell that is accessible and readily responded to is a type of being there. For nurses who work in community or outpatient settings there are several methods of conveying “you are not alone, what happens to you matters and that we are here for you.” Some of these methods include sharing clinic phone numbers and permission to call anytime, giving nurse pager instructions and assurance of immediate access, and even arranging for electronic mail computer linkages between rural home-bound clients and urban health care facilities.

To be with another is to give time, authentic presence, attentive listening and contingent reflective responses. In many ways to be with another is to give simply of the self and to do so in such a way that the one cared for realizes the commitment, concern and personal attentiveness of the one caring. Being with ranges from offering a joyful cheer at birth, to crying with the bereaved, to sharing the frustration of a family caregiver, to carrying a 24-hour beeper so that the adolescent with leukemia knows that his nurse is just a phone call away.

When being with nurses do so, with a sense of responsibility toward both the client and self, remaining ever aware of who is provider and who is recipient in any given clinical situation. There is a fine line between sharing the other’s reality and taking on that reality as your own. When such boundaries are crossed, painful outcomes are bound to ensue. Failure to remain
responsible to client and self results in nursing care that burdens clients, lessens the nurse's well-being and ultimately diminishes the nurse's personal and professional relationships and role performance. Given that nurses work in settings where the best and worst life has to offer can be commonplace, nurse administrators must set up organizations that take into account the need to care for and promote caring among nurses. In order to care without burdening themselves, their clients or their families, nurses must get their work related needs met through self-care and communities of caring in which the interpersonal work ethic is to be there for each other.

Doing For
Virginia Henderson captured the essence of doing for in her often quoted definition of nursing:

The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will, or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible. (Henderson, 1966).

Doing for, simply put, is doing for the other what they would do for themselves if it were at all possible. Doing for involves actions on the part of the nurse that are performed on behalf of the client's long term well-being. There is an efficaciousness to these actions, wherein the nurse acts ultimately to preserve the other's wholeness. Short-sighted, misplaced efficiency occurs when the actions are solely toward immediate preservation of the caregiver's time, energy or finances. Classic health care examples of not doing for include administering prematurely an episiotomy on behalf of the mother's loving gaze, nurturing milk and bodily warmth. The one from undo harm and ultimately preserving the dignity of capable the woman is to act on her own behalf. If it is clear that the woman is in danger and that it took all the woman had within her to even voice a desire to “quit using,” the nurse might dial the substance abuse hotline for her and hand her the phone (being aware that while the woman herself must talk, she needed that extra boost to access help). If, on the other hand, the woman states she is ready to quit and would like to know where to begin, the nurse might assess whether to offer the woman a narrow range of choices (“Here are pamphlets on two treatments programs within your city. I will check back tomorrow to see which one you called.”); broad options (“Look in the yellow pages under “A” for alcoholism. Call me Thursday morning and we can talk about your decisions.”); or simply a wide open response, such as “How may I be of assistance to you?” In each case, the level of nurse directiveness is the result of balancing the nurse's recognition that the woman must act on her own behalf with an understanding of the demands, constraints, and resources offered by the woman's life and environment. Doing for in each of these public health nursing examples is a balancing act between doing for the woman what she would do for herself if she had the knowledge and/or resources to do so and facilitating the woman's ultimate desire to realize life long sobriety.

Enabling
Ultimately nurse caring is about enabling others to practice self care. Enabling is defined "as facilitating the other's passage through life transitions and unfamiliar events" (1991). Enabling includes: coaching, informing and explaining to the other; supporting the other and allowing her/him to have her/his experience; assisting the other to focus in on important issues; helping her/him to generate alternatives; guiding her/him to think issues through; offering feedback; and validating the other's reality. As with doing for, the goal of enabling is to assure the other's long-term well-being.

Unfortunately, the term enabling has come to have a negative meaning in the popular vernacular of the mental health community. The term enabling often connotes a negative action in which the provider sets up or maintains a situation in which the other may sustain an unhealthy way of being. This popular use of the term enabling suggests that the provider may actually act as co-dependent to the other's pathological choices. Whereas this was never the intention of Swanson's labeling of this category, the term does, nonetheless, lend itself to offering a built-in warning to the potential pitfalls of caring. In many ways "enabling" highlights the two sides of the caring coin: one in which the self of both caregiver and recipient are enhanced by the care provider's actions and the opposite in which the self of provider and recipient are diminished by the provider's misdirected actions. Any discussion of caring in nursing must begin and end with the awareness of where professional responsibilities lie (to self and other); what constitutes nurturance versus diminishment (of self and other); how the boundaries of personal and professional roles are delineated; and when and where to seek support for the demands of caring.
The ultimate goal of nurse caring is to enable clients to achieve well-being. The potential for well-being rests on the capacity to practice self-caring to the fullest extent possible. As Orem (1980) and Henderson (1966) have suggested, sometimes enabling involves substitutive care (doing for the other what they are unable to do for themselves)—but doing no more than is necessary to conserve the client's energy or preserve the client's dignity. At other times enabling involves creating an environment in which self-healing can occur (similar to Nightingale's [1859] notions of providing an environment in which the body's inherent healing tendencies can operate). Sometimes it is the client's internal environment (i.e., self concept, knowledge or skills level) that is altered in order to enable healing; at other times it is the external environment that is manipulated (i.e., provision of safety devices, removal of physical, social or emotional threats or obstacles). No matter what form the enabling intervention might take, it gains the title "enabling" by virtue of its intended function: to facilitate the other's passage through difficult events and life transitions.

Conclusion

My dual purpose has been to justify the claim that "Nursing is informed caring for the well-being of others" and to further explicate an empirically derived theory of caring.

This theory delineates five overlapping processes that are best discussed as dimensions of one overarching phenomenon: caring. Mutual exclusivity amongst the processes does not exist and, in fact, their relationship to each other may be hierarchical. The proposed structure for the theory depicts caring as grounded in maintenance of a basic belief in persons, anchored by knowing the other's reality, conveyed through being with, and enacted through doing for and enabling.

When time is taken to observe and interpret nurses' actions, it becomes clear that nursing practice is the result of blended understandings of the empirical, aesthetic, ethical and intuitive aspects of a given clinical situation and a nexus of maintaining belief in, knowing, being with, doing for and enabling the other. Several examples were offered that illustrate that nurse caring frequently consists of subtle, yet powerful, practices which are often virtually undisclosed to the casual observer, but are essential to the well-being of its recipient.

References