

Complementary (Integrative) Theorizing (excerpts from an upcoming chapter in the 5th edition of *The Neuman Systems Model* (5th edition, Neuman, B & Fawcett, J, Eds) by Kolcaba, K. & Kolcaba, R. Integrative Theorizing: Linking Middle-Range Nursing Theories with the Neuman Systems Model.)

Like so many new ideas, the seeds for this chapter were planted at a nursing conference. The conference focused on the Neuman Systems Model (NSM) and, after many presentations, discussions were lively and forward thinking. While most of conference presentations focused on applications of the NSM in different cultures and settings, a few presentations offered compelling reasons for adding the explanatory power of alternative middle range (MR) theories which were thought to “complement” Neuman’s conceptual model. Discovering links and insights between appropriate middle range theories and the NSM became intriguing to some of us and benefits of doing so became apparent.

This type of theorizing consists of juxtaposing two levels of theory: the example used here is the juxtaposition of the NSM (a grand theory) with Comfort Theory by Katharine Kolcaba (a mid-range theory). This example represents a departure from what has been done before with shared and borrowed theories, because both the NSM and Comfort Theory originated within nursing and both retain their unique and original identities after integration. The general benefit for this juxtaposition is that additional insights are created, contributing to a more comprehensive vision of nursing practice and research that was not apparent in either the NSM or Comfort Theory by itself.

To name this process, I utilized Meleis (2007) who proposed in her fourth edition of *Theoretical Nursing* that an “integrative view of truth” represents a natural evolution for nursing knowledge because it denotes a holistic way of thinking and being a nurse. An integrative view of truth takes into account more than one perspective, justification,

pattern, or explanation when examining nursing problems and their solutions. An integrative view is based on perceptions of both patients and nurses and better enables researchers and practitioners to identify, define, address, and measure discipline-driven quality care outcomes. Thus, I use the term, *integrative theorizing*, to describe the process of deriving insights from the NSM that provide additional explanatory capabilities for Comfort Theory, while Comfort Theory adds definition and measurement capabilities to the NSM. The example given in this chapter can be used as a prototype for future integrative theorizing using other pairs of models and theories at different levels of abstraction and at least one of which can be from other disciplines.

Criteria for Compatibility

Several heuristic criteria can be applied to determine compatibility. What sorts of factors should be considered?

1. Shared assumptions. These assumptions pertain especially to the metaparadigm concepts: health, person, environment, and nurse. (If one of the pairings is borrowed from an outside discipline, the concept of nurse is excluded.) The kinds of questions to raise about shared assumptions are as follows: Do both views describe persons as holistic beings or as possessing particularistic systems? Do both views describe recipients of care as a community, a group, a family, or an individual? Do both views hold that the environment *blends* with the recipient(s) of care, as with energy fields, or that there are natural boundaries between the environment and the recipient(s)? Is health defined by both views as a continuum that encompasses chronic illness, death, and deficits or as a state of well being defined by a person and his/her family, an employer, a medical system, or politics.

2. Cultural applicability. Are both conceptualizations appropriate for the mix of cultures inherent in health care research today? In which culture(s) has the CM and MR theory been applied and found to be generalizable? This is a particular burden for trans-cultural research because most nursing theories, as systems of concepts, presently originate in the English language and by Western nurses. Integrating the NSM with a MR theory from a non-Western culture would help bridge that gap. (While Comfort Theory originated in the United States, the concept of comfort has trans-cultural direct translations and understanding.)

3. Disciplinary boundaries. Are both parts of the pairing limited to the discipline of nursing, or does one come from another discipline? Perhaps one of the pairings has language that is appropriate across disciplines, bridging disciplinary barriers inherent in non-standard specialized language.

4. Nursing education. Is the pairing suitable or parallel for enlightening or completing the nursing process which remains a standard in nursing education? And will the pairing render one or both systems more translatable to electronic data bases found in clinical settings where students learn how to document their observations, interventions, and results?

5. Focus of care. Are both parts of the pairing suitable for the targeted care setting such as illness or trauma care, preventive care, long term care, home care? Are both views suitable for targeted populations such as pediatrics, gerontology, women's or men's health care, psychiatric care, and other sub-populations such as cognitively impaired, out-of-control, unconscious or dying patients?

7. Process or product distinction. Do both parts of the pairing describe the process of patient care or the desired outcomes (product) of quality health care? Or, does the process-oriented part inform the outcome-oriented part whereby one describes actions and behaviors of health care providers as interventions while the other describes desirable, measurable, and logical outcomes related to those actions?
8. Shared values. Are techniques for establishing therapeutic relationships between health care providers and patients important in each part of the pairing? Does the pairing further inform providers about ways to perceive patients, interpret their needs, and provide a therapeutic presence? Does one part of the pairing describe ways of *being* a nurse?
9. Scientific orientation. Are the research methods inherent in each part similar or commensurable? Are those methods suitable for the specific research problem and the gathering of evidence for practice?

Giving consideration to the above questions is a fluid process with much give and take. The objectives of an inquiry decide if a suitable degree of compatibility exists. If a nurse seeks only a few insights among the levels of theory, then only some compatibilities may suffice. If a rather thorough integration of the pairings is sought, however, then most of the compatibility questions should be addressed. In the latter case, if only one or two of the criteria are met, then it may be more fruitful to think about a different pairing.

Example of Integrative Theorizing Utilizing the NSM and Comfort Theory

In a recent study, the effects of healing touch (HT) and coaching were measured in three groups of younger college students who self-identified as having symptoms of situational stress (Dowd, Kolcaba, Steiner, & Fashinpaour (2007). The authors stated that

Comfort Theory (Kolcaba, 2003; Kolcaba, on line) at the MR level, guided the research from design of the interventions to selection and measurement of desired outcomes, which were reduced stress-related symptoms and increased holistic comfort. The findings were that HT had better immediate beneficial results on stress and comfort, but had minimal carry-over effects. The coaching group had short term effects that were similar to the HT group, but more sustained long term effects. The group that received both interventions had “inconsistent” findings that were difficult to explain by Comfort Theory alone; that is, students in the combined group demonstrated less comfort and more stress symptoms 10 days (Time 3) after the last set of interventions than did the coaching group. Some students in the combined group stated anecdotally that coaching was better for stress management, and that HT was better for comfort. However, comfort was not sustained by the HT group or the combined group at time 3 while the coaching group continued to improve on comfort (Dowd, Kolcaba, Steiner, & Fashinpaour, 2007).

In post hoc integrative theorizing, the NSM (Neuman & Fawcett, 2002 & on line) provided the following explanatory insight for the recalcitrant data. As designed, the HT intervention did not include instructions in practices that would help maintain the immediate benefits of HT reported by students who received it. On the other hand the interventions of coaching, by definition, entailed maintenance strategies⁹ and when added to the HT intervention (as in the combined group), the coaching intervention provided necessary strategies for maintenance of stress management techniques but not for maintenance of HT techniques (Dowd, Kolcaba, Steiner, & Fashinpaour, 2007). Neuman emphasized maintenance in her broad definition of “tertiary care.” Her CM included

insights about practitioners who provide tertiary care to maintain stability gained from beneficial effects of treatments, after primary and secondary care have been given.

Had all students received some measure of tertiary care, the students in the HT group might have demonstrated stronger carry over effects from their intervention. Additionally, the combined group might have demonstrated the strongest positive effects on both stress and comfort compared to the other groups, as was expected when pairing these complementary therapies. Furthermore, the outcome of comfort would have been placed in a broader context if it had been conceptualized as a mediator for client stability and a moderator for client reconstitution. Both of these latter concepts from the NSM would also have gained operational status. Had Comfort Theory and the NSM been integrated, the abstract concepts from the NSM would then be more easily operationalized by other disciplines interested in stress management. In this example, NSM had more conceptual richness than did the MR theory, which was the initial organizing framework.

Figure 1 is a Venn diagram which shows a central intersection when the NSM (Neuman & Fawcett, 2002 & on line) and Comfort Theory (Kolcaba, 2003; Kolcaba, on line) are paired using integrative theorizing. The central area depicts shared foundational elements such as philosophical roots, assumptions, insights, values, and focus. The outer rings respectively depict areas that can inform the synergistic partner in order to more fully describe and develop evidence for practice. The bolded elements in the diagram depict insights relevant to the study with college students cited here. Examples of additional general conceptual leaps that could be applied to other research programs, are listed below the diagram. New explanations of recalcitrant data can be formulated

through this type of diagram which facilitates solutions, beginning with more complete definitions of concepts/constructs that are necessary to fill in the blanks in the recalcitrant data.