A Taxonomic Structure for the Concept Comfort

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The concept of comfort is an important one for nursing, but because of its complexity, it has not been analyzed, operationalized or structured for nursing science. In this paper, three technical senses of the term are derived from: (a) contemporary and archaic lexical entries; (b) analysis of how the concept is used in contemporary and historical nursing literature; and (c) theoretical support found in the disciplines of nursing and ergonomics. Next, the contexts of patients' needs are explored and four contexts are derived from the nursing literature on holism. When the three senses and the four contexts of needs are juxtaposed, a 3 X 4 grid with 12 elements emerges that encompasses the total domain of patient comfort. Each element describes an aspect of comfort from which empirical indicators, antecedents, consequents and test items can be developed. The grid represents a taxonomic structure of the concept that organizes the meanings of this complex concept. The structure can be used to develop comfort pretests as the nurse assesses possible needs in a given situation and to develop comfort post tests, to assess the effectiveness of comfort measures.

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Although comfort is a central concept for nursing, its contextual meaning is vague because there are many meanings of the term, some of which can apply simultaneously in a given situation. Comfort is frequently used when describing the art of nursing, such as in Donahue's statement, "It is through comfort and comfort measures that nurses provide strength, home, solace, support, encouragement and assistance... (1989, p. 7)." The term is an important one in the theories of Watson, Roy, Orlando, and Paterson and Zderad, and for many years was used in classification schemes for nursing diagnoses. For a more complete historical account of the use of comfort in nursing, see Kolcaba and Kolcaba (1991).

The term also has many different forms, such as comfortable, comforting, discomfort, comforted and comfort measures. In spite of the frequency and importance of its use in nursing, it is not yet theoretically defined or operationalized for nursing science. Indeed, it fits Ellis' description of "a concept that exists, that is associated with nursing, that has been felt to be rather specific to nursing, but that we have not yet made explicit, nor yet fully conceptualized" (1969, p. 1438). Therefore, the purpose of this paper is to identify, define and organize the aspects of comfort in such a way that they are consistent with the subjective experience of patients.

Review of the Literature

The organizing framework for structuring the many meanings of comfort for nursing is based on patients' needs in health care settings. Because the term comfort is ambigu-
ous, understanding it is predicated on analyzing the context of use. If the comfort needs can be structured, then the structure of comfort can follow in similar pattern.

The literature review is grounded in the semantic analysis of comfort, first as the term is used in modern English, and second, as it is found in archaic English. The common meanings of the term are the primary ones used in nursing and are the origins of two of the proposed technical senses. The last two definitions that are listed are obsolete in ordinary language, but are the origin for a third technical sense (Kolcaba and Kolcaba, 1991).

**Meanings of Comfort in Ordinary Language**

Four meanings of comfort are in contemporary English. The first is comfort as a cause of relief from discomfort and/or a cause of the state of comfort. This meaning is synonymous with a “comfort measure” because it denotes a cause of comfort. In nursing practice, comfort measures are initiated in response to a specific comfort need; if the measure is successful, the need is met and the outcome is comfort. It follows that this meaning can be eliminated from further consideration because comfort measures are actually the consequences of comfort needs and the antecedents of comfort outcomes.

The second meaning of comfort is a state of ease and peaceful contentment. Agents, such as nurses, often remove the cause of a potential discomfort in order to prevent the state of discomfort; that is, they identify and eliminate a source of discomfort before the patient experiences discomfort. Thus, the state of comfort can exist without a prior state of discomfort.

The third meaning of comfort is relief from discomfort. While the relief itself is a comfort, it need not be tantamount to a state of comfort; it may be relief that is incomplete, partial or temporary. In the first case (comfort as relief), it may be relief from just one of many severe discomforts. Secondly, it may last only a short time until discomfort arises again. By contrast, the state of comfort (meaning #2) presupposes the absence of severe discomforts, complete relief from discomforts and lasting rather than temporary relief from severe discomforts.

The fourth meaning of comfort is whatever makes life easy or comfortable. This meaning refers to the goal of maximizing pleasure and, for this reason, is not applicable to nursing science. It is thus eliminated from further consideration in this analysis.

The etymology of comfort reveals two obsolete meanings that come from the Latin word “confortare” meaning “to strengthen greatly.” From the *Oxford English Dictionary*, these meanings are: (a) comfort as strengthening, encouragement, incitement, aid, succor, support, countenance (meaning #5); and (b) comfort as physical refreshment or sustenance, or a refreshing and invigorating influence (meaning #6). Both indicate renewal, amplification of power, a positive mindset or readiness for action. It will be demonstrated that both obsolete senses, when combined, are consistent with a third technical sense for nursing.

The three senses that are relevant for a structure of comfort, as derived from lexical entries, are: (a) a state of ease or contentment; (b) the state of having a specific discomfort relieved; and (c) the state of having been strengthened or invigorated. These senses are evident in the five comfort themes described in Hamilton’s qualitative research on the subjective experience of patients’ comfort (1989). Hamilton also implicitly describes another dimension of comfort—the perceptions of needs occur in different contexts. The next step in developing a taxonomic structure of comfort is to find theoretical support for the three senses and to explicate the specific contexts of experience as implied by Hamilton.

**Toward Delineating the Structure of Comfort**

**Ease.** The discipline of ergonomics provided the theoretical background for the first sense of comfort as cited above. The domain of ergonomic interest was to enhance job performance through environmental manipulation; workers demonstrated higher productivity if they were in a state of comfort. In ergonomics, comfort was theoretically defined as a state of ease or contentment which facilitates routine performance (Kolcaba and Kolcaba, in press).

The ergonomic insights that are important for nursing are: (a) this sense of comfort is an enduring state; (b) it is a positive state that is more than the absence of discomforts (Chapanis, 1970); (c) it does not imply a previous discomfort from which relief is obtained; (d) it is important as a means to the end of routine task performance (Chapanis, 1970); (e) it is a reflection of person-environment fit and can be measured in correlation with features of the environment (Branton, 1969; Colquhoun, 1961); (f) comfort is experienced “physically and mentally” (Chapanis, 1970); (g) it is conceptualized as a baseline regarding comfort measurement; and (h) it is positively related to task performance. This sense is called the “state” sense (Kolcaba and Kolcaba, 1991).

**Relief.** The theoretical underpinnings for this sense of comfort came from early nursing theories about needs satisfaction. Orlando’s (1961) theory states that nursing actions should be designed to meet the physical and mental needs of patients and it focuses on how the nurse deciphers what the patients’ needs are. Henderson (1966) further specifies that 14 needs must be met in order for patients to resume normal activities. This sense is called “relief” for nursing because it is the only one of the three senses that specifies a prior discomfort from which the patient is relieved. Only after a discomfort is relieved can the patient proceed to recovery (or a peaceful death) (Henderson, 1966, p. 15).

**Transcendence.** This sense of comfort was identified in nursing by Paterson and Zderad (1976): “Comfort is the state in which the patient is free to be and become transcending and planning his own destiny in accordance with his potential at a particular time in a particular situation” (p. 112). This meaning is distinct from the other two senses of comfort because it entails the enhancement of ordinary powers through the nurse-patient relationship. This sense is called “transcend” (Kolcaba and Kolcaba, in press).

The theory is that, through relating to one another, the nurse and patient can experience well-being, and at times, “more-being.” Paterson and Zderad (1976) do not define more-being, nor do they describe how it is achieved, but if it occurs potential is realized. The characteristic that differentiates transcendence from the other theoretical senses of comfort is that it specifies the patient’s potential or extraordinary performance as an end state rather than ordinary performance, which is the end state for ease and relief. Extraordinary performance requires concerted effort and,
Comfort - the state of having met basic human needs for ease, relief and transcendence.

Ease - a state of calm or contentment.

Relief - the experience of a patient who has had a specific need met.

Transcendence - the state in which one rises above problems or pain.

Figure 1. Definitions of the Technical Senses of Comfort for Nursing

at the same time, a shedding of one’s preoccupation with pain, disability or other difficulties. For easier understanding of the term by patients and practicing nurses, this sense can be called inspiration. See Figure 1

The Contexts of Experience

Hamilton’s comfort themes (1989) indicated that some comfort needs were related to physical sensations, others to social interactions, spiritual life, environmental factors or activities. If these contexts of experience could be delineated, they would fill out a taxonomic structure of comfort. In order to accomplish this, the nursing literature on holism was consulted. Background for the contexts of patients’ experiences from these sources provided direction for finding the missing pieces of the structure.

The concept of holism was discussed by Levine in 1967. She proposed a model based on the basic interaction of individuals with their environments. Later authors contributed expanded ideas of holism. Fuller (1978) stated human beings have “biological psychological and sociological dimensions” (p. 702), and that the focus of nursing was the whole person in interactions with the environment. Cary and Posavac (1979) described holistic care as an integrated approach to patient care designed to meet the physical, emotional and spiritual needs of patients, Howarth (1982) also stated that the unifying concepts within a holistic framework were physical, intellectual and spiritual, but the latter was “in the generic sense,” that is, not related to religiosity.

In 1989, two nursing articles espoused a new model for holistic nursing practice called the "mind-body-spirit" model based on the view of many authors that the spiritual needs of patients were being ignored in the earlier biopsychosocial model (Burkhardt, 1989). During this time, other authors supported the inclusion of a spiritual dimension in a conceptualization of holism. Belcher, Detimore and Holzemer (1989) believed that, with the increased incidence of AIDS, other chronic illnesses and generally older (and presumably more spiritual) patient population, the biopsychosocial model was too mechanistic a view of humans (p. 16). Citing Travelbee (1977), these authors believed that persons facing life-threatening illnesses could be helped by finding meaning in their experiences.

Burkhardt (1989) incorporated the environment explicitly in her model of holism. She stated that a holistic view “implies an understanding of the human person as unity where body, mind, spirit and environment are descriptors of the interrelated manifestations of the person” (p. 60). From the holism literature, however, it was not possible to differentiate the experiences of mind from the spirit. Some problems encountered in this review included: (a) wide definitions of spirituality that overlapped with conceptualizations of “mind” (Labun, 1988); (b) wide definitions of spirituality that were operationalized with narrow empirical indicators of religiosity (Reed, 1987); and (c) the lack of any empirical indicators for transcendence that was claimed to be the significant benefit of spirituality (Reed, 1987; Labun, 1988).

A framework of comfort contexts based on the concepts most commonly cited in the review was synthesized. Those that were not clearly differentiated were combined. The result was four contexts of comfort experience: (a) physical, (b) social, (c) psychospiritual, and (d) environmental (Figure 2).

The Taxonomic Structure of Comfort

The four contexts (physical, social, psychospiritual, environmental), when combined with the three senses of comfort (ease, relief, transcendence) form a 3 X 4 taxonomic structure of 12 cells. The 12 cells represent the total Gestalt


taxonomic

<table>
<thead>
<tr>
<th>CONTEXT</th>
<th>Ease</th>
<th>Relief</th>
<th>Transcendence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>11</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td>Social</td>
<td>21</td>
<td>22</td>
<td>23</td>
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<tr>
<td>Psychospiritual</td>
<td>31</td>
<td>32</td>
<td>33</td>
</tr>
<tr>
<td>Environmental</td>
<td>41</td>
<td>42</td>
<td>43</td>
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</tbody>
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Figure 3. The Taxonomic Structure of Comfort
of patient comfort from the perspective of patients' needs and the fulfillment of their needs. The structure is diagrammed in Figure 3. The theoretical definition of comfort is the state of having met basic human needs for ease, relief and transcendence.

In this taxonomic structure, each element of comfort is assigned a number designating a specific combination of sense and context in which comfort needs are experienced by patients. Definitions of each element naturally follow, including antecedents, consequences and empirical indicators. The advantage of a taxonomic structure is specificity of the aspects of this complex concept resulting in their clear interpretation. A taxonomic approach to analyzing comfort produces a conceptual road map in which information is organized and available for easy access by future scientists.

Research Agenda

The taxonomic structure facilitates comfort research by explicating patients' comfort needs and desired outcomes of comfort measures geared towards those needs. Thus, the grid is useful to nurses who know their patients are not in a state of comfort but cannot distinguish the reason. Thinking about the aspects of comfort in specific ways gives direction to care and to instrument development to measure the effectiveness of the care.

Lynn (1986) states that, in the first step of instrument development, "the full content domain must be identified" (p. 383). She further states that this process is facilitated "by the use of a table of specification or a blueprint of the content domain" (p. 383). The taxonomic structure of comfort fulfills this function.

The second step in instrument development is to generate specific items from the content domain, ensuring "that all areas or cells of the table...or blueprint have been represented appropriately" (Lynn, 1986, p. 383). Using the structure as a guide, nurses who specialize in different areas can design their own comfort tools based on the priority needs of their unique clients. The aspects of comfort are derived from cross-referencing the desired sense of comfort to be achieved with the appropriate context of the comfort experience. Comfort measures and test items then flow easily from each of the aspects of comfort. For example, oncology patients who are depressed but not in pain need comfort in the transcendental sense and in the psychospiritual context (labeled 33). On the other hand, oncology patients who are depressed and lonely need comfort in the transcendental sense and in the social context (labeled 23). Patients with dementia often need the sense of ease in the environmental context (labeled 41). Once the needs are identified, comfort measures are designed to meet the needs. The structure can be used to design a post-test ascertaining the presence or absence of the desired comfort outcome.

By developing objective as well as subjective empirical indicators for comfort in various nursing specialties, objective or subjective comfort tools can also be designed. For example, brain damaged patients often cannot say why they are uncomfortable, but the nurse knows this is the case because of objective cues such as restlessness, hostility or sudden withdrawal. In these cases, objective indicators of discomfort can be developed in specialty areas for each of the aspects of comfort. In competent patients, subjective indicators reflecting priority needs can likewise be developed that serve as comfort pretests and post-tests and direct comfort measures to meet those needs.

Summary

As an organizing framework for comfort research, the grid ensures that all aspects of the concept are considered when designing intervention studies, yet only those elements that are relevant for specific patient needs are used in generating comfort measures and checklist items. The taxonomic structure of comfort is an alternative to traditional concept analysis because the total domain of comfort is studied and organized into defined and workable parts. Additionally, the structure provides a practical, conceptual road map from which can be developed: (a) empirical indicators for each aspect of comfort; (b) comfort checklists (pre- and post-); and (c) comfort measures to meet specific patient needs. The paucity of current intervention studies with comfort as the outcome is evidence of the prior difficulty of operationalizing this important nursing concept. It is hoped that this approach will inspire nurse researchers to design studies with comfort as an outcome.

References