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Comfort as Process and Product, Merged in Holistic Nursing Art

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Although many scholars discuss nursing as an art and science, the practice of nursing art remains unspecified and elusive, especially to learners. Nursing art is the esthetic use by nurses of scientific and humanistic principles of care applied creatively within specific contexts of care. One form of nursing art is called comfort care. Comfort care entails the process of comforting actions and the product of enhanced comfort, both of which have been described in separate programs of research. Because the process of comfort includes the product of comfort, the construct of comfort care designates a necessary merger between the programs of research. A template is presented that guides the practice of comfort care within a context of holistic nursing art.

Unlike the science of nursing, the art of nursing is abstract and difficult to explicate. In education and practice, proficiency in technical skills often is highly valued, but the artful process in which skills can be embedded remains undemonstrated or unarticulated. Personal exemplars of nursing art usually are not identified as such; hence, nurses and students of nursing have few, if any, designated role models for nursing art that could enrich practice esthetically. The problem is to present a framework for nursing art that students and experienced nurses can integrate into their practices.

A framework for practicing nursing art is derived from previous work concerning comfort (Morse, 1981, 1992; Hamilton, 1985; Kolcaba, 1991, 1992; Arruda, Larson, & Meleis, 1992; Cameron, 1993).

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This form of nursing art is called comfort care, and it has intuitive appeal because nurses have prior experience with their own holistic comfort. However, describing the framework is a complex task because the term "comfort" denotes both a process (a verb or adjective) and a product (a noun). Although the term is the same, its respective semantics are quite different and have, in fact, generated different and separate programs of research that heretofore have not been related to each other. The purposes of this article are to define comfort care, explicate the semantics of comfort entailed in comfort care, describe the relationship between comfort as process and comfort as product, and draw implications about comfort care for holistic nursing art. Such implications would demonstrate that enhanced comfort, the product of successful comfort care, has a reality independent of and greater than the sum of its parts (Dossey, Keegan, Guzzetta, & Kolkmeier, 1988).

Definition of Nursing Art

Peplau (1988) noted that, since the early 1900s, nursing has been referred to as an art and a science. Nursing is "an enabling, empowering, or transforming art whose aim is to produce favorable changes within clients through nursing services. Just as people are moved by music and inspired by paintings, they are often changed at a very personal level by nursing art" (p. 9). When drawing an analogy to art, Peplau claimed that the nurse is the medium. However, it may be more accurate to conceptualize certain nurses as artists, the process of artful nursing as the medium through which patients are changed, and a specified product (a selected outcome of nursing interventions) as the art. The patient, for whom the product is created, perceives the adequacy of nursing art.

Nursing art, then, is the esthetic use by nurses of scientific and humanistic principles of care applied appropriately within specific health care contexts. Competent, artful nursing is delivered with intentional caring. The nurse perceives meaning in the encounter, and this meaning is reflected in nursing action. The creative processes of engaging, interpreting, and envisioning are brought to bear on each care situation (Chinn & Kramer, 1991). The care is individualized and goal directed toward a product; the product changes the patient in a desirable way.

DEFINITION OF COMFORT CARE

Comfort care meets the above criteria for nursing art. Comfort care consists of comforting goal-directed activities (process) by which enhanced comfort (product) is achieved. The nurse-artist uses the medium of comforting actions, skills, and expressions to achieve the art of enhanced patient comfort. The process is initiated by the nurse, often in conjunction with the patient, after an assessment of the comfort needs of the patient. The nurse is engaged, interprets the needs of the patient, and envisions ways to enhance comfort (Chinn & Kramer, 1991). Because the specified product is enhanced comfort, success is evaluated by comparing comfort levels before and after interventions. Comfort care is holistic because comfort needs are interrelated, and meeting some needs will create a whole-person response of enhanced comfort in other untargeted components of comfort. Thus, total comfort is greater than what could be expected from meeting some needs.

The contemporary philosopher Dretske (1988) discussed the relationship between process and product. When the same word is used for both (e.g., decay and decay, comfort and comfort), there may be some ambiguities. The confusion is of little consequence in ordinary language because common sense points to correct meanings. However, there are some distinctions between the process and product of comfort that are important for nursing practice and research. First, the process specifies the product. Because they correspond, comfort is the only product for comfort the process. Second, the product does not occur as a separate entity after the process is over. Rather, the process is incomplete until the product is brought into being. Third, a specified product signals an end or completion of the process. Individual events within a process are steps in bringing about the product. Fourth, the product subsequently can continue a causal series or be nested within a larger process. And fifth, the product is the destination of the process, so the product entails the rationale for the process (Dretske, 1988).

Therefore, to study the process of comfort without evaluating the quality of its product called comfort is an incomplete exercise. In other words, comforting is a process only if its corresponding product, enhanced comfort, is achieved. The significance of the construct, comfort care, is that it entails the necessary merger between the process and the product of comfort. For the first time, the separate

lines of research about comfort, as reviewed below, are brought into a dependent relationship.

COMFORT AS PROCESS

Comfort has been described as "the most important nursing action in the provision of nursing care for the sick" (Morse, 1983, p. 6). Consistent with this conceptualization of comfort as process, the activities that nurses performed to comfort their patients in different settings were observed (Morse, 1983, 1992). In the first of such studies, the types of comforting techniques that nurses used in an emergency department were explicated (1983). Three major comforting techniques—talking, listening, and touching—were used in different combinations in response to patients' specific needs. In addition, it was pointed out that comfort also entailed "doing something," such as getting a tissue or making coffee (Morse, 1983, p. 11). In addition to comfort measures such as these and many others, nurses also supported the patients' own attempts to achieve comfort when they were able (Morse, 1993). Thus, comfort was not merely a passive process on the part of the patient.

In a second study, videotapes of nurses providing care to newborn infants in intensive care were analyzed (Cote, Morse, & James, 1991). The method was to categorize the infants' behavioral states, measure the duration of their distress episodes, and identify specific touch and vocal comfort methods used by the nurses. The conclusions were that infants in pain required different comforting strategies than normal newborns. Moreover, based on the long duration of the babies' distress episodes, nurses in this unit had difficulty interpreting and responding to their special comfort needs. In part, this difficulty might have been due to the babies' inabilities to communicate or to assist in comforting themselves.

In a third study, a nonparticipant observational technique was used to explicate types of comforting actions in an emergency room (Morse, 1992). Eight types of comforting were identified and defined. "Keeping things cool" referred to deliberate manipulation of occurrences so that the unit would appear to be relaxed; "clicking through the assessment" referred to efficient and accurate use of assessment skills. "Watching over, monitoring, and observing the patients" referred to unobtrusive but vigilant awareness of patients' needs and problems. "Helping patients retain/regain control and providing care within

their own comfort level" referred to a variety of touching and talking techniques executed in response to patients' needs. "Talking them through it" referred to reassuring speech patterns that helped patients through difficult situations. "Reaching the person in the body" referred to continued communication with patients who were brain damaged and showed no response to the nurses. "Keeping the doctors on track" referred to the nurses' directing the timing and logistics of physician care for each patient. The last activity was "bringing in and supporting the family," which involved concern and attention given to families in the midst of crisis. In this setting, comfort was given both directly (to the patients) and indirectly (through other personnel, family, or environment) by environmental manipulation (Morse, 1992).

In the studies in which comforting actions were found (Morse, 1983, 1992), nurses adjusted their comforting actions according to the needs of the patient. Often, comforting nursing care was called an intervention in and of itself. When possible, the patients assisted in comforting themselves. In these studies, comfort was not identified as a process per se, and the product of comforting actions was not discussed. Findings were not generalized to other settings.

In an attempt to gain insight into the process of comfort as patients experienced it, a qualitative study was conducted (Cameron, 1993, p. 426). Data about comfort as process were obtained directly from interviews with hospitalized medical and surgical patients rather than through observation of nurses at work. The most significant findings were that comfort was not a passive process and that patients did not wait in the hope of receiving comforting actions. Rather, comfort was a "dynamic process, with each patient actively engaged in increasing personal comfort" (Cameron, 1993, p. 424).

In summary, the process of comfort was stimulated by the perception of comfort needs; in the former work (Morse, 1983, 1992), nurses assessed the comfort needs of their patients and in the latter work (Cameron, 1993), patients perceived their own comfort needs and attempted to meet them. Nurses were to facilitate the process of self-comfort by becoming personally involved, interpreting comfort needs, and providing comforting actions. In all studies, the process of comfort involved cooperative actions of nurses and patients, when able. The process was observed to be strengthening for the patient, as in Nightingale's usage of comfort as a strengthening process. Cameron quoted Nightingale from *Notes on Nursing* (1859, p. 43): "I wish the recommenders would themselves try the experiment of

substituting a piece of bread for a cup of tea. . . as a refresher. They would find it a very poor *comfort*" (emphasis added). This strengthening attribute is consistent with an earlier concept analysis of comfort (Kolcaba & Kolcaba, 1991), and it provides a rationale for the practice of comfort care.

Comfort as Product

Early qualitative work on comfort as product was found in an unpublished nursing thesis (Hamilton, 1985). The study was conducted with 14 terminally ill cancer patients. Its purpose was to examine patients' meanings and attributes of comfort and factors contributing to and detracting from comfort. The broad comfort themes that emerged were (a) relationships with others, (b) illness and associated symptoms, (c) feelings, and (d) immediate surroundings. If discomforts were experienced in any of these components, comfort as an end product was compromised.

In a later published study, the same nurse explored comfort as product from the patient's perspective (Hamilton, 1989). In a semi-structured interview, patients in a long-term care setting were asked what comfort meant to them, what things made them comfortable, and what would make them more comfortable. Five major comfort themes resulted: (a) disease process, (b) self-esteem, (c) positioning, (d) approach and attitudes of staff, and (e) hospital life. These themes affected comfort as an end product. By compressing disease process and positioning into a theme called physical comfort, there would be four themes, consistent with those found in the earlier unpublished work and with four contexts of comfort explicated later by a different author in a taxonomic structure (Kolcaba, 1991). The taxonomic structure was a graphic representation of the "parts" of comfort, the product. In the qualitative studies above, no attempt was made to define or operationalize comfort as a product of nursing care. However, the studies were very important in explicating the necessary components of the realized product and the holistic relationships between the components.

The meaning of comfort from the perspective of immigrant Hispanic cancer inpatients also was investigated (Arruda, Larson, & Meleis, 1992). The components of comfort that emerged were congruent with the previous work cited above (Hamilton, 1989; Kolcaba, 1991). In addition, two Spanish terms for comfort were found that

were not readily translatable into English. These terms were *comodo* (related to accommodation, alignment, and positioning of body parts) and *animo* (related to positive mental drive or energy, being able to face what one is going through) (Arruda et al., 1992). In all of these studies about comfort as product, needs for comfort were readily identified and if those needs were met partially or wholly, comfort was enhanced. Comfort, as product, entailed a whole-person response and was a major concern for patients. When able, patients actively participated in enhancing their own comfort and, when successful, they felt strengthened.

Recently, the technical definition and operationalization of comfort as a product of nursing care have been undertaken, beginning with the concept analysis mentioned above (Kolcaba & Kolcaba, 1991), proceeding to the development of a taxonomic structure of holistic comfort (Kolcaba, 1991), and then to the definition of comfort as a nursing outcome (Kolcaba, 1992b). In this research, outcome was synonymous with product as in the sense of treatment outcomes (Jennings, 1991; Ware, 1984). A significant advance was to develop a method to measure comfort quantitatively, although the author acknowledged that statistical analyses were not able to demonstrate how total comfort could be greater than the sum of its parts (Kolcaba, 1992b).

Other findings were that comfort was bidimensional, with one dimension consisting of three types of comfort (relief, ease, and transcendence) and the second dimension consisting of four contexts in which comfort is experienced (physical, psychospiritual, environmental, and social). The outcome of comfort was defined as the immediate experience of having basic human needs met for three types of comfort in four contexts of human experience (Kolcaba, 1992b). Later, the strengthening aspect of enhanced comfort, noted in the studies above, was suggested in a theory of holistic comfort. In this theory, comfort was related to health-seeking behaviors (Kolcaba, 1994).

To summarize, comfort was defined for nursing as a desirable outcome or product of nursing care. In the research cited above, comfort as product was not linked to comfort as process. But, as a product, the consensus was that comfort is holistic, complex, individualized, dynamic, immediate, and measurable. Because enhanced comfort strengthened the recipient, a rationale for deliberate nursing actions directed toward patients' comfort needs was provided.

The Perceiver of Comfort Care

The patient (and/or family) is the perceiver of comfort care. Consistent with Dretske's (1988) explanation, the patient perceives the process of comfort including the product of comfort. If the process is not artful, responsive, or individualized, the product is not brought into being successfully.

This notion of perception differentiates comfort care from other types of nursing care, and it is consistent with Murray's (1938) view of perception from which arose the theory of comfort (Kolcaba, 1994). In Murray's view, perceiving is synonymous with experiencing; it can, but does not necessarily, entail cognition. Thus, demented or comatose patients or newborns perceive enhanced comfort and are quieted; they do not have thoughts about their comfort. (It is interesting to note that the early identification of the concept of comfort as an outcome of successful nursing interventions was on a dementia unit [Kolcaba, 1992a].) In cases in which perception does not include cognition, comfort (as product) is judged objectively by the nurse through observing the actions of the patient. This notion of perception is also consistent with the ways in which human beings experience art: They react, not so much from thinking about the art as from feeling the effects of art (Blocker, 1979).

There are four assumptions about human beings that underpin comfort care. First, they perceive components of comfort simultaneously at any given time. Second, they strive to meet, or have met, their basic comfort needs. Third, they perceive positive effects upon other comfort needs and holistic comfort when specific comfort needs are addressed. And fourth, they have inherent strengths that can be enhanced through artful nursing care. Although human beings respond as wholes, and processes in the mind cannot be isolated from processes in the body, individual aspects of human perception must be addressed and studied separately for purposes of intellectual clarification (Francis & Munjas, 1975; Levine, 1967).

Phillips (1976), a contemporary philosopher of science, shares this view about the intellectual understanding of holistic man. After an extensive critique of three positions on holism, Phillips summarizes as follows. First, holists are correct in emphasizing the dynamic relationship between parts of an organic whole. Second, resulting emergent properties of new elements are difficult to predict when they are brought into combination. Third, wholes in nature have natural boundaries. And fourth, whole human beings must be studied

in terms of their parts; otherwise, a strict view of an indivisible whole for research is "eminently unworkable" (1976, p. 123).

To summarize, patients are the recipients of comfort care and, when able, actively participate in enhancing their own comfort. They perceive the adequacy of comfort care in terms of the individualized design of comfort measures, the way in which they were delivered, and the extent to which their comfort was enhanced. Patients experience the effects of comfort care holistically and, when their comfort is enhanced through artful comfort care, patients are strengthened.

Template for Holistic Comfort Care

Comfort care is directed toward the product of enhanced comfort. But how do nurses direct their actions to achieve the product and how do they know if it has been achieved? These questions can be answered by incorporating a template for comfort care into nursing practice (Figure 1). The template provides a pattern for holistic nursing, but it is a heuristic device only. It is meant to be incorporated mentally into each nurse's practice in order to practice more artfully. It also is meant to be applied uniquely to each patient situation so that nursing care is individualized and based on specific comfort needs.

Using the template as a guide, a nurse can assess comfort needs in four contexts of experience both objectively (by looking at the patient) and subjectively (by asking the patient). Interventions are designed for comfort needs that cannot be met by the patient or his or her natural support system. Many interventions to enhance comfort can be implemented during one encounter with a patient, such as adjusting the light and straightening the room, talking and listening, teaching or reassuring if necessary, and attending to physical needs. The needs of those people in the patient's circle of concern are also addressed. Interventions are implemented artfully as the process of comfort care is engaged. Intervening variables that are relatively outside the scope of nursing, such as poverty, living alone, or having a terminal illness, are accounted for by the nurse. The patient perceives his or her resulting state of comfort in the context of intervening variables. Together, nurse, patient, and family decide what to do next, choosing between such options as continuing the interventions, trying something new, making referrals, or discontinuing the intervention if the recipient(s) deems it unsuccessful. Finally, because successful comfort care theoretically strengthens the patient, future health-

Name: Pt. ________________ Medical Diagnosis ________________

Comfort Needs	Interventions	Intervening Variables	Perception of Comfort	What Next?
Physical	*The nurse . . .*		*Objective*	*The patient will . . .*
Psychospiritual			*Subjective*	
Environmental				
Social			*Supporting*	

Physical Comfort Needs: Pertaining to bodily sensations and the physiological problems associated with the medical diagnosis.

Psychospiritual Comfort Needs: Pertaining to the internal awareness of self, including esteem, concept, sexuality, and meaning in one's life. Can also encompass one's relationship to a higher order or being.

Environmental Comfort Needs: Pertaining to the external background of human experience; encompasses light, noise, ambience, color, temperature, and natural versus synthetic elements.

Social Comfort Needs: Pertaining to interpersonal, family, and societal relationships.

Figure 1: Template for comfort care.

seeking behaviors are mutually selected. Health-seeking behaviors refer to those activities that facilitate self-fulfillment, optimum function, healing, or a peaceful death (Schlotfeldt, 1975, 1981).

Users of the template should refrain from thinking linearly about comfort needs, interventions, perception of comfort, and future activities. Rather, a plan for comfort care is created by addressing one column at a time. Comfort needs are identified according to descriptions of contexts of comfort as given in Figure 1 (Kolcaba, 1992b). Together, the needs suggest holistic (broadly targeted) interventions. The simultaneous effects of all needs, interventions, and intervening variables are interrelated and perceived by the patient "all at once." The nursing assessment of the patient's perception of comfort, after interventions, is of the patient's whole response to the comforting actions of the nurse. Comfort is assessed by the nurse objectively (through observing the patient) and subjectively (through the patient's testimony). Supporting data include testimony of other people

and information in the chart. If comfort is not enhanced compared with baseline, comfort care was unsuccessful (see appendix).

The template of comfort care is a heuristic device. Once the principles are integrated into nursing practice, the framework for providing comfort care becomes a mental pattern for creating efficient, warm, individualized, and holistic nursing art.

CAVEATS

It is important to note that the context of physical comfort entails nursing knowledge and skills specific to the patient's medical and nursing problems, such as interventions for pain, infection, organ failure, skin breakdown, confusion, fractures, emergencies, and so on. For this reason, the medical diagnosis is included in the template to provide direction for comfort needs that are specific to the patient's physical/mental problems or reasons for being in the health care setting. The competency of the nurse is perceived by the patient and also is related to his or her experience of comfort. But the esthetic and unique quality of comfort care is manifest when nurses attend to comfort needs in all contexts of experience, thus resisting the tendency to overemphasize physical needs.

Because of the demands of health care situations in which patients find themselves, absolute or total comfort in the hospital setting is rare. Rather, the nurse's goal when rendering comfort care is to enhance comfort by designing specific interventions for comfort needs that are identified by the nurse or stated by the patient. Sometimes, relief or ease cannot be enhanced satisfactorily because of intractable discomforts; at other times, patients must endure difficult or painful therapies in order to recover. In such cases, nurses try to address the need for transcendence by encouraging or inspiring patients to rise above adversities from any context of experience.

Needs for transcendence also may be apparent when patients are not motivated to participate in rehabilitative, curative, or palliative therapies. Nurses can try to inspire or move these patients to try harder, or to "give therapy a chance." Sometimes, patients despair because of poor social support or a threatening diagnosis, and nurses convey feelings of concern and caring to help the patients overcome their discouraged state.

IMPLICATIONS FOR HOLISTIC NURSING

Nursing care that is directed to four contexts of human experience at one time is holistic for several reasons. First, interventions are based on a unique combination of patients' needs, including the needs of the family. Second, the nurse recognizes that comfort needs are interrelated; meeting some needs will positively affect other comfort needs. Third, positive effects on comfort needs that are not specifically targeted render greater total comfort than can be accounted for by addressing some parts of comfort. Thus, the whole is greater than the sum of its parts.

The analogy of nurse as artist and patient as perceiver of the art may sound simplistic, but it has important implications for holistic nursing. Because comfort care entails process and product, effective care consists of comforting actions and enhanced comfort. If comforting actions are incorporated into nursing care but the patient does not perceive that his or her comfort is enhanced, comfort care has not been effective and the nurse has not been "artistic." However, when comfort care is successful, the patient feels well cared for and comforted because the care was efficient, individualized, targeted to the whole person, and creative. The nurse also feels rewarded because his or her art was brought into being and perceived as such by the patient.

The template for comfort care offers guidelines for practice that are easy to understand because its presentation is at a lower level of abstraction than previous guidelines for holistic nursing. The schema for comfort care also accounts for positive responses of patients to interventions that heretofore were considered by nurses to be insignificant because they were nontechnical. Examples of such interventions include removing clutter, smoothing sheets, or touching the patient's hand. When comfort care is the framework for nursing practice, each intervention is important if it enhances comfort. Further, each intervention is part of an integrated schema for artistic and holistic practice that is targeted to the whole patient and family.

APPENDIX

Case Study

The following vignette, taken from recent clinical experience, is an example of how to implement comfort care. John was an 83-year-old man who had abdominal pain of unknown origin. I walked into John's room for the first time and noticed that his face was tense and he was clutching his sheets tightly. Upon inquiry, he said, "I just got some bad news. The doctors couldn't find anything causing my abdominal pain on the CAT scans so they want to do exploratory surgery to find the cause. I'm too old for this!" I addressed his psychospiritual discomforts by sitting with John, helping him verbalize further, discussing how negative CAT scans might be *good* news, and educating him about the advances in anesthesia for older patients. I also was aware that an important part of this interaction was entailed in the process of comfort care, so I listened attentively, shared some relevant information, used eye contact, and touched his shoulder to emphasize my concern. Intuitively, I assessed other comfort needs as well. In this situation, the room was cluttered (environmental comfort addressed by straightening the unit) and his family began to arrive, bringing a smile to his face (no further intervention needed for social comfort). John reported no pain, hunger, constipation, or thirst (no physical comfort needs), and the signs of discomfort (tense expression and clutching of sheets) were diminished. All of the interventions took 5 minutes, but the patient felt cared for and I knew he was experiencing enhanced comfort. I made mental notes to reinforce some of the comfort measures during my next interaction with John to maintain psychospiritual comfort and to help him gain courage and confidence (strengthening component) about the surgical procedure.

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