Comfort Theory

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GNUR 5410 Theory Critique: Comfort
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On my honor I have neither given nor received help on this assignment, nor will I do so X: Alyssa Wolf
Abstract

Providing comfort is a necessity in the care of patients in the hospital setting. Currently, comfort is being viewed as a last result for terminally ill patients and not used as a standard hospital protocol or prophylactically to improve patient’s health status. Dr. Katherine Kolcaba was one of the first nurse researchers to develop a theory of comfort to improve patient’s satisfaction and outcomes as well as improve institutional integrity. This paper aims to describe the Comfort Theory, its strengths and weaknesses as a middle range theory, its application to the health care setting and beyond, areas for potential research and the relevance of this theory to the health care system and health care professionals.
Comfort Theory and its Application to an Institution Wide Approach

Comfort is a vital part of the treatment and recovery of patients. At the beginning of the 20th century, comfort was highly valued in nursing because of the lack of medical treatment and development of medications. Comfort measures were dictated by physicians and were shown to not only improve patients physically, but mentally as well (Peterson & Bredow, 2009). As technology enhanced and medications were created, comfort measures became an increasingly minor focus. Comfort between the 1970’s and 1980’s had become reserved for patients whom were terminally ill or patients where medical treatment options were no longer working or available (Peterson & Bredow, 2009).

One of the main tribulations with comfort was that there was no concrete definition of it. "In early nursing texts, the meaning of comfort was implicit, hidden in context, complex and general. Many semantic variations such as comforting, to comfort, in comfort and comfortable were used and the term could be in the form of a verb, a noun, an adjective, or an adverb" (Peterson & Bredow, p. 256). There have been four definitions commonly identified for comfort. Comfort is a cause of relief from discomfort, a state of ease and peaceful satisfaction, a state of comfort and whatever makes life pleasurable. (Kolcaba & Kolcaba, 1991). Comfort has always been a defining characteristic in the nursing profession, but was never made into a nursing theory. Katharine Kolcaba was the first to take this simple concept and turn it into a theory that has become applicable and beneficial to patients.

Description of the Theory of Comfort
Katharine Kolcaba, who is a PhD nursing scholar, devised the comfort theory. In her theory she describes comfort in three different forms: relief, ease and transcendence (March & McCormack, 2009). “Kolcaba defines holistic comfort as the ‘immediate experience of being strengthened by having [one’s] needs for relief, ease and transcendence met in four contexts (physical, psychospiritual, sociocultural and environmental)” (Goodwin, Sener & Steiner, 2007, p. 279). Relief is when the patient has had a comfort need met. Ease is defined as a state of tranquility or contentment and transcendence is “a state of comfort in which patients are able to rise above their challenges” (March & McCormack, 2009, p.9). These states of comfort are continuous, interdependent and can overlap (Kolcaba, 1993). Kolcaba discusses a physical context as one that pertains to any bodily sensations. The psychospiritual context refers to comfort in the context of ones identity, sexuality, self esteem and any other spiritual relationship with a higher being. Sociocultural comfort arises from interpersonal and societal relationships along with family. “The environmental comfort is defined as the external background of human experience (temperature, light, sound, odor, color, furniture, landscape, etc)” (Kolcaba, Tilton & Drouin, 2006, p. 540).

Katharine Kolcaba’s main proposition for this theory is that when patients and family members feel more comfortable, they will engage in more health seeking behaviors. These health-seeking behaviors include internal behaviors, external behaviors and a peaceful death. Internal behaviors occur at the cellular level, such as immune functioning. External behaviors refer to activities of daily living (ADL’s) and health maintenance programs. When patients and family members are engaging in
more health seeking behaviors as a result of increased comfort due to interventions, members of the health care team will be more content, will ultimately perform better and improve institutional outcomes (Peterson and Bredow, 2009). Public acknowledgment of these institutions will arise and these institutions will flourish and benefit from reduced costs of care, reduced length of stay, enhanced financial stability and increased patient satisfaction. (March & McCormack, 2009).

Internal Theory Critique

*Clarity:* Katharine Kolcaba clearly identifies the main components in this middle range theory as being a matrix of relief, ease and transcendence with comfort occurring in four contexts, physical, psychospiritual, sociocultural and environmental. The author describes each of the states clearly and precisely as well as the contexts in which they occur, providing key examples. The author describes the way in which these states can be applied to patients in the hospital setting as well as providing examples of how they pertain to an outpatient setting. The author gave her definition of comfort, however, this definition is constantly evolving and expanding to include and encompass a wider array of health behaviors. Her definition of comfort is clear, but the way that other authors interpret her meaning of comfort can be misleading. This theory is easily understood by readers and has a clear focus and direction.

*Consistency:* The key components of the theory remain consistent throughout the explanation of the theory. In all of Kolcaba’s different research projects, her definitions of the states of comfort and contexts of comfort have always remained the same. When she first began defining key components of her theory, the four
contexts of holistic experience were physical comfort, psychospiritual comfort, social comfort and environmental comfort. Social comfort has now been changed to sociocultural comfort to incorporate cultural traditions and family. (Peterson & Bredow, 2009). Since she implemented this change, it has been consistent in all of her texts and research, as well as in journals and the research of others. The three original states that Kolcaba defined were relief, ease and renewal. Renewal has since been changed to transcendence. This term has also been constant since the change in term. The explanations of the terms (states and contexts) are congruent with the examples provided for each. The assumptions of this theory fit the theory.

Adequacy: The theory claims that it “can be adopted to any health care setting or age group, whether in the home, hospital, community, region or state” (Peterson & Bredow, 2009, p.260). However, the author mainly provides examples of comfort measures and how these work in the hospital. The author also relates comfort measures to improving health-seeking behaviors and benefiting institutions and institutional integrity. The author does not include how these health-seeking behaviors can improve companies where the patients may work, insurance companies, local clinics and other health institutions. The theory addresses comfort and how it can improve patient outcomes, but fails to expand adequately on how these comfort measures can be used outside of the hospital setting. Many researchers are taking the Comfort Theory and extrapolating it to be useful in other health care settings.

The theory is positioned within the domain of nursing. Kolcaba should consider expanding the theory to an institution wide approach. When she describes
using nursing interventions to provide comfort, she is “limiting the implementation of interventions leading to enhanced comfort as a function of only those healthcare providers who specialize in nursing” (March & McCormack, 2009, p 9). If other researchers fill this gap, it can refine the theory and greatly benefit the health care environment. It will enhance the institution even more than if the nurses alone were implementing the theory.

The theory accounts for the subject matter under consideration, the patient and family. However, the theory says it can be implemented in all areas of the health care system. Kolcaba does not discuss in her core definition of the theory, the importance of providing comfort to the nurses. When the comfort of nurses is enhanced, they are more satisfied. When the nurses are content, they are more committed to the institution and provide better health care. By providing better health care to the patients, patient outcomes improve and thus strengthen the institution (Kolcaba, Tilton & Drouin, 2006).

**Logical Development:** The theory follows a logical development throughout time. When a new concept is being developed in a discipline, a concept analysis is necessary. In 1988, Kolcaba undertook this task. She studied concepts of comfort from a multitude of dictionaries. She then compared those definitions to definitions from an extensive literature search (Peterson & Bredow, 2009). The theory of comfort does proceed in a logical fashion and the arguments are well supported. Comfort was well studied and supported at the beginning of the 20th century because of the lack of medical treatment. It is increasingly becoming a minor focus due to enhanced medical equipment and technology. It is necessary for this theory
to be in the forefront of health care and research because it can greatly enhance patient outcomes.

*Theory Development:* Comfort theory has been clearly defined in journals, research and literature. Dr. Kolcaba published the theory of comfort as a middle range theory. It fits in the category of a middle range theory because it has fewer concepts and propositions than a grand theory, it is easily testable, easily applicable and interpreted and more narrow in scope. The theory has a low level of abstraction. This theory is still in early development. “Concepts and propositions are readily operationalized. The theory had been tested in many settings. The outcome of comfort is operationalized easily using the taxonomic structure of comfort as a guide for item generation” (Kolcaba, 2001, p. 91). The theory is still being tested and applied to a wider institutional approach. Because Kolcaba’s theory has still not been adapted in all of the researched settings, the benefits and outcomes are currently just speculated. Research of this theory is ongoing and constantly evolving.

**External Theory Critique**

*Reality Convergence:* Dr. Kolcaba was one of the first nursing researchers to create a theory of comfort. She did not rely on past nursing theorist work to design her theory. She only relied on past definitions of comfort. She used these definitions to build and create her theory. She was not a deconstructionist; rather she used previous knowledge from a variety of different disciplines to create the most encompassing definition of comfort possible. This theory has a great deal of reality convergence. It builds upon the premise from which it is derived and relates it to
Comfort Theory

reality (Peterson & Bredow, 2009). Her theory is easily interpreted and applicable to patient settings. The theory is represented in the nursing realm. “A traditional goal of nursing has been to attend to patient comfort. Patients expect this from nurses and give them credit when comfort is delivered. Through deliberate actions of nurses, patients receive what they need and want from their nurses. This theory explicates how and why to do so” (Kolcaba, 2001, p. 91). The theory provides directionality for nursing practice because it provides measurable outcomes (Kolcaba, 1993, p. 1183).

Utility: The comfort theory can be applied to patients of all ages, cultures backgrounds, communities, state or regions. It is also applicable to patients in the hospital, clinic or home. Though it has not necessarily been tested in all of these areas, it can be used to enhance any person’s health status in any practice setting. The nurse researcher employing this theory will find it very useful because of its ease of application. The researcher can take this theory and apply it to whatever setting and it is easily tested with a variety of instruments including, General Comfort Questionnaire, Shortened General Comfort Questionnaire, Visual Analogue Scales and Comfort Behavior Checklists. It provides direction for performance review, outcomes research and quality improvement (Kolcaba, Tilton & Drouin, 2006, p. 541).

Discrimination: Kolcaba describes the nurse’s role in providing comfort. The nurses need to meet the basic physical, psychosocial and spiritual human needs “through provision of empathic care and comprehension of the personal meaning the patient attaches to his/her experience” (Malinowski & Stamler, 2002, p.605).
The theory describes nursing practice as being holistic, humanistic and needs related. It describes different nursing interventions intended to promote comfort for the patients provided by nurses. This theory differentiates nursing from other health related disciplines by demonstrating the different types of comforting measures provided by differing members of the health care team.

Scope: The theory is broad in scope because it can be applied to a variety of patient settings and patients of all ages and backgrounds. The theory can be viewed as being narrow in scope because it focuses solely on patient and families. However, it is easily extrapolated to other areas of practice. Once this occurs, the theory will be mainly viewed as being broad in scope.

Significance: If nurses and other health care providers implement this theory into their practice, patient outcomes will significantly improve. This theory will not only enhance patient results, but it will help prevent impending medical problems. This theory addresses the most essential and relevant issues in the nursing realm. Using this theory not just for patients, but for nurses will improve retention rates of skilled health care professionals and recruitment rates. This theory only provides benefits and there are no known risks for using it.

Complexity: The theory presents three main concepts with four contextual components; relief, ease and transcendence with regards to physical, psychospiritual, sociocultural and environmental contexts. The description of the theory is not complicated and can be easily understood with few variables and without extensive details and descriptions. The author provides examples of how the concepts fit together. The author created a taxonomic structure; “three types of
comfort were juxtaposed with the four contexts of experience” (Peterson & Bredow, 2009, p.258), into a 12-cell grid. This grid was helpful in deriving the meaning of comfort and the attributes of comfort. The grid was useful for assessing patient’s needs, planning interventions and evaluating the effectiveness of those interventions (Kolcaba, 2007). The grid helped contribute to the understanding and utility of the theory. “Comfort theory posits relationships between nursing interventions, patient comfort, health seeking behaviors and institutional integrity. Any of all of these relationships can be tested through nursing research” (Peterson & Bredow, 2009, p. 384). The theory allows for interrelationship of multiple variables.

Relevance to Nursing Practice

Comfort is a positive outcome that is linked to an increase in health seeking behaviors and to positive institutional outcomes (Kolcaba & DiMarco, 2005). Nurses are constantly utilizing the three types of comfort mechanisms and try to move patients towards the transcendence phase without necessarily knowing it. Nurses do assessments throughout their shifts on patients, which include assessing their physical, psychospiritual, sociocultural and environmental needs. When nurses assess the physical needs of patients, they are looking at deficits in the physiological mechanisms of an ill patient due to a disease, virus or surgery. Some physical comfort needs that can be treated without medications include pain, nausea, vomiting, shivering and itching. Nurses can use different interventions to help alleviate these problems and increase patient satisfaction.
Psychospiritual needs include teaching confidence and motivation through discomfort. Ways that nurses can implement comfort measures are through massage, allowing visitation, caring touch and continued encouragement (Kolcaba & DiMarco, 2005). Sociocultural comfort needs are the needs for cultural sensitive reassurance and positive body language. Nurses can provide these needs through coaching, encouragement, camaraderie and explaining procedures. Environmental comfort needs of patients comprise a quiet and comfortable environment. Nurses can help patients achieve this environment by lowering the lights, closing the doors, interrupting sleep minimally and limiting loud noise around the patients rooms (Kolcaba & DiMarco, 2005).

Nurses document patient’s states before and after the use of comfort measures to verify if the measures are improving or worsening the patient’s condition. Nurses knowing a patient’s condition can provide comfort measures prophylactically to prevent negative outcomes. If a patient is coming back from surgery, a nurse may be aware of the possibility of breakthrough pain. If the nurse is attentive to this and notices an increase in the patient’s blood pressure, facial grimacing and anxiety, the nurse may realize that he/she should administer pain medication instead of blood pressure medication. The nurse could also provide massage, guided imagery or other interventions based on the type of surgery and intensity of the pain. Being able to determine when comfort measures are necessary or useful is vital to improving the quality of patient care.

When patients are more comfortable, they are more likely to engage in health seeking behaviors. Patients are more likely to comply with postoperative exercises,
“exercise regimes, increased compliance with prescribed diets for diabetic patients and more peaceful deaths when palliative care is the appropriate goal” (March & McCormack, 2009, p. 10). When patients increase their health seeking behaviors, nurses are more satisfied and improve their quality of care. The improvement of care increases the institutional integrity, overall improves the hospital experience and enhances the care of all health care professionals.

Conclusion

Katharine Kolcaba’s middle range theory of comfort is applicable to all areas of the healthcare field. Though her theory is currently patient and family centered, the possibility of expansion is endless. “Structuring a healthcare institution around the concepts of the comfort theory would improve societal acceptance and appreciation of the institution, as well as increase patient satisfaction” (March & McCormack, 2009, p. 10). The theory can be used in nursing education. The theory can be used in comforting the learner or student in an educational environment. Researchers can test the benefits of comfort on learning. This theory does not necessarily have to involve just health care settings; it can be implemented in any field with any member of the health care team (Goodwin, Sener & Steiner, 2007).
References


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