CONSIDERING A SENSE OF
CONNECTEDNESS AND EFFECTIVENESS IN ELDERS:
HEALTH CARE DELIVERY, NURSING THEORY, NURSING EDUCATION

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A sense of connectedness and effectiveness is critical to all human beings and an integral element in nursing theory. The large potential for losses as people age increases the potential for a sense of disconnectedness and ineffectiveness challenging their independence and personal integrity. A sense of integrity and self-definition are multifactoral and are considered from the patients perspective, and the views of nursing theory and health maintenance. A table depicting the representation of themes and a model of concept interactions are presented.
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DEFINITION OF TERMS

Acceptance - A present oriented activity requiring energy and characterized by receptivity toward and satisfaction with someone or something, including past circumstance, present situations, others and ultimately, the self (Haase, et al, 1992).

Caring - Painstaking or watchful attention; to feel interest or concern; to give care; to have a liking, fondness or taste (Webster’s, 1993).

Competence - The quality or state of being competent; having requisite or adequate abilities or qualities (Webster’s, 1993).

Contribution - The act of contributing; to give or supply in common with others (Webster’s, 1993).

Connectedness - A sense of significant, shared, and meaningful relationships with other people, a spiritual being, nature, or aspects of one’s inner self (Leidy & Haase, 1999).

Dignity - The quality or state of being worthy, honored, or esteemed (Webster’s, 1993).

Effectiveness - Characterized as a sense of being able, expressed through physical being and through the perception of competence, contribution, and purpose through daily activities, including self-care, family roles and tasks, and work (Leidy & Haase, 1999).

Empathy - The action of understanding, being aware of, being sensitive to, vicariously experiencing the feelings, thoughts, and experience of another of either past or present without having the feelings, thoughts, and experience fully communicated in an objectively explicit manner (Webster’s, 1993).

Energy - An ability to perform various activities with spontaneity and ease (Leidy & Haase, 1999).

Expertise - The application or use of experience and knowledge (Leidy & Haase, 1999).

Health - A person’s subjective sense of well-being in body, mind, and spirit which is dynamic in context (Merritt, 2000).

Hope - An energized mental state involving feelings of uneasiness or uncertainty and characterized by a cognitive, action-oriented expectation that a positive future goal or outcome is possible (Haase, et al, 1992).

Independence - Not subject to control by others; not requiring or relying on something else (Webster’s, 1993).
Individuality - Total character peculiar to and distinguishing an individual from others (Webster's, 1993).

Integrity - Represents a sense of satisfying wholeness that encompasses the integration, totality, and collective of intrapersonal and interpersonal characteristics, including one's physical appearance and functioning, skills, roles, knowledge, memories, environment, family and friends. It is a sense of one's individuality and wholeness as a human being (Haase, et al, 1992).

Purpose - Something set up as an object or end to be attained (Webster's, 1993).

Self-definition - That part of self-related knowledge that contains attributes crucial for the definition of oneself. A window to the central issues and life domains in which a person is involved (Freund & Smith, 1999).

Self-transcendence - The experience of extending one's self inwardly in introspective activities, outwardly through concerns about others, and temporally such that the perceptions of one's past and anticipated future enhance the present (Haase, et al, 1992).

Spirituality - The experiences and expressions of one's spirit in a unique and dynamic process reflecting faith in God or a supreme being; a connectedness with oneself, others, nature or God; and an integration of all human dimensions (Meraviglia, 1999).

Trust - Assured reliance on the character, ability, strength or truth of someone or something (Webster's, 1993).
Considering a Sense of Connectedness and Effectiveness in Elders:

Health Care Delivery, Nursing Theory, Nursing Education

Introduction

Interactions with geriatric populations are increasing as the population of elders continues to grow at a rapid rate. An awareness and understanding of relationships and their context to support the independence and personal integrity of older persons has been promoted by the international community for over ten years culminating in the designation of 1999 as the International Year of Older Persons. As this population continues to grow in numbers, it becomes increasingly important for health care providers to explore the multiple facets they must balance when considering the profound influence of self-definition and public perceptions on health care delivery to elders.

Self-definition or the perceived ability to interact within the world is related to personal integrity which is supported by a sense of connectedness and effectiveness, "being with" and "being able" (Leidy & Haase, 1999). Changes in living arrangements, physical attributes and deaths can challenge personal integrity which is supported primarily by a sense of connectedness and effectiveness. These are reflective of points of transition which have been a major focus of nursing research and are often the point of contact for health care providers. Anecdotal evidence tells us that elders often do not seek health care when they feel they need to because their provider "doesn't care", "doesn't listen" or they were "unable to get into the office." Those involved in placement decisions of older persons at points of transition have described a lack of support from professional staff (Dellasega & Mastrain, 1995; Penrod, Dellasega, Strang, Neufeld & Nolan, 1998) and elderly women have described a sense of being "talked down to" by their providers (Blair & White, 1998) even though a sense of connectedness has been identified as an important factor in seeking health care by older persons (Leidy & Haase, 1999).
A common public perception is that elders are unable to care for themselves and require nursing home care, yet the nursing home population represents less than 4% of elderly persons (Administration on Aging [AoA], 1998). Many schools, elementary through college, utilize these residences as an introduction to the elderly in our communities. While this is an attempt to foster good relationships and positive attitudes, thus providing a sense of connectedness for all concerned, in actuality this can promote perceptions of elders as in poor physical or mental health, needy and dependent. These are traits which are understood in our society as negative and to be avoided at any age.

Research has shown that students of nursing generally want to prepare for a role in an acute care setting as opposed to community or aggregate care such as geriatric populations (Jacobson, MacRobert, Leon & McKennon, 1998; Schneiderman, Jordan-Marsh & Bates-Jensen, 1998; Blair & White, 1998). Supporting perceptions of connectedness through changes in nursing education may shift student choices to support future aggregate and community work.

Jessie Scott states, “Nursing must be the voice and conscience in the health care system” (Kearns, 1997). A sense of connectedness and effectiveness is critical to the health of human beings and broadly discussed throughout nursing literature. Connectedness must be supported to provide the best possible health outcomes especially in elders who have a great potential for losses resulting in a feeling of disconnectedness.

**Aging Profile**

**Demographics**

In 1997 one in eight persons in the United States (34.1 million Americans) were over the age of 65 and that number has continued to grow rapidly. Persons aged 65 or older had a net increase in population of 587 per day and an average life expectancy of 83 years. By the year 2030 older persons are projected to make up 20% of the population or

Contrary to popular belief the living situation for the majority of elders remains non-institutional. In 1997 80% of men and 57% of women lived in some type of family setting with the balance living alone or with non-relatives. With a median income of $13,049.00, most of this population, again contrary to popular perception, is forced to relocate from their family homes into the homes of other family members or some form of subsidized housing facility (AoA, 1998). This can potentiate a sense of disconnectedness and ineffectiveness through the loss of familiar surroundings, relationships and a perceived lack of competence or contribution.

**Health Concerns**

The Administration on Aging reports that spending for Medicare and social security made up approximately 7% of the gross domestic product (GDP) in 1997. Projected changes in population over the next 30 years indicate that these costs are expected to consume up to 12% of the GDP by the year 2030 (Population aging and the US budget, 1998). While those over age 65 represent approximately 13% of the United States population, they account for 40% of hospitalizations and consume nearly 36% of health care dollars (AoA, 1998).

The management of chronic conditions requires a sense of connectedness between patient and provider to facilitate strategies that will prevent exacerbation's of chronic disease states and subsequent hospitalization or death. In 1994 more than half of older persons described at least one disability with many reporting multiple chronic conditions (AoA, 1998). Nationally, cardiovascular disease accounts for 40% of all deaths and 11 million persons over 65 report disability caused by heart disease or stroke (Centers for Disease Control and Prevention [CDC], 1997). Diabetes is a major cause of heart disease
and has been diagnosed in 6.3 million persons over age 65 (Diabetes statistics, 1999).

In Washington State alone 71% of all deaths were due to four chronic disease states common to older persons: cardiovascular disease, cancer, chronic obstructive pulmonary disease and diabetes (Washington: most common causes of death, 1995).

**Trends in Primary Care**

To explore how to foster a sense of awareness and connectedness with older persons an understanding of the patient population that is served by primary care providers (PCP) is needed. An analysis of the National Ambulatory Medical Care Surveys from 1978 to 1994 provides a 17 year window of information. It is important to keep in mind that this time frame represents only the very beginning of the “aging of America.” During this period visits to PCPs by elders increased by 8% accounting for 32% of all patient visits (Stafford, Saglam, Causino, & Starfield, 1999).

The practice of blood pressure monitoring and dietary counseling rose by 50% among general internists, and patient visits became longer, increasing from 15.3 to 18.1 minutes on average. These changes have been largely attributed to an aging population with greater preventative care needs (Stafford, Saglam, Causino, & Starfield, 1999).

Although some preventative services have increased in incidence others have not. Studies have shown that less than 50% of elderly patients receive recommended vaccinations, Pap tests, mammograms or prostate exams. Compliance among providers with the recommendations in the Guide to Clinical Preventative Services can be difficult to evaluate. Several reasons for a lack of compliance have been suggested including negative attitudes of providers or patients, lack of priority in the clinic or visit situation, documentation problems and ageism (Blair & White, 1998; Hershey & Karuza, 1997).
Relationships

Intergenerational relationships and self-definition are central themes impacted by a sense of connectedness within family and social relationships as people age. Ageism limits people of all ages by denying and invalidating knowledge and contributions in our society through the shaping of perception and identity (Laws, 1995; Flemming, 1998). Group perceptions are based on perceived positive or negative traits within society, while a positive self-perception is supported by a sense of connectedness and effectiveness which is dynamic across the life span.

Anderson, 1996, interviewed twelve women individually and later six of those twelve and another eight women in two focus groups to explore their perceptions of their families of origin. These women described their homes as cold, abusive, unsafe and transient which no doubt perpetuated their isolation and lack of connectedness promoting negative societal images. Education varied broadly from not completing high school to the completion of a master's degree. The subjects either were currently homeless or had been homeless in the past. Utilizing a descriptive qualitative design involving intensive interviewing with subjects ranging in age from 21-56 years, each was interviewed one to three times over a 1 1/2 year time frame. A "lack of connectedness" and "being without" surfaced as relevant meanings for homeless women describing their family of origin, without home, employment and support.

Among youth, connectedness with family and community was assessed by addressing perception of caring by adults, school personnel, church, parents, parental understanding and having fun with family. Wagman, Borowsky, Resnick, Ireland and Blum, 1999, utilized the results of the 1990 National American Indian Adolescent Health Survey in an effort to identify factors associated with suicide. Subjects were Indian and Alaskan native youth in grades 7-12 (n=11,666). While risk factors were identified, three
protective factors also surfaced: discussing problems with family or friends, emotional health and a perception of connectedness. Females had an additional protective factor if there was a nurse or a clinic in their school. In this study it became apparent that increasing protective factors was more effective in the promotion of health behaviors than the reduction of risk factors. Many of the factors associated with increased risk of suicide were health related issues such as health problems that limited attendance, functional disabilities, a history of learning disabilities or mental health issues and dissatisfaction with body image (Wagman, et al, 1999). It has been well documented that elderly men maintain the highest suicide rates which leads one to wonder if increasing the protective factors identified by Wagman, et al would provide the support needed to promote independence, and personal integrity while reducing suicidal tendencies.

Depression and self-esteem were the most strongly contributing variables in a study done by Pesa, 1999. Analysis was conducted on data from 2,536 females participating in Wave I of the National Longitudinal Study of Adolescent Health (Add Health) representing students in grades 7-12. Psychosocial factors of the study were examined to determine significant differences between groups. Family connectedness was not significant in this analysis. However, questions in seven of the eleven areas analyzed reflected a sense of connectedness or belonging. While these individually may not be significant, one must wonder if those consistent variations in total are clinically significant.

The predictive value of a sense of belonging for depression was considered by Hagerty and Williams, 1999. Subjects consisted of 31 persons diagnosed and being treated for major depression and 379 college students in the Midwest ranging in age from 18 - 75 years. Data were gathered and analyzed from the Beck Depression Inventory, Sense of Belonging Instrument (psychological and antecedent), Revised UCLA Loneliness Scale and the Interpersonal Relationships Inventory. The researchers found that a
psychological sense of belonging and loneliness had significant effects on depression. This provides an important basis for continued assessment and support of interpersonal relationships while treating biological illness.

These studies are limited by age, school attendance, gender and race. There may also be discrepancies in the data due to self-reporting and the potential for minimizing information which may be negatively viewed by peers, such as family violence, poor economic conditions or emotional health.

The public perception of aging often depicts negative images as well, with elders viewed as “over the hill”, needy, and dependent. These negative images can not help but come forward as we age. As longevity increases considerations and fears may include the likelihood of chronic disease or disability, out-living financial resources, family and friends, and the potential for loneliness and isolation (Leidy & Haase, 1999; Freund & Smith, 1999; Kerchner & Pegues, 1998). These factors can challenge a sense of connectedness and effectiveness and are important for primary care providers to consider when working with aging patients.

**Connectedness**

A sense of connectedness provides support for personal integrity which involves meaningful relationships primarily supported by family interactions or intergenerational relationships. “Being with” or a sense of “meaningful relationships” are terms used to describe connectedness (Leidy & Haase, 1999; Knebel, et al, 1998). These are described as significant, shared and meaningful personal relationships with another person, a spiritual being, nature or perhaps an aspect of one’s inner self. The breadth of these relationships is a key factor in the ability to support integrity, or possibly move through despair, and involves the balanced exchange of help and support (Haase, Britt, Coward, Leidy & Penn, 1992; Meraviglia, 1999; Knebel, et al, 1998; Hagerty & Williams, 1999). In contrast the
homeless and those with risk for depression and suicide describe a lack of connectedness or “being without” family, trusting relationships, nurturance, voice, support or love (Anderson, 1996). In elderly populations, as connections are severed through deaths, moves and physical changes personal integrity becomes challenged (Leidy & Haase, 1999; Freund & Smith, 1999; Kerchner & Pegues, 1998).

Areas that were identified with connectedness and which also supported emergent themes include continuing to learn and travel, experiencing new things, giving to others, having friends, expressing interest in others, displaying kindness toward others, spending time with family, and showing concern for those with less (Freund & Smith, 1999; Kerchner & Pegues, 1998; Knebel, et al, 1998). Personal integrity and emotional well-being are bolstered by having a depth and breadth of connections or roles which can be provided or experienced through the above-described behaviors.

**Effectiveness**

Effectiveness or “being able” is primarily a physical endeavor supported by a perception of competence, contribution and purpose in activities of daily living. Being effective involves the ability to do for others as well as self (Leidy & Haase, 1999; Knebel, et al, 1998).

Emergent themes were supported by a variety of factors associated with effectiveness including keeping active, functioning as a productive citizen, helping to make the world a better place, having meaningful work and remaining involved in the community (Freund & Smith, 1999; Kerchner & Pegues, 1998).

Functional status as a physical ability can challenge one’s perceived effectiveness through dependence or limitation forcing a re-evaluation of priority with planning and pacing of activity to continue being as effective as possible. As physical function declines a re-telling of previous perceptions of effectiveness helps to preserve integrity through
imagery which is often supported through intergenerational relationships (Leidy & Haase, 1999; Freund & Smith, 1999; Kerchner & Pegues, 1998; Knebel, et al, 1998).

**Self-definition**

Self-definition is how one perceives themselves in relation to their ability to interact with their world. It is a subjective view of perceived attributes that separate or connect self and other. Personal integrity and individuality are central themes of self-definition (Leidy & Haase, 1999; Freund & Smith, 1999; Kerchner & Pegues, 1998).

Freund and Smith, 1999, worked with a heterogeneous age by sex stratified sample representative of western districts of Berlin (n=516) to identify domains represented by self-definitions of older persons. Subjects were predominantly German, aged 70-103 years. A combination of qualitative and quantitative designs were used. The researchers noted significant references to family, life review and health. The authors acknowledge the potential for eliciting responses due to the present tense framing of the question and loss of relevant data or data complexity by categorizing responses. Results indicated that self-definition is multifactoral, is important in the maintenance of well-being and seems to be a protective mechanism against the onset of depression.

A sense of personal integrity emerged as a central theme when elders were asked about important aspects of day-to-day activity. Qualitative research designs have brought forward key aspects of integrity. Questions or statements that have been used with a variety of populations varying from multigenerational groups to the Berlin Aging Study include, “The first thing that comes to mind when I think about getting older is...,” “I believe the key to healthy aging is...,” and “Who am I.” Themes that were revealed included, “to have meaning in my life,” “meaningful involvement,” “positive mental outlook,” and “relationships with others” (Freund & Smith, 1999; Kerchner & Pegues, 1998). Responses to these questions generally fell into two categories: retaining or having a
perception of connection, and remaining or having a perception of being effective. These two primary characteristics support a sense of individuality and integrity (Leidy & Haase, 1999; Knebel, et al, 1998).

Leidy and Haase (1999) used a naturalistic qualitative design with a purposive sample of six men and six women recruited from a chronic obstructive pulmonary disease (COPD) clinic in the Southeastern United States in an effort to describe the meaning of functional performance from the perspective of the patient. Subjects were aged 50-76, English speaking and of varied socioeconomic backgrounds. The authors point out that while the subjects had COPD, they described support of personal integrity, not the treatment or symptoms of disease, as meaningful in functional performance.

In 1998, Knebel, Leidy and Sherman recruited 33 subjects ranging in age from 34-64 years (21 men, 12 women) with Alpha-1 Antitrypsin Deficiency from a larger study to examine functional performance. Data from the Chronic Respiratory Disease Questionnaire were categorized within an integrity framework and analysis of frequency distributions and importance ranking were conducted. Analysis revealed that while areas describing connectedness were mentioned less often than those describing effectiveness, the ranking of importance was higher for areas reflecting a sense of connectedness.

These studies have limited generalizability due to their small sample size, specificity of disease and geographic limitation. One has to wonder if involvement with a COPD clinic promoted connectedness supporting self-transcendence and allowing the subjects opportunity to look beyond their physical selves. The traditional role of nurse as advocate can support independence and personal integrity through education and interventions that consider the fuller context of the patient’s situation.
Nursing

Nursing describes several facets as central concepts which are fundamental to, or the essence of the profession, including transitions and caring. Issues that challenge the ability of an older person to maintain a sense of personal integrity, connectedness and effectiveness are often the work of nursing during life transitions and may be related to a perceived sense of caring. Morgan and Marsh, 1998, challenge nursing to look at each individual uniquely within their own context and be supportive of those values that promote wellness.

Theory

Nursing theory is defined as an organized framework of concepts and purposes designed to guide the practice of nursing (Mosby’s, 1998). Many of the theories of nursing describe concepts related to communication which seem to be central to the generation of a sense of connectedness for both the patient and the nurse. The descriptive elements of theory include developing an understanding of the perspective of the patient in determining care, the relationship of self to others, choices in the display of self, dynamic interaction, interrelations, patterns of interaction and reaction, self-awareness and the meaning of life (Cody, 1999; Carlson, 1999; Newman, 1998; Hertz & Irvin, 1996).


The concepts of spiritual perspective, hope, acceptance and self-transcendence are terms common to nursing. They are used to describe phenomena in practice, coping, and outcomes of care and education. Haase, Britt, Coward, Leidy and Penn, 1992, designed a simultaneous concept analysis (SCA) and used a consensus group method of analysis made up of the authors to generate a process model to consider these relationships across nursing literature. They developed validity matrices to identify common factors across the
concepts. The model considers antecedents, critical attributes and outcomes for each area as well as process direction. Connectedness was found to be shared across these concepts as an antecedent to hope, an attribute to spiritual perspective and an outcome of acceptance and self-transcendence while life experiences, energy, purpose and meaning, self-transcendence, self-worth, and personal growth were shared in a more limited way. Methods that are designed and analyzed within a closed group are questionable, however, it does provide a basis for future research in areas that are dynamic and relevant to nursing care. This perspective demonstrates dimensions supporting the centrality of connectedness in nursing care.

Meraviglia, 1999, conducted an extensive review of literature across disciplines to look at the concept of spirituality and concluded that nursing literature integrates the perspectives of all other disciplines. The defining attributes identified were faith, connectedness and integration which was described as unifying the body, mind and spirit of each person. She describes the outcomes of spirituality as including love, hope, trust, self-transcendence and spiritual, psychological and physical well-being. This work provides support for the previously discussed work of Haase, et al (1992). An increased understanding of potential spiritual representations may improve assessment and patient care especially during the turmoil of transition.

Transitions

Transitions have been described by numerous theorists and are represented within a wide range of phenomena. A review of nursing literature from 1986 to 1992 was used by Schumacher and Meleis, 1994, to address three questions: “What are the types of transitions addressed in nursing literature?”, “What conditions influence transition?”, “What constitutes a healthy transition?” Much of their review of literature discusses transition in the context of clinical descriptions, personal ideas and experiences. Four types
of transitions were identified: developmental, situational, health-illness and organizational. The universal properties included process, direction and a change in one of many areas such as roles, relationships, abilities or function. Seven factors influencing transition or transition conditions were identified: meanings, expectations, level of knowledge or skill, environment, level of planning, and emotional and physical well-being. A sense of subjective well-being, mastery and well-being of relationships were identified as indicators of healthy transitions. Descriptive elements of these indicators included a sense of dignity, personal integrity, competence, self-confidence, family adaptation, meaningful interactions and closeness. These concepts were repeated across the literature regardless of the type of transition. Incongruence in these areas during times of transition may promote uncertainty and powerlessness which challenge self-definition. Assessment, education and role-supplementation were identified as primary nursing therapeutics to support successful transitions.

The family stresses experienced during and after the decision to transition an elder family member into a nursing facility were studied by Dellasega and Mastrain, 1995, and Penrod, Dellasega, Strang, Neufeld and Nolan, 1998. These studies used qualitative methodology to examine issues and identify common themes. Subjects were recruited while the elder was an inpatient in an acute care setting or within six weeks of placement (n=7; n=10). Eighty percent of subjects were women. Emergent themes included singularity, role redefinition, uncertainty, loneliness, urgency and a perceived lack of support and caring from professional staff. The findings were illustrative of the conflict involved with transition and support the importance of the nursing therapeutics identified by Schumacher and Meleis.

Generalizability is limited by sample size, gender and geographic location. The acute time frame is also limiting but reflective of the point of interaction with health care
services that often occurs. To enable positive outcomes an identification of the perspective of those experiencing the transition is critical to the work of nursing. Indicators of healthy transitions and descriptive elements appear consistent with those supporting a sense of connectedness and effectiveness.

**Caring**

Caring has been conceptualized by theorists from different perspectives. Marla Salmon states, “Caring and advocacy are two things we ought to hold close to us and use as measures of whether we’re successful or not” (Kearns, 1997).

Morse, Bottorff, Neander, and Solberg, 1991, completed a critical review of nursing literature to look at conceptualizations and implications to nursing related to the concept of caring. Five areas of conceptualization were identified: caring as a human trait, moral imperative, affect, interpersonal interaction and as a therapeutic intervention. The outcome of the experience may be centered on the patient, nurse or both. Components and therapeutic interventions used to support these conceptualizations include: maintenance of patient dignity, expressing empathy, helping, being connected, trusting, mutual involvement and being present. Various arguments arise: caring is central to womanhood not the nursing profession; essential to humanness not nursing; if caring is the essence of nursing it is placed in an unattainable position; caring is the basis of ethics in nursing; if it is central then it must be measurable and accountable to support the legitimacy of the profession (Morse, et al, 1991). The authors bring forward significant questions: “is caring unique to nursing?”; “Does the caring intent of nursing vary?”; “Can caring be reduced to behavioral tasks?”; “Is the power of caring instrumental or creative?”

The discussion is continued by Smith, 1999, using an analysis of the dialogue on “caring” within nursing with a process of concept clarification. Based on her analysis of the dialogue from the 1989 Wingspread Conference examples are provided to support six
clarification is undertaken through literature review to identify conceptual meanings in context. Theoretical niches are then identified within the Science of Unitary Human Beings (SUHB) resulting in five constitutive meanings reflective of the perspective of SUHB. Finally, narratives are presented from the viewpoint of the nurse to promote understanding of the abstract through concrete examples. Smith has attempted to do what is called for by Morse, Botterff, Neander & Solberg, 1991, “If caring is really the essence of nursing then it must be demonstrated and not simply proclaimed.” She clarifies the concept concisely within the framework of SUHB. It seems clear that while there is agreement that caring is a factor in nursing care, how it is demonstrated, implemented and conceptualized within each model or theory must vary.

The literature previously discussed revealed a commonality of concepts. A table depicting the representation of the themes identified with connectedness and effectiveness in the areas of: (1) descriptive elements of nursing theory; (2) the preservation of integrity and self-definition from the patient’s perspective; and, (3) support of the maintenance of health are presented in Table 1. A model of the interactions between concepts is presented in Figure 1. Interpersonal relationships are well represented across the literature and are the primary support for a sense of connectedness and effectiveness.

The antecedents represent our interactions within those relationships, the attributes reflect a sense of connectedness and effectiveness and fluctuate based on the strength of that sense, while the outcomes are a result of a sense of connectedness and effectiveness. At the periphery of the model, in the areas of attributes, outcomes, and those areas that are supported by a sense of connectedness and effectiveness, there appears to be less consistency across the literature, although, the concepts are broadly represented. People seem to be more concerned with the antecedents and the areas that are supported by a sense of connectedness and effectiveness, nursing emphasizes antecedents and outcomes while the maintenance of health looks at antecedents and attributes.
A purposive sample representative of each area was used and each of the themes were depicted only if they were explicitly stated or if, within the context of the work being reviewed, the terminology was consistent with the definitions being utilized. This may have caused under-representation in some areas. While a sense of connectedness and effectiveness are not consistently stated explicitly among theories of nursing the themes and concepts previously identified appear to be an integral element. Caring as a concept seems to flow as a thread, describing support in a variety of areas and implicit in many theories of nursing. A sense of connectedness and effectiveness appears to be central to the patient's perspective and bolstered by a perception of caring. These perceptions are central to the sense of self and the maintenance of personal integrity.

Education

The healthcare educational system is striving to find ways to encourage practitioners of all levels to seek work with elders and the community, even though this may be a formidable task in the face of popular perception and stereotypes. Communities of teaching and learning are being challenged with satellite campuses, video and Internet courses and the resurgence of service learning (McBride, 1999). Service learning is defined by Peterson and Schaffer, 1999, as "...a reciprocal relationship between students and communities in which both parties engage in service and learning." Service learning has the ability to promote intergenerational relationships and facilitate the ability of elders to age in place by supporting them in remaining in their community and maintaining strong communication ties (Galambos & Rosen, 1999; Graham, 1998). The years 1998 and 1999 have seen several schools of nursing utilize service learning as a way to support the changing role of nursing. These have been community based programs which provided exposure to well elders supporting the concept of preventative care (Schneiderman, Jordon-Marsh & Bates-Jensen; Jacobson, MacRobert, Leon & McKennon; Doerr, Sheil, Baisch, Forbes, Howe, Johnson & Vogtberger; Naylor & Buhler-Wilkerson, 1999; Peterson & Schaffer, 1999).
The impetus for each of those projects came through curriculum review by their respective institutions. Unifying themes across those changes were a need to address the changing role of nursing in aggregate care, elder care, health promotion and the wise use of resources. Additionally, diversity among student populations has defied the concept of the "typical student." The utilization of service learning may assist with the integration of a diverse student population adding depth and breadth to student perceptions as they promote meaningful relationships with and among the recipients of their care. This can support a sense of connectedness and effectiveness for patients and students. Much of the positive response to those programs was expressed in the context of interpersonal interaction reinforcing the most basic of nursing therapeutics: communication and listening. Elders felt that the students both learned from them and provided useful information, and they enjoyed the exchange (Schneiderman, et al, 1998). Over all, students rated the programs positively, with a more positive attitude toward those nursing areas providing support for program continuation.

Summary

The 1982 International Plan of Action set aside 1999 as the International Year of Older Persons. An emphasis of the plan of action was research to identify ways to enrich the quality of life for older persons (Annon, 1999; Antonucci, 1999). One way to support that goal is through nursing research that defines those areas that promote independence and personal integrity. The population of persons aged 65 years and older is growing at a faster rate than at any time in history allowing nursing to play a greater role in the management of chronic illnesses common to older persons as the health care system seeks ways to control cost. Marie Henry states, "...we have to look at all of the parameters of what touches people" (Kearns, 1997).

A sense of connectedness and effectiveness support personal integrity and individuality which have been identified as central themes of self-definition. This has been
found to be consistent across diverse research populations and significant across the life-span. The pervasiveness of the description of a sense of connectedness and effectiveness leads one to believe that they are cornerstones of integrity and self-definition and therefore must be central to nursing practice.

Connectedness or its descriptive elements are discussed throughout nursing theories. Margaret Newman, 1999, considers connectedness a shared rhythm of interaction between client and nurse that establishes the relevancy and effectiveness of nursing practice. Caring as a central theme of nursing has created great debate, yet it is described as involved in the preservation of dignity, a sense of belonging, interconnectedness and spirituality (Smith, 1999; Morse, et al, 1991; Meraviglia, 1999). A sense of dignity and personal integrity are descriptive elements identified with healthy transitions. These are supported by a sense of connectedness and effectiveness (Schumacher & Meleis, 1994). Elements of many theories of nursing also bolster or define a sense of connectedness and effectiveness such as the relationship of self to others, interrelations and patterns of interaction (Cody, 1999; Newman, 1998; Carlson, 1999; Hertz, 1996).

Research has shown that students of nursing are resistant to pursuing employment in the areas of elder care or community nursing (Jacobson, et al, 1998; Schneiderman, et al, 1998; Doerr, et al, 1998). Community and aggregate based care has increased in focus offering schools of nursing opportunities to work with community partners to support health care needs. The utilization of service learning in selected areas may promote a sense of connectedness between students and underserved community populations encouraging future employment in those areas.

“Nursings work for the new century is to recognize that nurses can never get a complete understanding of any one dimension of the person,” (Drevdahl, 1999). In order to provide a framework to guide nursing practice further research is needed to identify the context of connectedness and effectiveness within nursing theory and practice.
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** Schumacher and Meeks, 1994.
***** Carlson, 1999.

+++ Leidy and Haase, 1990.
++++ Freund and Smith, 1999.
+++++ Smith, 1997.

** Hagerby and Williams, 1999.
***** Anderson, 1996.
MODEL OF CONCEPT INTERACTIONS

FIGURE 1
References


Naylor, M.D. & Buhler-Wilkerson, K., 1999. Creating community-based care for the new millennium. *Nursing Outlook, 47*(3);120.


