

Visions: The Journal of Rogerian Nursing Science

Volume 18 Number 1 2011

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Society of Rogerian Scholars
New York University
College of Nursing
726 Broadway 10th floor
New York, NY 10003

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ISSN 1072-4532

Indexed in CINAHL

VISIONS: THE JOURNAL OF ROGERIAN NURSING SCIENCE

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4. Authors will follow the format of the *Publication Manual of the American Psychological Association* (6thEd.).
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Organization of manuscripts:

1. Identification page (name, address, phone number, affiliation and professional title and running title) (Optional: e-mail address).
2. Title page (no author identification).
3. Abstract followed by 3-4 key words for indexing.
4. Text of 15-20 pages plus references.

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Editorial

Development of a Simple Non-language Based Measure of Well-Being: A Personal Journey

By Sarah Hall Gueldner, DSN, RN, FAAN, the Arline H. and Curtis F. Garvin Professor of Nursing at the Frances Payne Bolton School of Nursing, Case Western Reserve University

Unlike many of the terms used by Rogerian Scholars, well-being is a term that is generally understood in everyday language. It denotes a sense of being well, and is presumed to be the ultimate goal of virtually every person and of society in general. But because the term conveys different images to different people, sense of well-being is not easy to measure. Addressing that goal, my colleagues (some were students at the time) and I began the daunting task of developing a non-language based paper and pencil pictorial scale that could measure general sense of well-being in persons around the world. That goal required several years of developing simple one inch line-drawn black and white pictures that depict opposite ends of a well-being scale (i.e., the sun out bright or behind clouds; eyes open or closed; a candle lit or not lit; a lion or a mouse). We sketched the pictures ourselves at first, but on the advice of our wise and well-meaning peers, a student artist was eventually hired to draw the simple coloring book style pictures that portray universally recognizable simple images perceived to represent positive or negative sense of well-being.

The images were taken to national and international nursing meetings over a two year time period, and participants were invited to judge whether each item represented a positive or negative view of well-being (or neither). Only the strongest items were retained and posted as positive versus negative well-being picture pairs, separated by a line with 7 selection options. As before, participants at national and international nursing meetings were invited to review the paired pictures and indicate those items that they felt best represented a strong versus weak pairing of items. The scale was also tested at international conferences to confirm which items had universal recognition. An 18-item test was developed first, but as it was administered to groups it became apparent that some items were stronger than others, and the scale was eventually reduced to 14 then 10 items (which is the present version of the scale). It is interesting to note that over time some items became out of date or otherwise inappropriate. For instance, a drawing of the first space shuttle on the launch pad represented a highly positive icon at the beginning of the tool development, and was included on the original 18-item scale because it generated a highly positive sense of well-being. However, it had to be removed from the scale after the space shuttle exploded on takeoff, because at that point it had come to portray a tragic and thus negative image to participants.

The present 10-item scale has been administered to several thousand participants in the USA, Canada, Taiwan, Japan, Egypt, and most recently Africa, and the psychometric properties continue to remain strong in both national and international samples. It has also been used to measure sense of well-being in both community and nursing home dwelling elders, and in other groups who may have compromising circumstances. The five picture pairs that have emerged to be the most consistent items across all samples are: 1) puzzle pieces together and separated, 2) balloons inflated and deflated, 3) sun behind a cloud and without a cloud (all three representing the concept of awareness); 4) eyes open and closed (representing frequency), and 5) the lion and the mouse (representing power). A children's version of the instrument has recently been developed by Susan Terwilliger (2008) for use in her doctoral research.

In summary, the WPS was developed with intent to provide a simple measure of well-being for all persons, including those who can not read or speak English, who have difficulty seeing, or who may be too weak or otherwise unable to respond to more complex or lengthy measures of well-being. I am so pleased that the findings of three studies using the WPS are reported in this issue of *Visions*, and it especially pleases me to learn that one of the studies was conducted by an author (Jabrenta Hubbard) who is not a nurse. To my knowledge, this is the first time that the WPS has been used as a research measure in a discipline other than nursing, fueling my hope that it will become a tool that is used across disciplines.

The developers and I greatly appreciate those who helped develop and have used the WPS as a measure in their research, and we encourage others to use it in their studies, as well. A copy may be obtained without charge by emailing me at shg13@case.edu.

VALIDATION OF THE WELL-BEING PICTURE SCALE (WPS) AS A MEASURE OF MOOD

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Abstract

This paper reports the extension of the psychometric properties of the Well-Being Picture Scale (WPS) developed by Gueldner and colleagues (2005). A convenience sample (N=220) of generally healthy registered nurses as well as nursing and psychology students in two Mid-Atlantic academic settings completed the WPS and the Profile of Mood States (POMS). The Rogerian energy field concepts of frequency, action, awareness, and power were found to correlate significantly with age ($p=.027$). Correlations between the scores and education, ethnicity, and gender were not found to be significant. An inverse association was found between the WPS and POMS Standard scores ($r= -.343$; $p<.001$), as might be expected. Confirmatory factor analysis revealed that the “eyes open” and “shoes tied” items accounted for 62.7 % of the variance in this sample. The overall Chronbach alpha was .838, which is consistent with the findings of previously reported work. This inaugural comparison demonstrating an inverse relationship between the WPS and the POMS suggests that the WPS composite score holds considerable promise for clinical usage to assess mood state.

Keywords: Well-Being Picture Scale, Sarah H. Gueldner, psychometric evaluation, mood state, Martha E. Rogers, Profile of Mood States, clinical assessment

Rogers (1992) stated that the purpose of nursing is to “foster the well-being of humans in our care wherever they are in the environment” (p. 28). Well-being was not defined by Rogers, but is typically understood to mean a state of being healthy. In order to foster the well-being of another, one must come to understand the other’s health. But health can be difficult to assess, especially the aspect of mood of another human being. A number of measures to screen for disturbed mood states exist for nurses to use; however, most use a negatively worded scale.

The Well-Being Picture Scale (WPS) developed by Gueldner et al. (2005) approaches the assessment of human well-being from a positive energy perspective. This scale attempts to capture a sense of well-being using black and white line drawings depicting the concepts of frequency, awareness, action, and power of the individual at a specific point in time. The purpose of this paper is to report the findings of a study using quantitative methods to further examine the psychometric properties of the WPS in a sample of generally healthy individuals. The research questions are 1) Is there a relationship between scores on the WPS and the Standard Profile of Mood States (POMS), 2) Is the WPS sensitive to assess mood state in the general population, and 3) Is there a significant difference of the factor

analysis between previously reported findings in a sample from the United States, Taiwan, Japan, and Africa (n= 1027) (Gueldner et al., 2005), and the sample from the United States who participated in this study.

Well-Being in the Context of Rogerian Theory

Rogerian science posits that humans are always in the process of “becoming” rather than just “being” (Parse, 1997), and that the focus of nursing is on humans within their mutual human-environmental field. Rogers uses the term in her definition of nursing, “the purpose of nurses is to promote health and well-being for all persons wherever they are” (Rogers, 1992, p. 28). So central to the purpose of nursing is well-being.

Well-being is defined by Hills (1998) as a sense of relative harmony and satisfaction in one’s life. Connections between well-being and health have emerged, including a movement toward self-fulfillment or realization of one’s potential (Smith, 1981; Todaro-Franceschi, 1999) and personal commitment (Parse, 1997). Newman (2008) proposes that well-being cannot be distinguished from health, but rather is a manifestation of expanding consciousness not separate from the illness experience. Morris (1991) and Hills (1998) link well-being with awareness based on integrality, resonancy, and helicity. An understanding of these

homeodynamic principles is essential to the definition of well-being. *Helicy* refers to “the continuous, innovative process within the human-environmental field pattern, manifested as movement toward one’s potential, and is positively associated with a sense of well-being even in the presence of illness or other challenging life experiences” (Rogers, 1992, p. 31). *Resonancy*, described by Capra (1975, p. 226) as the “continual cosmic dance,” characterizes the human-environmental energy field. Resonancy describes energy patterns from lower to higher frequencies, and is postulated to be associated with a heightened sense of well-being (Gueldner et al., 2005). *Integrality* is defined as the “continuous mutual human field and environmental interchange” (Rogers, 1992, p. 31). Malinski (1994) summarizes the relationships among these three important concepts by stating that helicy is the nature of change, resonancy is the process of change, and integrality is the context of change.

Well-Being Picture Scale (WPS)

Gueldner, Bramlett, Johnston, and Guillory (1996) revised the 18-item Index of Field Energy (IFE) to a shorter and simpler scale of ten picture pairs known as the Well-Being Picture Scale (WPS). It is postulated that the principles of helicy, resonancy, and integrality are embedded in the experience of well-being. Like its precursor the IFE, the WPS is designed to measure general well-being in an individual integral with his or her unique human-

environmental field process, and is designed to be easily administered in the broadest possible range of adult populations. Like the longer IFE scale, the WPS measures well-being according to the four constructs of power, frequency, awareness, and action, as described below. It should be noted that a children’s version of the WPS (Terwilliger, Gueldner, & Bronstein, in press) has recently been developed and tested for use with fourth grade and older elementary school children.

Power derives from the principle of helicy and is defined as the capacity of an individual to engage consciously (i.e., knowingly) in change (Barrett, 1990). Within the WPS, the lion-mouse item represents power. *Frequency* refers to the motion within human-environmental energy field(s), and is related to resonancy, as described by Capra (1975). Changes across a continuum ranging from lower to higher frequencies are portrayed in simple line drawn pairs of eyes open and closed, a lighted and unlit candle, a faucet running full or dripping, and a butterfly paired with a turtle. *Awareness* is derived from helicy and integrality. Awareness refers to an individual’s potential or readiness for change within the environmental field, and is positively associated with a sense of well-being. This concept is reflected in the drawing of a sharp pencil opposite a dull pencil, and in puzzle pieces scattered and puzzle pieces together, balloons inflated or drooping, and sun in full view or behind clouds. *Action* derives from

the principle of integrality as an emergent of the continuous mutual human field process (Rogers, 1992), but also reflects resonancy. Activities of daily living are included in actions such as eating, preparing food, personal grooming, engaging in social events, or doing chores. A single item reflecting action is the sneakers with laces untied opposite sneakers with laces tied and running. The WPS has been administered to over one thousand individuals around the world, including the United States of America (USA), Taiwan, Korea, Japan, Arabic speaking countries, and Africa. Confirmatory factor analysis and internal consistency measures reveal strength (Cronbach $\alpha = .8795$) (Gueldner et al., 2005).

Mood Defined

Mood is defined as a relatively long lasting emotional state and reflects the health status. Moods differ from simple emotions in that they are less specific, less intense, and less likely to be triggered by a particular stimulus. Moods are viewed as having either positive or negative valence, and are often expressed as being in a *good mood* or a *bad mood* (Thayer, 2001). Unlike sudden fear or surprise, or other acute emotional feelings, moods often last for hours or days. Mood is an internal, subjective state with potential for long term disturbances such as depression, and can often be inferred from posture, behavior, or other body language. Thayer (2001) goes on to describe mood as a product of two dimensions: energy and tension. The

reference to energy as a component of mood supports the tenets of the Science of Unitary Human Being. These authors postulate that a person in a state of well-being would be in a good mood. Conversely, it is postulated that a person with a mood disturbance would experience a decreased sense of well-being. Rogers's concept of resonancy appears to most closely embrace mood state within the human environmental field, in that it describes energy patterns from lower to higher frequencies, and sense of one's self as energy is a key aspect of mood state.

A commonly utilized instrument to measure mood is the Profile of Mood States (POMS) (Lorr, McNair, Heuchert, and Droppleman, 1971). A review of the literature for the use of the Profile of Mood States in clinical research revealed numerous studies. The POMS is used in nursing and biomedical research with both healthy and patient samples to measure mood state. Reliability and validity of the POMS have been well established. In reviewing only studies since 2004, research in four different specialties, including cancer (Knois, Aaronson, Uebelhart, Fransen, & Aufdemkampe, 2005), chronic pain (Dworkin, et al., 2008), psychology (Andersen, Farrar, & Golden-Kreutz, 2004), and hypothyroidism (Grozinsky-Glasberg, Fraser, Nahshoni, Weizman, & Leibovici, 2006) all utilized the POMS to evaluate baseline and subsequent change in mood across the respective clinical trials. In this study

both the POMS and WPS were compared.

Methods

Design

This descriptive correlational study contributes to the understanding of the validity of the WPS by correlating a composite score on the WPS with the score on the POMS.

Sample

The convenience sample was comprised of 220 nurses as well as nursing and psychology students in two academic settings from different Mid Atlantic states. Age ranged from 18-67 years with a mean age of 35.45 (+/-12.98) and included

participants for a range of 49 years. Eighty-two percent (82%) of the sample were born in the United States (U.S.) and the remaining 17% were born in Bosnia, England, Germany, Haiti, India, Japan, Kenya, St. Maarten, and Ukraine, representing every continent except Antarctica. The minimum education was “in college now” (70%) and the maximum was “graduate education” (30%). This homogeneous sample consisted of 94% females and 6% males. Table 1 provides demographic characteristics of the sample.

Table 1
Demographic Characteristics of Sample

Country	USA
Sample size (N)	220
NY	(80) 36%
PA	(140) 64%
Ethnicity	
Caucasian	(182) 82.7%
African-American	(20) 9.1%
Latina/Latino	(10) 4.5%
Asian/Pacific Islander	(8) 3.6%
American Indian/Alaska native	0
Other	0
Gender	
Female	206 (94%)
Male	14 (6%)
Education	
<HS	0
HS graduate	0
Vocational Training	0
College or Higher	220 (100%)
Registered Nurses	100 (45%)
Nursing and Psychology students	120 (55%)
Age	Range 18-67 (mean 38.69±12.98)

Procedure

After obtaining human subjects research approvals from the State University of New York at Binghamton, New York and Cedar Crest College in Allentown, Pennsylvania, nursing faculty in a rural upstate New York setting and a suburban midlevel region in Pennsylvania recruited a convenience sample of nurses, nursing students, and psychology students as part of class activities to experience research methods first hand. After informed consent was obtained, participants completed a one-page demographic sheet and the two instruments, WPS and POMS.

Instruments

Well-Being Picture Scale.

The Well-Being Picture Scale (WPS) is a 10-item non-language based pictorial scale that measures general well-being (see Figure 1) and was based on Martha Rogers' view of human beings as energy fields in continual mutual process with their environment. The Well-Being Picture Scale was designed for use with the broadest possible range of adult populations, including persons who are unable to respond to English-based text or complete a more lengthy or complex measurement instrument. The overall Cronbach's alpha is .8795 (Guedner et al., 2005).

Profile of Mood States Instrument (POMS).

The Profile of Mood States (POMS) developed in 1971 by Lorr, McNair, Heuchert, and Droppleman consists of 65 items taking approximately 10 minutes to complete, and is concerned with the phenomenology of feelings and emotions. Each subscore is derived from the sum of ratings for 7 to 15 adjectives. Reliability estimates using the Kuder Richardson 20 statistic (KR-20) ranged from 0.84 to 0.95. Test/retest correlations ranged from 0.65 to 0.74 with a median of 0.69 (McNair, Lorr, & Droppelman, 1981). The respondent rates items on a 5-point scale ranging from "Not at all" to "Extremely." The items fall into six identified mood factors (five negative pairs and one positive pair): Tension-Anxiety, Depression-Dejection; Anger-Hostility: Fatigue-Inertia, Confusion-Bewilderment, and Vigor-Activity. Examples of feelings that respondents mark include "worn out," "grouchy," "energetic," or "listless." Sub scores for Tension, Depression, Anger, Fatigue, and Confusion are summed and then the subscore for Vigor-Activity is subtracted, resulting in either a negative score for mood stable participants or a positive score for those with mood disturbance. Norming of a sample of college students revealed a range of scores from 168 to -3 (mean = 55) (Lorr, McNair, Heuchert, & Droppleman, 2003).

Figure 1. Well-Being Picture Scale: A refined version of the Index of Field Energy






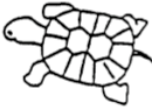




Well-Being Picture Scale

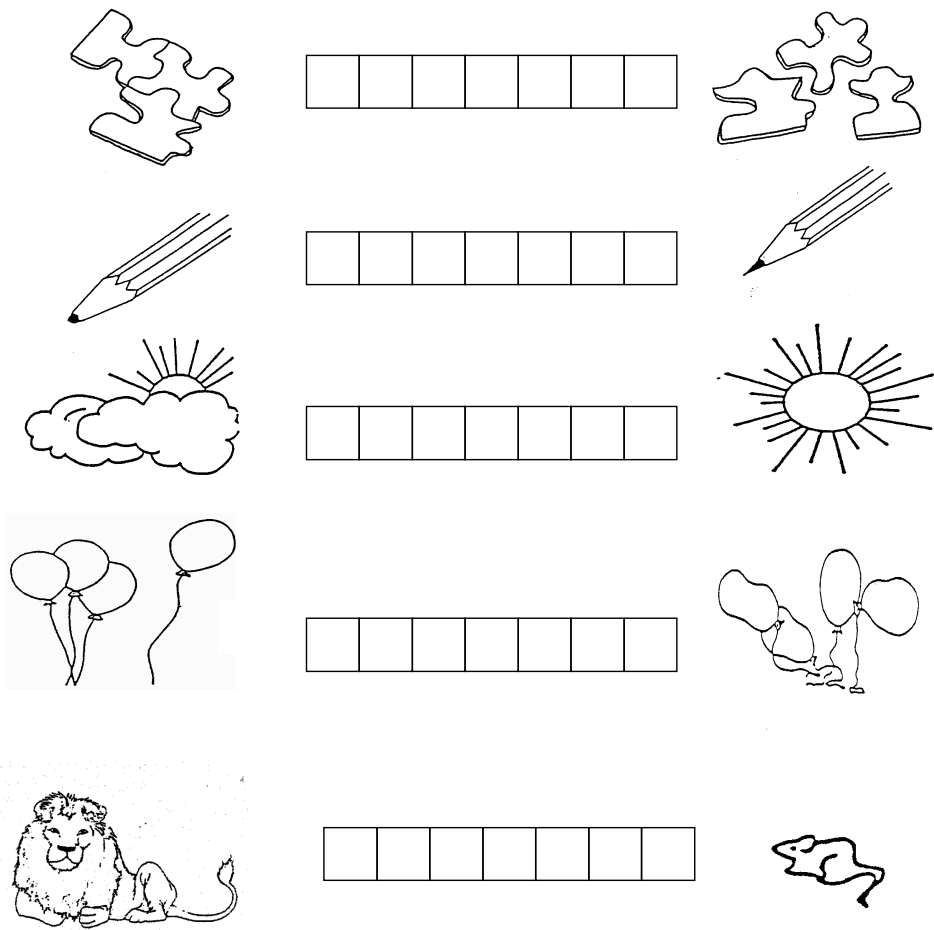
Page 1 of 2

Subject ID _____ Date of evaluation _____

Instructions:

Look at the scale between each pair of pictures. Mark [X] at the place on the scale that best describes how you feel now.

	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
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Gueldner, S.H., Michele, Y., Bramlett, M. H., Liu, C. F., Johnston, L. W., Endo, E., Minegishi, H., Carlyle, M.S. (January 2005). The Well-being Picture Scale: A Revision of the Index of Field Energy, *Nursing Science Quarterly*, 18(1), 42-50.

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Statistical Analysis

Data was analyzed using the Statistical Package for the Social Sciences (SPSS) Version 16.0 (2007). Correlations between composite WPS, POMS, and demographic variables were conducted using Spearman's rho. Additional analyses of the WPS calculated factor loadings on individual items contributing to instrument validity. A calculation of missing data revealed .01% missing data or 37 items omitted by participants, out of 3,280 possible data pieces.

Results

WPS and Demographics

A composite WPS score was calculated by summing the Likert rating for each item and dividing by 10 (the total number of items in the instrument). Using this method WPS scores ranged from 10-70. The mean WPS score was 4.831 (+/-1.11). A positive correlation was discovered between the WPS composite score and the demographic variable of participant age ($r=.408$, $p < .001$).

Correlations were calculated for each item of the scale based on the demographic variables of age, education, and gender. Education and gender did not reveal significant associations. However, as was seen in the previous finding with age and the total WPS score, age was significant for every item. There was a positive association with age.

Differences in WPS scores also emerged between the Pennsylvania and New York participants. Even though the sample size was skewed toward

Pennsylvania, the POMS scores for the New York participants were significantly higher ($r=.192$; $p=.011$). However, comparisons of WPS composite scores between Pennsylvania and New York participants were not significant ($r=-.056$; $p=.223$).

Item Analysis of WPS With Age

Power. The mean lion-mouse score was 4.74 (+/-1.5). For the age variable $r=.198$, $p=.027$.

Frequency. The concept of frequency was measured by four items: eyes, turtle, candle, and faucet.

- Eyes. The mean eyes score was 4.81 (+/-1.648). For age the $r=.466$, $p<.001$.
- Turtle. The mean turtle score was 4.93 (+/-1.62). For age the $r=.290$, $p=.001$.
- Candle. The mean candle score was 5.09 (+/-1.47). For age the $r=.239$, $p=.007$.
- Faucet. The mean faucet score was 4.67 (+/-1.52). For age the $r=.383$, $p<.001$.

Awareness. The concept of awareness was assessed by four items: puzzle pieces, pencil, sun, and balloon.

- Puzzle. The mean puzzle score was 4.63 (+/-1.66). For age the $r=.293$, $p=.001$
- Pencil. The mean pencil score was 4.89 (+/- 1.45). For age the $r=.299$, $p=.001$
- Sun. The mean sun score was 4.74 (+/-1.71). For age the $r=.234$, $p=.009$.
- Balloon. The mean score for balloon was 4.76 (+/- 11.71). The r score was .246, $p=.006$.

Action. The concept of action was measured by the sneakers; the mean sneakers score was 4.50 (+/- 1.56). For age the $r=.204$, $p=.022$.

POMS Findings

The POMS scores ranged from -8.2 to 94. The mean composite score was 26.84 (+/-8.53), with a positive score indicating that some participants (N=10; POMS score >83) were experiencing disturbed mood.

Correlation of WPS to POMS

The correlation revealed an inverse association between the WPS scores and the POMS scores ($r= -.343$; $p<.001$), as would be expected, given that mood was measured as a negative trait and well-being was measured as a positive trait.

Internal Consistency

The Cronbach alpha ($\alpha=.838$) was somewhat lower than reported by Gueldner et al. (2005) ($\alpha=.8795$), but is still considered to be a strong indicator.

Factor Analysis

A factor analysis was performed using Principle Component Analysis with Varimax rotation, as was also performed in a sample from the United States, Taiwan, Japan, and Africa (Gueldner et al., 2005). A four-factor structure of the WPS was evident, consistent with previous results (Gueldner et al, 2005). As shown in Table 2, current results reveal that all 10 items were consistent with the proposed structure. Across all four samples, five of the ten items were completely consistent with the proposed structure (puzzle, balloon, sun, eyes,

and lion). The remaining items (pencil, candle, faucet, butterfly, and shoes) were consistent across three samples.

Discussion

The data collection phase for this study lasted from June 2006 until September 2009, or 3 years and 2 months. The sample for this study was mostly female, predominantly U.S. citizens, all nurses or nursing and psychology students, which limits the generalizability of the findings. Every item in the WPS correlated with age in a positive direction; namely, the older the person the higher the WPS score. One possible explanation applying Rogers's theory could be that most of the older participants were registered nurses, older, and perhaps more evolved toward self-awareness, in contrast with the younger nursing and psychology students who were perhaps in an earlier stage of "becoming".

The candle item achieved the highest mean score (5.09) and was also highly significant ($p = .007$), bringing to question the possibility that the metaphor of the lighted candle may have prompted a special connection with the traditional icon of the lighted lamp as a professional symbol in this sample that included nurses and student nurses. The principle of frequency is at work in this item and represents the state of pattern in the "cosmic dance." However, it should be noted that in the confirmatory factor analysis "candle" accounted for only 1.75% of the variance.

Table 2
Factor Analysis Results

	Taiwan (Gueldner et al., 2005)	USA (Gueldner et al., 2005)	Japan (Gueldner et al., 2005)	Combined (Gueldner et al., 2005)	USA (Current study)
N	360	449	218	1027	220
Chronbach's alpha (α)	.8602	.8266	.9129	.8795	.838
Item					
Pencil	F4	F1	F1	F1	Awareness
Puzzle*	F1	F1	F1	F1	Awareness
Balloon*	F1	F1	F1	F1	Awareness
Sun*	F1	F1	F1	F1	Awareness
Eyes*	F2	F2	F2	F2	Frequency
Candle	F2	F2	F1	F2	Frequency
Faucet	F3	F2	F2	F2	Frequency
Butterfly	F2	F2	F3	F2	Frequency
Lion*	F3	F3	F3	F3	Power
Shoes	F2	F4	F4	F4	Action

NOTE: * = Factors identical across all four sample

The correlation between the WPS mean score and the POMS demonstrated an inverse relationship. As the WPS score increased (representing a state of well-being), the POMS score decreased (representing the absence of mood disturbance) in this generally healthy sample, suggesting that a high sense of well-being can exist only in the presence of a balanced mood.

The frequency (i.e., eyes, candle, faucet, and butterfly) and action (i.e., shoes) items account for more than 60% of the items on the scale, and it seems possible that items such as the open eyes and

shoes in movement could foster special interpretations among this sample of nurses. For instance, nurses and nursing students may see themselves as the “eyes” for sick patients and their families. Likewise, nurses and nursing students may see themselves as “on the move,” and today many nurses wear sneakers as they provide care to patients and families; therefore it seems possible that nurses and nursing students might respond in a different way than others to the frequency and action items. This question could be examined more specifically in future studies.

The factor analysis results demonstrate strong support for the proposed factor structure in addition to general consistency across this sample and three previous samples (Gueldner et al., 2005). Five of the ten items were completely consistent with the proposed structure (puzzle, balloon, sun, eyes, and lion) and the remaining items were consistent across three samples. Overall, participants in this study and in previous samples (Gueldner et al., 2005) show a similar interpretation of the items on the WPS scale, demonstrating that the items produce an acceptable degree of consistency across languages, cultures, education levels, and cognitive abilities.

Conclusion

It was found in this study that the WPS score and POMS score are associated in a significant inverse relationship, indicating that they represent related but opposite constructs. Based on the strength of internal consistency, the researchers calculated a WPS composite score, allowing for a comparison with the composite POMS score; both scales were previously analyzed using confirmatory factor analysis, both utilize a Likert scale, and the findings of both result in ordinal data. This inaugural comparison demonstrating an inverse relationship between the WPS and the POMS suggests that the WPS composite score holds considerable promise for clinical usage as a more simple measure to assess mood state. The findings of this study also confirmed that age and WPS composite scores are

highly correlated, which has implications for future applications.

In future studies it is important to include participants with a variety of demographic characteristics such as urban or rural setting, religious affiliation, occupational category and income, marital status, and level of education. The investigators also suggest that it might be informative to include a general short answer question at the beginning of the testing session, asking them to indicate how they feel, such as, "How are you feeling today?" It is also important to extend testing of the WPS to other vulnerable or underrepresented populations, including frail elders, individuals with mental health problems such as depression and dementia, minority segments of the general population, individuals who are incarcerated in prisons, and other individuals with special needs. Finally, it is important to continue to test the recently developed children's form of the WPS, to provide a simple yet reliable measure of well-being in children.

The findings of this study are offered in support of an instrument based on Rogers's theory that uses "imaginative and creative use of knowledge" (Rogers, 1988, p. 100) in human service. It represents an exemplar of the promise that the Science of Unitary Human Beings can provide a foundation for expanding the quality of the nursing product by assessing "those who are otherwise too sick or weak" to have a voice (Gueldner, Britton, & Terwilliger, 2008, p. 122).

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EVALUATION OF A BRIEF MINDFULNESS-BASED PROGRAM ON RECALL AND SENSE OF WELL-BEING IN A SAMPLE OF OLDER AFRICAN AMERICANS

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Abstract

This study examined the effect of mindfulness training, a natural healthful approach which is consistent with the Rogerian construct of unitary and inseparable human-environmental field, on recall and sense of well-being. A number of studies have demonstrated positive benefits from the practice of mindfulness; however, it does not appear from the literature review that mindfulness interventions have previously been studied in older African American populations. Addressing this understudied population, the sample (N=14) for this preliminary study was recruited from African Americans 65 years or older who live in a senior living community. The volunteers were randomly assigned to the experimental group (n=7) or the control group (n=7). The study examined the ability of four 30-minute group sessions of mindfulness intervention to improve recall capacity and sense of well-being when compared to the control group who did not engage in mindfulness training, but rather participated in four 30 minute group discussions on aging. Baseline recall was measured by having each participant listen to a recorded 100 word short story, then asking them to immediately recall verbally all that they could remember of the story. Participants were also asked to complete the *Well-Being Picture Scale* as a base line measure prior to their participation in the study. Immediately following completion of the fourth mindfulness training and discussion sessions, both groups were again measured for recall capacity and sense of well-being. While no statistically significant differences were found between the experimental and control groups with regard to recall or sense of well-being, the tendency toward improvement supports replication of the study in a larger sample over a longer period of time.

Keywords: Mindfulness, African Americans, Older Adults, Dementia

ACKNOWLEDGMENTS

First and foremost, I would not be anywhere near where I am today without the strength, courage, and direction that the Lord has always provided for me. Thanks also to my parents for always pushing me to do my best and for always being by my side. I would also like to express my deepest appreciation for the support of my academic committee members as well as the residents and staff of the facility for their participation and support of the study. Finally, thank you Dr. Sarah H. Gueldner of Case Western Reserve University for allowing me to use your *Well-Being Picture Scale*, an integral component to this project.

Introduction

For the first time in American history, older adults age 65 and above outnumber people under the age of 25 years (Spence, 1995). Accounting for 8.3% of the older adult population in 2008, it is anticipated that the number of African American seniors will rise to 11% by 2050 (U.S. Administration on Aging [AOA], 2010). In general, health is expected to decline in the older adult population (Rejeski, 2008). Specifically, research findings predict a higher prevalence of mild cognitive impairment and various types of dementia in the older adult African American population (Doniger, Jo, Simon, & Crystal, 2009; Gurland, et al., 1999). Addressing these concerns, this study tested the ability of a brief mindfulness training program to improve the memory and well-being in a group of older African Americans.

Aging, Memory Decline, and Mindfulness

During the aging process, normal age related declines are apt to occur, and for some, decline in cognition or memory may become problematic. Studies indicate that the African American population is at higher risk for dementia related illnesses as compared to non-African Americans (Doniger, et al., 2009; Gurland, et al., 1999). Memory is affected by the ability to process stimuli, and with age the processing speed decreases (Luo & Craik, 2008). Given the increased risk of

dementia in the older African American population, it is important to investigate practices that can aid in reducing cognitive decline in this population.

Research findings have also shown significant links between cognition and the body. One practice that is based on this relationship is that of mindfulness. It is believed that mindfulness connects the mind and body and subsequently aids in the healing process (McBee, 2008). Mindfulness is denoted by “paying attention in a particular way: on purpose, in the present moment, and nonjudgementally” (Kabat-Zinn, 1994, p. 4). This ability to be attentive, to completely experience the present, and to maintain focus has been correlated with improvements in various aspects of life (Raffone, Tagini, & Srinivasan, 2010). Kabat-Zinn (1990) and other mindfulness educators suggest that practicing mindfulness based approaches should foster seven specific features: “ non-judging, patience, having a beginner’s mind, trust, non-striving, acceptance, and letting go” (p. 32).

The Practice of Mindfulness

The practice of mindfulness began in the Eastern cultures of the world, and key teachings have evolved from Buddhist practices. Being actively aware in the present moment with tolerance, acceptance, and without judgment is being mindful, or as Kabat-Zinn (1994) states, it is “the art of conscious living” (p. 6). For

instance, as you eat a meal, you notice each burst of flavor and each unique texture without adhering to the curiosity of whether the meal is appealing or distasteful. The food is just a food. This non-judgmental, present, and accepting practice of living in every moment can be applied to all aspects of life (Sanderson, n.d.).

Mindfulness can be practiced on a daily basis during any daily task. However, the formal practice of mindfulness involves meditation, walking, and yoga. Mindfulness also emphasizes and practices techniques that include mindfully breathing, eating, walking, and being mindfully aware of the body (Berceli & Napoli, 2006). In the professional arena, mindfulness has been developed into various programs. One frequent approach is that of mindfulness-based stress reduction (MBSR), developed by Jon Kabat-Zinn. Kabat-Zinn introduced the MBSR program for patients with chronic pain at the University of Massachusetts Medical Center in 1979.

The idea of accepting, welcoming, and being open to drifting thoughts while remaining focused in each moment and unique experience separates the mindfulness meditation from other meditative techniques (McBee, 2008). With mindfulness meditation, there is nothing that should be expected, there are no goals. This particular practice involves letting go of goals. There is not anything in particular that is being strived toward (Kabat-Zinn, 1990; McBee, 2008).

With no expectations or goals, control is actually gained (McBee, 2008). Learning to focus awareness is often practiced and aided by directing one's attention to their breath (McBee, 2008; Kabat-Zinn, 1990). Focused awareness can be fostered by concentrating on the breath that flows throughout the body, "Just breathe and let go. Breathe and let be" (Kabat-Zinn, 1994, p. 13).

General Health Benefits

Mindfulness has been intensely studied and has been associated with various medical improvements, both physical and cognitive. Regarding physical pain, the work of Baer and Krietemeyer (2006) suggest that mindfulness can be used to reduce the focus on pain and hinder the negative attention and focus placed on the pain (as cited in McCracken, et al., 2007). Mindfulness has also been found to aid one's personal and emotional thoughts and behaviors (Jain, et al., 2007). Specifically, Jain and colleagues observed that participants involved in the MBSR program experienced positive outcomes in regard to distress levels and mood states. In addition, participants resulted in decreased stress, anxiety levels, distraction, rumination levels, and improved attention (Jain et al., 2007). Mindfulness meditation has also been shown to improve cognition and mood, to help access information from working memory, and to aid in "cognitive processing" skills (Zeidan, et al., 2010a, p. 603), as well as to reduce mind wandering (Smallwood, Fitzgerald, Miles, and

Phillips, 2009). The practice of mindfulness has also been associated with positive results on well-being (McCracken et al., 2007; Shapiro, Oman, Thoresen, Plante, & Flinders, 2008; Pradhan, et al., 2007; Mayo Clinic, 2009). The central aims in the mindfulness philosophy is to amplify awareness, heighten attention, and intensify focus, thus allowing for the separation from the autopilot, programmed behaviors and tendencies (Brown & Ryan, 2003). It is postulated that through mindfulness interventions, associations exist with positive health outcomes and increased positive feelings, thus indirectly resulting in an improved sense of well-being (Brown & Ryan, 2003; Shapiro, et al., 2008).

An important segment of mindfulness is cultivating and enhancing one's awareness, as well as controlling and focusing attention (Raffone, et al., 2010). To assess whether mindfulness can help increase attention in older adults, Levy, Jennings, and Langer (2001) completed a study with four groups (two mindfulness groups and two control groups) of older adults. The mindfulness intervention was interpreted by the number of distinctions noticed in a set of pictures. The two mindful groups told to notice a specific number of distinctions recalled a larger number of pictures compared to the control groups who did not receive instructions to notice distinctions. Levy and colleagues (2001) found that awareness and action taken to improve attention through the

process of mindfulness are able to aid older adults in their recall by opening the mind to novel experiences and stimuli without attending to disturbing and dominating thoughts. These authors stress that in using mindfulness practice to improve attention and thus recall in older adults, it is important to "embrace distraction and let attention wander" (p. 192).

Stress and Recall

A number of studies have demonstrated that elevated stress levels are associated with a reduction in the ability to recall certain events (Kramer, Buckhout, Fox, Widman & Tusche, 1991; Schwabe and Wolfe, 2010). Conversely, mindfulness has been shown to aid in the reduction of stress and anxiety (Kabat-Zinn, 1990).

Brief Mindfulness Training in the Older Adult Community

Kabat-Zinn created the mindfulness-based stress reduction (MBSR) program to be completed in 8 weeks. His customary meeting time consists of twenty-six hours, with one class meeting each week for two and a half hours, followed by one six hour class retreat in the sixth week of the program (Carmody & Baer, 2009). In addition to the class assembly time, daily homework assignments are given. It has been noted that although the mindfulness training can potentially become an extremely beneficial program, it may also become an intensely time demanding and strenuous commitment. Carmody & Baer (2009) acknowledge that some

individuals may not be able to accommodate their schedules to complete a practice with this intensive time commitment. In the senior adult population, particularly the older population that resides in adult living homes and facilities, various engagements and activities are often required during strictly scheduled time periods.

The findings of several studies suggest that participation in the complete mindfulness program is not mandatory for benefits and positive outcomes, but that a brief period of training may also be effective. Jain et al.'s, (2007) one month program consisting of four one hour and thirty minute sessions resulted in decreased levels of stress, anxiety, rumination, distraction, distress, and increased positive states of mind for the mindfulness group compared to a waitlist control group. Shorter interventions have also been shown to have positive outcomes (Carmody and Baer (2009) Tang, et al., 2007; Zeidan et al, 2010a; Zeidan, Gordon, Merchant, & Goolkasian, 2010b; Zeidan, Johnson, Gordon, & Goolkasian, 2010c).

Purpose of the Study

The purpose of this study was to examine whether recall ability and sense of well-being could be improved through a mindfulness intervention in an older adult African American population. Specifically, the study compared a group of older adults who had never received any training in mindfulness techniques to a group of individuals who were taught and practiced mindfulness on a daily basis for four consecutive

days. Each participant's recall ability was assessed and monitored prior to and following the four day intervention. Each participant's sense of well-being was also monitored pre-and-post treatment.

It was postulated that the elders who participated in the mindfulness practice sessions would:

Hypothesis 1: Have improved recall compared to their pre-test recall.

Hypothesis 2: Have better recall than the control group at the time of the final test.

Hypothesis 3: Have an increased sense of well-being, as compared to the pre-test.

Hypothesis 4: Would experience a greater sense of well-being than those in the control group.

Hypothesis 5: Would exhibit a greater level of mindfulness than the control group at the completion of the training.

METHODS

Sample

The sample consisted of 14 older adults from a senior assisted living community located in North Carolina. This facility is unique in that all of the residents are African American, thus the ethnicity of the population consisted of 100% African American. Participants were required to be sixty-five years of age or older and proficient in English. The sample was recruited from persons who had indicated that they were interested in either 1) learning

mindfulness or 2) being a part of a discussion group on aging topics. Individuals who had previously practiced mindfulness were not eligible for the study. By completing the informed consent form, each participant was aware that they would be assigned to either a group who would participate in the

mindfulness intervention or a group which would discuss aging topics; 7 participants were randomly assigned to the mindfulness group and 7 to the discussion group. The demographics (age, ethnicity, gender) of the population are displayed in Table 1.

Table 1. Population's Mean (M) and Standard Deviation (SD) for Demographics

Population's Mean (M) and Standard Deviation (SD)	<i>Experimental Group</i>		<i>Control Group</i>		<i>t/χ²</i>	Significance
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
<i>Demographics</i>						
Age	77	10.65	79	7.99	0.41	n.s.
Gender (Female)	71%	-	86%	-	0.51 (χ ²)	n.s.
Ethnicity (African American)	100%	-	100%	-	-	n.s.
Education Level (At least high school grad.)	71%	-	57%	-	0.69 (χ ²)	n.s.
Note: * p < 0.05						
t= t-test, χ ² = chi square						
n.s. = not significant						

Interventions

Mindfulness Training Group (Experimental Group).

The mindfulness intervention used in this study was patterned after the Mindfulness-Based Stress Reduction (MBSR) program developed by Jon Kabat-Zinn at the University of Massachusetts Medical Center. However, compared to Kabat-Zinn's eight week MBSR program, this intervention was shortened to thirty minute sessions for four consecutive days, based on the findings of studies that reported the success of shorter mindfulness

interventions (Jain, et al., 2007; Tang, et al., 2007; Zeidan, et al., 2010a; Zeidan, et al., 2010b; Zeidan, et al., 2010c; Carmody & Baer, 2009).

This mindfulness intervention incorporated formal practice techniques, including mindfully breathing, guided meditation, and silent meditation. Though daily homework is traditionally administered in the MBSR, this intervention did not give homework assignments, nor asked the participants to practice on their own outside of the allotted program time.

The mindfulness intervention was directed by an instructor/facilitator who has studied mindfulness practice for the past sixteen years; the researcher attended each session. At the beginning of the first session, participants were given a brief description of mindfulness. This session began by asking the participants to close their eyes, relax, and focus on their breathing. As thoughts and emotions entered their mind, the participants were told to be aware of these passing thoughts, but to allow them to enter and then pass along by refocusing on the breath. During the last 5 minutes of this session, the participants were introduced to mindfulness meditation. In session 2, the instructor directed the participants to continue working with the breath. The instructor transitioned the breath into practicing mindfulness meditation. During the last 10 minutes, the facilitator presented the class with sitting meditation. The essential theme of accepting thoughts and feelings and allowing them to pass and refocus on the breath was reemphasized. A

continuation of the previous two sessions occurred in session 3 and 4. The facilitator instructed the participants to attend to the breath with nonjudgmental moment to moment awareness when thoughts arose, she directed the participants to attend to the breath, and assisted the individuals in their mindfulness meditation. At the beginning and end of each session, participants were asked if they had any questions or comments about their mindfulness and meditation practices. Each session was 30 minutes in length and was held in the facility's conference room at the same time for each meeting.

Discussion Group (Control Group).

A discussion group on various topics such as aging and memories was conducted for individuals in the control group. The control group sessions were held the following week after the experimental group. However, each variable paralleled with the experimental group except for the dates (same day of the week, same time of the day, same conference room, different days of the month – see Figure 1).

Figure 1. Experimental and Control Groups' Intervention Schedules

	Pre-Test	Stimulus	Post-Test
Experimental Group (Week 1) n = 7	1) Tests: FMI, Well-Being Picture Scale, Self- Rated Health Scale 2) Listened to recorded Story A & then tested on recall of Story A	Mindfulness Intervention Course (4 consecutive days for 30 minutes)	1) Tests: FMI, Well-Being Picture Scale 2) Recalled Story A 3) Listened to recorded Story B & then tested on recall of Story B
Control Group (Week 2) n = 7	1) Tests: FMI, Well-Being Picture Scale, Self- Rated Health Scale 2) Listened to recorded Story A & then tested on recall of Story A	Discussion Group on memories and aging topics (4 consecutive days for 30 minutes)	1) Tests: FMI, Well-Being Picture Scale 2) Recalled Story A 3) Listened to recorded Story B & then tested on recall of Story B

Led by the researcher, the control group discussed various topics including childhood memories and hobbies, world travels, and healthy aging strategies. In session 1, the participants were given a brief overview of the topics of discussion for the four sessions. The participants discussed and reminisced about their childhood memories. Session 2 began with a discussion of the group's travels and ended with conversation about each other's hobbies. In Session 3 and 4, discussions about healthy aging strategies occurred. Each session totaled 30 minutes.

Pre-and Post-Intervention Measures

The following measures were administered prior to the start of the respective treatment and control interventions, and again upon completion of the 4-day intervention:

Freiburg Mindfulness Inventory

The Freiburg Mindfulness Inventory (FMI) consists of fourteen questions that assess the individual's familiarity with and understanding of mindfulness (Walach, et al., 2006). The FMI is a reliable test that accurately assesses one's openness to mindfulness thoughts. Each response consists of scaled answers from 1 (rarely) to 4 (almost always); the maximum score possible is 56 and the lowest possible score is 14. The higher the score, the "greater degree of mindfulness", as well as the greater the likelihood of the individual understanding and partaking in the mode or act of being mindful (Zeidan, et al., 2010a, p.

599). This test was administered pre-and-post intervention to determine mindfulness changes that resulted from the intervention. This inventory has been used in studies that have included African American participants, and thus has been validated within this population (Zeidan, et al., 2010a).

Well-Being Picture Scale

The Well-Being Picture Scale (WPS) was also administered to each participant prior to beginning the intervention and again immediately after the intervention was completed (Gueldner, et al., 2005). This scale is described elsewhere in this journal.

Self-Rated Health Scales

The Self-Rated Health Scale was read to each participant involved in the study. The Self-Rated Health Scale was used to determine if correlations existed between self-perceived health, well-being, and ultimately recall ability (Levy, et al., 2001). Each participant was asked to rate both their physical and mental health level on a five point Likert scale, from 1 (excellent) to 5 (poor). The higher the score, the lower the individual's self-perceived physical or emotional health, respectively (Stanford Chronic Disease Self-Management Study, 1996). This scale has been previously validated in studies with African American participants (Lincoln, Taylor, Chae, & Chatters, 2010; Ibrahim, Burant, Siminoff, Stoller, & Kwoh, 2002).

Each individual was also asked to rate their overall vision and their overall hearing ability, and to rate their memory, compared to other

people their age. Statements were rated on a five point Likert Scale, from 1 (excellent) to 5 (poor), with higher scores indicating poorer self-perceived vision, hearing, and memory, respectively. This test was administered pre-and-post intervention.

The self-rated health questions of physical health, mental health, vision, hearing, and memory were scored together as each of these items compose the individual's health. Each response was individually rated 1 through 5. The health ratings were totaled at the completion of rating the five questions. The total score ranged from 5 to 25, with higher scores being indicative of lower self-rated health.

Recall Test (Short Story A).

Prior to the start of the program, a recall test was administered to each participant on an individual basis. Each participant was told that they would be asked to listen to a short (100 word) tape recorded story (short story A); after listening to the story, each participant was asked to repeat the story to the investigator to the best of their ability (Joseph, n.d.). This process was used to establish the participant's baseline for comparison at the end of the intervention. At the completion of the study, each participant was again instructed by the researcher to tell all of the short story that they could remember. This test was used to determine if the mindfulness training had affected retrieval, since the story was already encoded prior to the intervention.

The Flesch-Kincaid reading level for Story A is 5.3.

Post-Intervention Measures

The recall test of short story B was only administered one time, at the completion of the intervention.

Recall Test (Short Story B).

A different short story (short story B) was also presented at post testing following the intervention, and recall of this story was also assessed for each participant (Heather916, 2011). This short story was used to further determine any influence of the mindfulness intervention on retrieval capabilities. If members of the mindfulness group were able to recall both stories (stories A and B) better than the control group participants, it would establish that the mindfulness intervention had exerted a positive influence on retrieval. However, if the mindfulness group presented with better recall than the control group only on the second story (story B), then it would indicate that mindfulness effects on encoding would have been obtained by the treatment group. Testing the recall of both short stories A and B at the end of the intervention helped determine whether mindfulness effects encoding and retrieval or only one or the other. Both short stories A and B consist of 100 words each; the Flesch-Kincaid reading level for short story B is 4.2.

Each recall test was scored by marking each detail that was repeated by the participant. Credit was given for each detail from the story, including an accurate or acceptable phrase that was

determined to be equivalent to the original story phrase. Equivalent details were considered if they were synonyms for the original word. For instance, the original sentence may have stated, "There once was a sad king who was very ill." If each word was exactly stated, this counted as 10 points. If the participant repeated, "There was a queen who was sick," this was scored as 6 points. The word queen was not given credit, but the word sick did receive credit. Each correct detail or story unit was scored as one point. All details from the story that were mentioned were totaled for the recall score. The lead researcher scored the two stories. However, in order to assess reliability of the scoring, another individual also scored the two stories.

PROCEDURE

After informed consent forms were signed and the participants were randomly separated into either the experimental or control groups, a day of testing commenced. Pre-testing was initially only completed by the experimental group and was completed one day prior to the start of the mindfulness intervention. The following week, one day before the discussion (control) group intervention, these individuals also completed the testing period. The two programs (the mindfulness program and the discussion group) paralleled each other in that they met on the same day of the week, same time of the day, same room, but different days of the month – see Figure 1.

Pre-Intervention Testing - Day 1 (Experimental Group and Control Group):

In a one-on-one setting with the researcher, each participant in both the treatment and control groups completed the Freiburg Mindfulness Inventory, the Well-Being Picture Scale, the Self-Rated Health Scales, and the recall test of short story A.

Sessions 1-4

Depending on the intervention assigned, the treatment and control groups participated in their respective programs. The experimental group practiced their mindfulness skills that consisted of mindfully breathing and meditation and the control group discussed their memories and travels, as well as aging topics and strategies. Both groups completed a training period totaling 120 minutes (i.e., 30 minutes per day for 4 consecutive days).

Post-Intervention Testing - Day 6 (Experimental Group and Control Group):

Following the intervention, on a one on one basis with the researcher, each participant completed the Freiburg Mindfulness Inventory, the Well-Being Picture Scale, the Self-Rated Health Scales, and again were tested on their recall of the original short story (A) that they had listened to at the beginning of the study. They were also given another recall test on short story B. Recall of short story B involved having participants listen to the recorded story, and then the researcher asked each individual to

recall as much as they could remember.

Statistical Analysis

The population's demographics and responses were statistically analyzed using the t-test between two samples assuming equal variances and the chi-square. To test for differences between the experimental group and the control group before and after the interventions, data were analyzed using a 2 X 2 univariate analysis of variance (ANOVA) where pre- and post-test was a within variable and experimental versus control group was a between variable. Cronbach's alpha was used to measure the reliability of the scores from the two raters for the recall tests of short story A and short story B. A significance level of 0.05 was used for all statistical tests.

FINDINGS

The demographic of the population and the baseline scores were calculated based on age, ethnicity, and gender. The baseline mean and standard deviation for the demographics of the population were assessed using the t-test (t) and chi square (χ^2). The age range was from 65 to 93. The mean age of all participants involved was 78, the median age was 77 years of age, and 100% of the older adults were African American. The population demographics are reported in Table 1 and the baseline scores for the self-reported measures and the cognitive tasks can be seen in Table 2. No significant differences existed between the experimental group and the control group in regard to the sample's demographics and baseline measures.

Table 2. Population's Mean (M) and Standard Deviation (SD) for Baseline Measures and *Self-Reported Measures*

Baseline Mean (M) and Standard Deviation (SD)	<i>Experimental Group</i>		<i>Control Group</i>		t/χ^2	Significance
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
<i>Self-Reported Measures</i>						
FMI	41.43	12.74	39.71	7.61	-0.31	n.s.
Well-Being Picture Scale	51.43	12.18	56.14	10.04	0.79	n.s.
Self-Rated Health Scale	13.71	2.14	11.43	3.26	-1.55	n.s.
<i>Cognitive Measures</i>						
Recall Ability	8.43	5.91	9.00	6.81	0.17	n.s.
Note: * $p < 0.05$						
t = t-test, χ^2 = chi square						
n.s. = not significant						

Cognitive Tasks

The recall test scoring for short story A and short story B indicates a high internal consistency and high reliability (see Table 4). Table 3 shows that the effectiveness of this brief mindfulness training on improving cognitive tasks, in particular that of recall, was not statistically significant on either the encoding or the retrieval of the stories administered. The recall of short story A between the experimental and control groups and

the interactions between pre- and post-test and experimental and control groups for short story A resulted in no significant differences, respectively, $F(1, 24) = 0.03, p = 0.87$ and $F(1, 24) = 0.03, p = 0.87$. However, the change between the groups from pre-intervention to post-intervention was statistically significant, $F(1, 24) = 21.31, p = 0.00$. The recall for short story B resulted in no significant difference between the two groups, $t = 0.649, p = 0.53$.

Table 4. Reliability of Short Story A and Short Story B

Recall Tests	α
Pre-test (Short Story A)	0.97
Post-test (Short Story A)	0.96
Post-test (Short Story B)	0.97
Note: α = Cronbach's alpha	

DISCUSSION

This study evaluated the effectiveness of a brief mindfulness program on older African American adults' well-being and recall when compared to a control group. To date, this is the first study of a brief mindfulness intervention conducted with a 100% African American older adult population. Although no significant effects were seen following the four day (30 minute per day) mindfulness training in increasing well-being or recall scores

between the experimental group and control group from pre-intervention to post-intervention, several individual participants expressed their gratitude and personal benefits from the program. A few of the qualitative responses included comments that learning mindfulness and meditation helped in the ability to relax and to be aware of personal thoughts. One of the participants expressed her enjoyment of the intervention as she said, "When you are 91 and you learn something, it makes you feel good."

Though statistically significant changes did not occur within the mindfully treated group compared to the discussion group, it is interesting to note that a significant increase occurred amongst the mindfulness levels for both groups from the pre-test to post-test period. Regarding the mindfulness levels, it can be speculated that the experimental group benefited from their mindfulness intervention in which awareness and presence of mind was learned, while the control group also benefited from the mere interaction and discussions in the group setting. The control group expressed their enjoyment of the discussion sessions. The positive social experience of the control group suggests that the control group also benefited from their experiences.

The failure to achieve significant results of the mindfulness training on the older adults' mindfulness levels and well-being are somewhat surprising. These results tend to contrast prior research which indicates positive associations of mindfulness on well-being (Brown & Ryan, 2003; McCracken et al., 2007; Shapiro, et al., 2008; Oman, Thoresen, Plante, & Flinders, 2008; Pradhan, et al., 2007; Mayo Clinic, 2009). The insignificant results in this study may be partially due to the different interpretations of the administered Well-Being Picture Scale as some individuals tended to point toward a picture rather than a place on the scale.

Previous studies have reported the effectiveness of

mindfulness on cognition, particularly in terms of working memory (Zeidan, et al., 2010a). It was predicted that the tranquil and relaxing effects of the mindfulness training, while simultaneously learning to bring wandering thoughts to the present, would aid in improving recall (Zeidan, et al., 2010a). However, this study resulted in unexpected outcomes when testing recall. For the analysis of the short story A and short story B, both recall tests resulted in findings that were not statistically significant between the experimental and control group and their interaction from the pre-test to post-test periods. In both groups, a significantly lower level of recall was apparent from the pre-test to post-test of short story A. Participants recalled less of the story during the post-test as opposed to immediately after the recording was played during the pre-test period. Story B also resulted in no significant differences between the two groups during the post-intervention testing.

Limitations

A principal limitation in this study was the small sample size. Associated with the small sample size is the low statistical power to analyze differences in the change over time and the differences between the experimental and control groups. With a larger sample, differences between the two groups from the pre-test period to the post-test period may have been easier to discern. Also, the data collected and studied only apply to a small population of older African Americans of age 65 years of age

and older gathered from only one senior living community. These data cannot be generalized to a larger population. Though brief mindfulness has shown to be beneficial in various populations (Jain, et al., 2007; Tang, et al., 2007; Zeidan, et al., 2010a; Zeidan, et al., 2010b; Zeidan, et al., 2010c; Carmody & Baer, 2009), the lack of significant results may possibly be due to the short time frame of this intervention and may have been improved with a longer training period and/or the inclusion of homework assignments. As individuals continue to practice and understand true mindfulness, it would be expected that benefits will inevitably increase (Shapiro, et al., 2008).

Mindfulness can be defined and interpreted in various manners. Although the Freiburg Mindfulness Inventory is able to be generalized, it is largely based on a one-dimensional concept of mindfulness that associates the two factors of presence and acceptance (Kohls, Sauer, & Walach, 2009). Thus, mindfulness could possibly have been measured in another manner that incorporates a broader perspective or meaning. Capturing a broader perspective of mindfulness may possibly be accomplished by testing mindfulness with a multifaceted test (Shapiro, et al., 2008).

Finally, the effect of demand characteristics within the population's answers to their questionnaires is a possibility. As the Freiburg Mindfulness Inventory,

the Well-Being Picture Scale, and the Self-Rated Health scales that were administered were physical self-reported handouts, it may have been inadvertently apparent to the participants that awareness, well-being, and evidently health were being tested. This recognition could possibly have caused the participant to respond in a manner that they believed to be appropriate or correct for the specific test.

Strengths and Future Studies

Though the study resulted in unexpected outcomes and limitations do exist, this study has the potential to lead to opportunities for subsequent mindfulness studies, particularly in the older adult population. As a unique study that combines the memory and well-being of an aged population with a brief mindfulness intervention, this study serves as a substantive contribution to the current body of literature. Research indicates a higher prevalence of mild cognitive impairments in the African American population (Doniger, Jo, Simon, & Crystal, 2009; Gurland, et al., 1999). Future studies may direct additional investigations that examine mindfulness and its benefits in the older adult African American population. Within this specific population, future investigations might replicate this study in a larger sample, or possibly administer a longer mindfulness intervention with the experimental group. From qualitative comments from participants in the experimental group, in addition to studying mindfulness practices, future

research may also study the effects of meditation, relaxation, or even simple discussion group techniques on the older adult African American population.

CONCLUSION

This controlled study is the first to assess the effects of a brief mindfulness intervention on recall and well-being when administered to a group of older African American adults. In regard to recall and well-being, the findings of this study resulted in no statistically significant difference between participants who received brief mindfulness training and those who do not undergo the intervention from pre-intervention to post-intervention. Although the findings did not achieve statistical significance, it is important to note that positive changes did occur in both the treatment and control groups. Participants in both the experimental and control groups increased their levels of mindfulness from pre-intervention to post-intervention. Therefore, further research should be continued to explore the positive effects of mindfulness in the older adult African American population.

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Establishing the Correlation between Well-Being and Presenting Symptomatology in Persons Who Are Seriously Ill

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Abstract

The purpose of this study was to compare distress in radiation oncology patients (N=57) as measured by the Brief Symptom Inventory - 18 Item for Oncology Patients (BSI®-18) and the Gueldner Well-being Picture Scale. Findings were statistically significant and although both tools measured distress, the Gueldner Scale was easier to administer and for patients to complete.

Key Words: Well-Being, Psychological Distress, Well-Being Picture Scale, Brief Symptom Inventory.

Background

As part of a regional cancer center located in a semi-rural area of Upstate New York, the Radiation Oncology Department of a community hospital receives many patient referrals for initial or adjuvant radiation therapy. Assessment of patients' levels of psychologic distress is an important element of the admission assessment (NCCN, 1999) and is standard of care in the Radiation Oncology Department. The registered nurse (RN) who completes this assessment administers the Brief Symptom Inventory – 18 Item (BSI-18) for Oncology Patients and the Social Work Department scores the tool. Patients whose scores indicate distress (above 64), either on the Global Severity Index or one of the

three subscales (Somatization, Depression or Anxiety), are referred to a Social Worker for follow up. Although the BSI-18 for Oncology Patients is easy to administer, adding this tool to the admission paperwork can be overwhelming to patients.

Purpose

The purpose of this study was to evaluate efficacy of the BSI-18 for Oncology Patients, as compared to the Well-being Picture Scale (Gueldner, et al., 2005) to determine general well-being and symptomatology in cancer patients referred for radiation therapy. It was hypothesized that both instruments would elicit comparable results, but that the Gueldner Scale (pictured and described elsewhere in this

journal) would be easier for oncology patients to complete.

Methods

After receiving approval from the hospital's Institutional Review Board (IRB), data collection was initiated. All patients referred to the Radiation Oncology Department for radiation therapy were invited to participate in the study by the RN who completed their initial assessment. Those who agreed to participate signed the informed consent form. Admission paperwork completed by patients included the BSI-18 for Oncology Patients, Gueldner Scale, a brief demographic form and the basic Radiation Oncology intake forms. The BSI-18 was scored by the Social Work Department and the Gueldner Scale was scored by one of the investigators.

Sample

A total of 57 cancer patients participated in the study. The majority of subjects (56%) had breast cancer, followed by prostate (16%), lung (12%) and other cancers (16%). Forty-six (46) percent had been diagnosed within two months or less prior to coming for their initial assessment and treatment planning, 26% within four months and 28% five months or longer. Of the patients who declined participation, most stated that they were "overwhelmed" and could not do anything more.

Measurement Instruments

The *BSI-18 for Oncology Patients* (Derogatis, 2000) consists of 18 items each with a possible score of 0 to 4. Individuals are asked to respond to "How much were you

distressed by ..." for each item. The instrument is divided into three subscales: Somatization (SOM [6 items, i.e. "faintness or dizziness"]); Depression (DEP [6 items, i.e. "feeling no interest in things"]); and Anxiety (ANX [6 items, i.e. "suddenly scared for no reason"]). Raw scores for the subscales are summed to determine a Global Severity Index (GSI). Raw scores for the GSI and subscales are plotted on the BSI[®]18 profile to determine normalized T scores which are used to interpret an individual's psychologic distress. The raw scores indicating no feelings of distress are 0 and the corresponding T scores are 36 (GSI), 40 (SOM), 42 (DEP) and 39 (ANX). Scores higher than 64 on the Global Severity Index or any subscale are considered to indicate distress. The instrument generally took approximately 10 minutes to complete by this seriously ill population.

The *Well-Being Picture Scale* (WPS) (Gueldner et al, 2005) is comprised of ten simple picture pairs (i.e. a line drawing of the sun partially behind a cloud or the sun out bright and not behind a cloud) on a 7-point linear scale. (See Figure A, below) Participants are asked to mark the place along the 7 choice line that best describes their feelings at the moment. The maximum score is 70, and a score of 40 or lower indicates potential for depression. The WPS usually takes less than 10 minutes to complete, but may take longer in patients who are compromised (such as elders who may be unable to see well). A picture of the WPS is provided below.

Figure A. Well-Being Picture Scale with Scoring Key

SCORING KEY

Wellbeing Picture Scale

(A refined version of the Index of Field Energy)

Subject ID _____ Date of evaluation _____

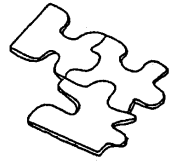
Instructions:

Look at the scale between each pair of pictures. Mark [X] at the place on the scale that best describes how you feel now.

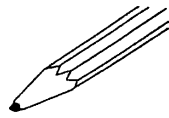
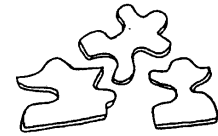
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7	6	5	4	3	2	1			

Instructions:

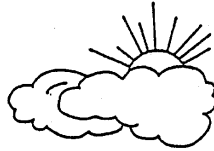
Look at the scale between each pair of pictures. Mark [X] at the place on the scale that best describes how you feel now.



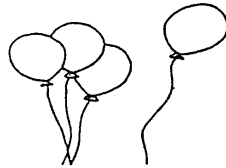
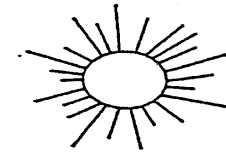
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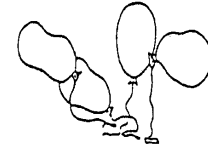
1	2	3	4	5	6	7
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1	2	3	4	5	6	7
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7	6	5	4	3	2	1
---	---	---	---	---	---	---



7	6	5	4	3	2	1
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70 is the maximum score possible;
 10 is the lowest score possible;
 Higher scores indicating higher wellbeing.

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Results

Data were analyzed using descriptive statistics and t-tests for dependent samples. All 57 subjects identified themselves as white, not of Hispanic origin; 56 were born in the United States and 1 was born in South Korea. Their ages ranged from 25 to 88 years, with a mode of 57 years. Twenty-six percent of the subjects were male and 74 percent were female. Educational levels were as follows: 8 attended school but did not graduate; 24 completed high school; and 25 attended college.

Because on the BSI-18 for Oncology Patients, scores above 64 on the Global Severity Index or any subscale indicate distress and on the Gueldner Well-being Picture Scale, a score below 40 indicates distress, it was anticipated that there would be an inverse relationship between the scores for patients who were distressed. As expected, scores on the BSI-18 Global Severity Index (GSI) and subscales of Somatization (SOM), Depression (DEP) and Anxiety (ANX) were statistically significantly related to the Gueldner Well-being Picture Scale (WPS) as follows: GSI and WPS ($p = .004$); SOM and WPS ($p = .028$); DEP and WPS ($p = .015$); and ANX and WPS ($p = .005$).

Discussion

As anticipated, subjects whose scores on the BSI-18 indicated moderate to high levels of distress also had scores on the Well-being Picture Scale that indicated distress. Patients who had received a cancer diagnosis and were referred to Radiation Oncology within two

months had higher distress levels than those whose interval between diagnosis and referral was longer. Of interest is that one subject actually participated in the study twice, three months apart, and showed dramatic improvement. His BSI-18 scores (GSI and subscales) decreased significantly ($p = .006$), and his WPS scores increased accordingly (from 25 to 60).

Although the findings from this study cannot be generalized to other settings and patient populations, they do support utility of the Gueldner Well-being Picture Scale as an easier to complete tool for measuring distress in seriously ill individuals. Patients are stressed when they come to Radiation Oncology for their initial consultation and even though the BSI[®]-18 is a relatively short tool, it is cumbersome as a screening tool for this patient population. The Gueldner Well-being Picture Scale was easier for subjects to complete.

Limitations

There were several limitations to this study. The sample was relatively small and subjects lacked variation in serious illness (e.g., all had cancer), ethnicity, race and educational level. Except for one subject, distress level was measured only one time. It can be expected that as patients progress through treatment and are able to experience improvement, their distress will decrease.

Recommendations

The authors recommend replication of this study using the Gueldner Well-being Picture Scale

(WPS) with multiple populations of seriously ill individuals being treated in a variety of clinical settings. The tool should be used not only for screening but also to track psychologic distress experienced by patients periodically during treatment. Measurement of distress at different points in time could reveal opportunities for psychologic support during treatment and also provide empirical evidence of distress levels as patients progress through treatment or adapt to their illness and therapy.

The WPS also could be used to measure distress in survivors of serious illness, especially those who participate in support groups. Support groups are intended to help individuals cope and the Gueldner tool is an easy to administer tool that can be used in multi-cultural settings.

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HUMOR AND FIELD ENERGY IN OLDER ADULTS

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Abstract

The purpose of this study was to gain an understanding of humor from the perspective of the Science of Unitary Human Beings as described by Martha Rogers. It was proposed that there would be mutual patterning of humor and field energy in older adults who are either institutionalized or non-institutionalized, and that both humor and field energy would be significantly lower in the institutionalized group.

This study used a descriptive correlational design. The sample ($N=80$) consisted of individuals who were 55 years of age or older. The individuals in the sample were either residents of various nursing homes ($n=40$) or resided independently and attended activities at one of several different regional senior centers ($n=40$).

Humor and field energy scores for the entire sample were significantly correlated ($p = .000$), as well as for institutionalized elders ($p = .000$) and for non-institutionalized elders ($p = .000$). Additionally, when potential influences were controlled, the hypothesized relationship between humor and field energy ($p = .000$) was further supported regardless of group membership. Field energy was significantly lower ($F = 16.93$; $p = .000$) in the institutionalized, older adults than in the non-institutionalized older adults. Humor did not differ significantly between institutionalized and non-institutionalized subjects.

Key Words: Field Energy, Gerontology, Humor, Science of Unitary Human Beings, Martha Rogers

Introduction

During this time of prolific gerontological research (McCormack, 2009) there is a marked deficiency of research on the potential therapeutic value of humor in older adult populations (Merz, et al., 2009). The relationship between

humor and the vibrant qualities of the human spirit, i.e., field energy, two quintessential characteristics of human beings has received virtually no attention in the nursing research literature, or in the greater body of available scientific literature. Accordingly, the purpose of this

study was to investigate the relationship between humor and field energy in samples of institutionalized and non-institutionalized older adults.

Background

Humor

Recent descriptions of humor suggest that humor is spontaneous and incongruent, involving a change of mind (Bellert, 1989, Southam, 2003). Flugel (1954) described humor as the quality in individuals that mediates the amusing, the comic, the laughable, the ludicrous, the witty, and the funny. Tansey (1988), on the other hand, constructed a definition of humor from a phenomenological study with adolescent males, defining humor as an expression that was produced when an individual cognitively perceives amusement stimulated by an incongruence or absurdity in the ordinary pattern of life. This definition emphasizes the cognitive aspect of humor, the stimulus for humor, and that humor has some type of expression.

In addition to definitions of humor, there are many descriptions of the functions of humor. Robinson (1977) described humor as having four primary functions: (1) physiological, (2) psychological, (3) social, and (4) communicative.

Physiologically, laughter is known to cause: (1) a rise in one half a Fahrenheit degree of body temperature; (2) an increase in pulse and blood pressure, then a drop back to baseline; (3) an elevation of serum oxygen levels; and (4) the contraction with subsequent relaxation of thoracic abdominal

musculature (Berk, 1989; Black, 1984). The "twinkle or sparkle in the eye" is postulated to result from the moisture produced by tear glands due to reflex lacrimation during smiling and moderate laughter (Black, 1984).

The positive psychological benefits of humor have not gone unnoticed.

Cousins (1989), a popular journalist, advocated the power of positive humor in the recovery process and used his own life as an example of these phenomena.

Primarily, however, the psychological benefit of humor has been documented as a positive coping strategy for dealing with stress (Martin & Lefcourt, 1983). Martin and Lefcourt (1983) as well as Labott and Martin (1987) indicated that coping by using a sense of humor buffers the effects of negative events on mood states. There is support for humor-coping as a stress moderator by acting as a buffer in college aged subjects (N=334). Humor buffered negative life events upon mood disturbance.

As a social function, humor has been used by health care workers to deal with gory and gruesome situations or situations in which they are emotionally unprepared to cope. Warner (1991) found in a group of student nurses (N=38) that they used humor to cope with stressful person-environment relations of which they were emotionally unequipped to handle.

Humor is also a communication tool (Robinson, 1977). Humor provides an outlet to

express oneself about subjects that might otherwise be socially unacceptable. The messages that are conveyed are usually emotionally tinged.

In addition to the functions of humor, humor, as a therapeutic modality, has received considerable attention in the literature. Some examples of techniques that have been recommended are plain laughter, humor as a distracter, rational emotive therapy with humor, and the humorous imagery situation technique (Alligood, 1990; McCaffery, 1990; Prerost, 1989; Shibles, 1991).

Humor, as an indicator of well-being, has been empirically understudied, although the concept of well-being in gerontological studies is more common (Merz, et al., 2009). A study by Tennant (1991) examined the effect of humor on the well-being of older adults (N=31). Defining morale as a means to enhance well-being, Tennant's experimental study, found no statistical significance to support the hypothesis that humor raised morale.

Humor, within the Rogers' conceptual framework, has been studied with phenomenological methodology by both Malinski (1990) and Reeder (1991). Malinski (1990) found in a sample of older adult couples (N=20) that the experience of laughing at oneself facilitates awareness of the harmonious process between a person and their environment. Reeder (1991) discovered that senior citizens (N=24) who have a transcendent life perspective believe that laughing at

oneself is "knowing what to care about in life and choosing to trust and live by it, spontaneously and deliberately" (p. 275).

Motion of the Human Energy Field

Motion of the human energy field is an indicator of "the continuously moving position and flow of the human field pattern" (Barrett, 1986, p. 175), and is manifested by human energy field patterning. Manifested by continuing change from lower to higher frequency waves (Rogers, 1970; Ference, 1979, 1986; Gueldner et al., 1996), motion of energy fields is characterized by an intense absorption and awareness of self without regard to time or space (pandimensional patterning) and illustrates the principle of resonancy. With higher frequency motion, there may be a sense of exuberance, sometimes associated with a relaxed and revitalized feeling (Ference, 1979). Higher field energy, therefore, may reflect an inward sense of well-being or vitality for life, while an individual with lower field energy may seem lackluster.

Environments of Institutionalization and Non-institutionalization

Long term care facilities (institutions) are the environments where many older adults reside (Miller, 1990). The institutional setting is provided for those individuals who need survival assurance due to loss of function (Simms, Jones, & Yoder, 1982). Institutionalization, as a threat to survival, is considered to have

profound negative effects on older adults (Simms, Jones, & Yoder, 1982) and has been linked to disturbances in well-being (Reed, 1986).

Humor, Field Energy, and the Environment

The flow of energy, associated with humor, characterized as a harmonious surge of vitality in the human field, creates a feeling of exuberance in the energy field. The exuberance that the individual feels is associated with an enhanced sense of well-being, or change in field energy that is characterized by movement from a lower to higher wave frequency. Human beings who experience humor more frequently are postulated to have higher field energy. In other words, there would be a mutual patterning of the experience of humor and field energy.

Furthermore, the environment provides the context for the experience of humor (Fine, 1977). Since the experience of humor is environmentally conditional (Fine, 1977; Prerost, 1989; Rogers, 1986) and the environmental energy field and the human energy field are integral (Rogers, 1986), an individual's residence or primary environment is proposed to have a significant relationship with the experience of humor as well as field energy. In institutionalized older adults, the stifled environment may be mutually patterned with lower field energy and a decrease in the frequency of the experience of humor. Non-institutionalized older adults may experience humor more

frequently and have higher field energy. Therefore, this study proposes that the primary environment or residence of a human being is directly related to the mutual patterning of the experience of humor and field energy.

Method

Sample

The target population for this study was older adults who reside in either institutions or independent living arrangements. A total sample of exactly 80 participants was obtained (n=80) with half of the subjects (n=40) residing independently in the community and the remaining half (n=40) residing in institutionalized settings.

The total sample ranged in age from 65 to 95 years of age with a mean age of 79.1 years. The institutionalized participants ranged in age from 55 to 95 years of age with a mean age of 82.675 years. The non-institutionalized participants ranged in age from 65 to 92 years of age with a mean age of 75.525 years. The two groups were significantly different in age ($p=.000$). Participants residing in the institutionalized setting were significantly older than the non-institutionalized participants.

Situational Humor Response Questionnaire (SHRQ)

The SHRQ is a 21 item Guttman-like scale designed to assess the humorousness of an individual based on the frequency of the individual's report of laughter (Lefcourt & Martin, 1986), and is non-particulate and unidimensional.

Measuring the propensity for laughter, a phenomenon judged to be a manifestation of human beings, it was evaluated to be conceptually consistent with the theoretical underpinnings of Rogers' conceptual system. Respondents are asked to react to a variety of situations. The first 18 items of the scale describe common situations that ask subjects to recall their reaction to a similar situation or, if they could not remember a similar situation or experience, to imagine what their reaction might be with an experience. Simon (1990) established reliability of the SHRQ in a sample (n=73) of non-institutionalized older adults with a Cronbach's alpha of .81.

Lefcourt and Martin (1986) cited the need to revise the SHRQ for use in populations other than college students. Since the original form of the instrument was developed and normed on college students, the investigator of this study revised the SHRQ to be more sensitive and age appropriate to the older adult population. Minor revisions were made to several questions and new situations were created for 3 questions. Internal consistency reliability of the revised SHRQ was calculated for the total sample (N=80) in this study using a Cronbach alpha. The Cronbach alpha for the 21-item scale was .8045. Additionally, the Cronbach alpha for the 21-item scale was computed for each group in the study: the institutionalized group (n=40) were .8276 and the non-institutionalized group (n=40) was

.7639.

Index of Field Energy (IFE)

The IFE (Gueldner et al., 1996) is an 18-item pictorial semantic differential scale. It is designed to measure the pandimensional experience of motion of the human energy field (Gueldner et al., 1996; Rogers, 1991). The respondent is asked to mark a point on the scale between pairs of pictures, which corresponds to how they feel at the moment. The scale ranges from 1 to 7. Scoring is summative with a possible range of 18 to 137. Eighteen indicates lower field energy and 137 indicates higher field energy. The IFE has established reliability. Internal consistency was documented by a Cronbach's alpha coefficient of .95 (Gueldner et al., 1996). Internal consistency reliability of the IFE was calculated for the total sample (n=80) in this study using a Cronbach's alpha. The Cronbach alpha for the 18-item scale was .8651. Additionally, the Cronbach's alpha for the 18-item scale for the institutionalized group (n=40) was .8474 while the Cronbach's alpha for the non-institutionalized group (n=40) was .8384.

Results

Correlations between humor as measured by the Situational Humor Response questionnaire (SHRQ) (Lefcourt & Martin, 1986) and field energy, as measured by the Index of Field Energy (IFE) (Gueldner et al., 1996) in the total sample of older adults were computed. Comparing the total score on the SHRQ with the total score on the IFE, the Pearson product-

moment correlation (Pearson's r) for the combined group was positively significant ($r=.5148$, $p=.000$) as well as for the subsamples, institutionalized ($r=.5904$, $p=.000$) and non-institutionalized ($r=.3503$, $p=.027$) older adults. Therefore, humor and field energy were significantly and positively correlated in the overall sample and the subsamples of institutionalized and non-institutionalized older adults.

ANOVAs were completed to test the difference between institutionalized and non-institutionalized older adults in humor as measured by the group SHRQ scores. The mean score on the SHRQ for the non-institutionalized participants was 52.80 ($n=40$) while the mean score for the institutionalized participants was 49.850 ($n=40$). Consequently, humor was not found to be significantly different between the two groups ($F=1.723$, $p=.193$).

ANOVAs were utilized to test the differences in field energy as measured by the IFE between institutionalized and non-institutionalized older adults, comparing the total scores on the IFE for both groups. The mean score on the IFE for the non-institutionalized participants was 91.06 ($n=40$) while the mean score for the institutionalized participants was 73.76 ($n=40$). Consequently, field energy was found to be significantly different between the two groups ($F=16.925$, $p=.000$). Therefore, field energy is different in institutionalized and non-institutionalized participants. Not only

is field energy different, but is significantly higher in the non-institutionalized group.

Supplementary analyses

Power analysis. Post hoc power analysis was performed to corroborate the validity of the statistical conclusions for this study. For the ANOVA tests, the SHRQ was found to have an effect size of .25 while the IFE was found to have an effect size of .98. Applying the power calculation to sample size tables for ANOVA as presented by Cohen (1988), the investigator recalculated the needed sample size for this study. For the SHRQ with an effect size of .25, 250 subjects would be needed in order to obtain 80% power at the .05 level of significance. For the IFE with an effect size of .98, 20 subjects per group would have been needed to conduct this study at 80% power for the .05 level of significance. Therefore, the IFE had sufficient power for this study while the SHRQ did not.

Age humor and field energy.

Supplementary analysis of demographic variables, humor, and field energy revealed additional significant findings. Age was found to be a covariate of both humor ($F=4.869$, $p=.030$) and field energy ($F=7.786$, $p=.007$). Notwithstanding the fact that age was a covariate of humor, there continued to be no demonstrated differences in SHRQ scores between the two residential groups. However, significant differences between residential groups on the IFE continued to be demonstrated when statistically

controlling for age. In conclusion, controlling for age does not change the pattern of results of this study. The two groups still do not differ on humor, but institutionalized individuals continued to score lower than non-institutionalized individuals on field energy.

Discussion

Humor and field energy were correlated in the overall sample as well as within the groups of institutionalization and non-institutionalization. Since there was no evidence as to the direction of the relationship between humor and field energy in the literature, the direction of these findings were not specified in the statistical testing. However, the data indicate a significant positive correlation between humor and field energy in this study sample. Furthermore, in this study sample of institutionalized and non-institutionalized older adults, humor and field energy were found to be significant correlates, regardless of residential location. As humorousness varies from individual to individual, field energy concomitantly varies, i.e., not only is there a positive relationship between humor and field energy, but the relationship suggests that humor and field energy are mutually patterned.

From the perspective of the Rogerian conceptual system, these two variables would have been expected to correlate positively and be mutually patterned. Humor, within the context of the Rogerian conceptual system, is a human energy field manifestation associated with a flow of energy or harmonious

surge of vitality in the human field. Field energy is a manifestation of motion in the human and environmental fields, characterized by varying frequencies and pandimensional patterns (Gueldner et al., 1996). The principle of resonancy, which proposes that change occurs in the direction of higher frequencies, provides the base for the prediction that humor would be positively correlated with field energy. Thus, the data supports the theoretical proposition that humor and field energy are mutually patterned. The data further supports the validity of the Rogerian Science of Unitary Human Beings.

However, the statistical differences in humor between institutionalized and non-institutionalized older adults, was not supported by the data. This seems to be difficult to interpret when examined in relationship to the finding that humor and field energy were significant correlates and that field energy was significantly different in the institutionalized and non-institutionalized groups. Tentative explanations may have to do with the lack of precision of measurement of humor by the SHRQ. Thorson and Powell (1991) found that the SHRQ measures the propensity to laugh. However, this measurement may not be a comprehensive measure of the construct of humor, i.e., the instrument may measure only select manifestations of humor. Even though humor and field energy were found to be significant covariates, their correlation may have been even

stronger if the SHRQ had been more precise in measurement (Mishel, 1989).

Additionally, power analysis of the SHRQ revealed an effect size of .25. According to sample size tables (Cohen, 1988), the sample size in this study was not large enough to detect significant differences in the two groups on the variable of humor.

A final possible explanation of these results may rest with the conceptual framework of this study. Derived from available multidisciplinary literature and the Rogers' Science of Unitary Human Beings, the conceptual propositions upon which this study is based may be inaccurate. Humor may not vary between institutionalized and non-institutionalized elderly.

The differences in field energy between institutionalized and non-institutionalized older adults were supported by the data. In addition to a significant difference between the two groups, findings revealed that this difference was directional. Institutionalized older adults had lower field energy than non-institutionalized older adults. This is consistent with the literature on the negative impact of the environment in institutionalized older adults (Simms, Jones, & Yoder, 1982). However, the finding must be viewed with some caution considering the potential influence of age as a covariate.

Age was found to be a significant covariate. Age was found to be a significant covariate of both humor and field energy with chronologically older participants

scoring lower on both the humor and field energy scales than younger participants. This is difficult to interpret within the Rogerian framework that considers chronological age as an artifact that is not necessarily related to the individual's evolutionary development. However, this finding may present an alternative interpretation for non-institutionalized participants who were found to score significantly higher on the IFE than their institutionalized counterparts. As is typical of the institutionalized population-at-large, institutionalized participants in this sample were significantly older than non-institutionalized participants. The Science of Unitary Human Beings does not recognize chronological age as a valid indication of development. Furthermore, if chronological age were considered an indicator of development, the Rogerian conceptual system would predict that older subjects would be characterized by higher field energy. Therefore, one must not overlook the possibility that the theoretical framework itself is in need of revision. In the present study, it is impossible to determine whether the differences in field energy are associated with age, or with environment, or a combination of the two. Further studies with age-matched samples would be necessary to clarify these results.

Supplementary Findings

SHRQ. The reliability of the SHRQ was confirmed in this study. The readability of the SHRQ was 6.8 years of education (Lynn, 1989).

This was well within the educational level of the groups of older adults, the institutionalized and non-institutionalized.

IFE. The reliability of the IFE was confirmed in this sample. However, the administration of the IFE was not without problems related to administration.

Institutionalized participants seem to have difficulty grasping the concept of a scale as explained in the directions to the IFE, as did some non-institutionalized participants. Participants made remarks, such as, "I do not feel like either picture or anywhere in between," or "I chose this picture because I like the picture" rather than choosing a picture on the basis of how one felt at the time of questionnaire administration. Perhaps the instructions on the IFE should be reconsidered for clarity, especially if the scale is to be used with elderly populations.

Implications for Nursing

There were limitations to this study. Low statistical power of the SHRQ, evaluation apprehension of the research subjects, and limited generalizability since the sample was not random. Another variable, length of residence in an institutionalized setting, may have had a potential impact, but no specific limits were placed on length in the institutional setting, therefore, this impact cannot be evaluated.

Additionally, nursing homes as well as other settings that serve environmentally deprived clients need to be cognizant that field energy may be lower under conditions of such deprivation.

Nursing care needs to be planned that allows for as much independence in decision-making as is possible. Also, diverse environmental resources would increase stimulation. Environmental diversity and independence, if coordinated, could increase positive feelings about self, adding energy to an individual's life.

Humor is an important component of every individual's life, despite the type of residence. Nursing homes and all types of institutions where elderly reside need to be cognizant of the use of humor as a communication and support device. Additionally, humor presents a means to add environmental diversity. Structured programs of humor or guided "humor reminiscence" may be indicated. However, further studies need to be conducted to determine efficacy of these ideas prior to any implementation of structured humor programs or guided reminiscence sessions involving humor.

Conclusion

This study was based on the proposition that the energizing nature of humor, employed as a nursing intervention, could facilitate patterning of the individual's field energy. Patterning characterized by a zest for living was proposed to have a strong relationship with enhanced well-being and quality of life for the vast number of older adults, many of whom are confined to institutional settings. The nature of the relationship between humor and field energy has been explored in a sample of older adults, yet questions

remain. Field energy was significantly lower in institutionalized than non-institutionalized older adults, whereas the groups did not differ in humor as operationalized in this study. Because there were problems associated with sample size and the measurement of humor, further study needs to be conducted with a larger sample size to determine whether humor is different in the two groups, or whether the measurement of humor as measured by the SHRQ is the substantive problem. Efforts to confirm the relationships predicted by Rogers' Science of Unitary Human Beings were hampered by these problems.

The results of this study have limited generalizability because of sampling bias that may be present in non-random samples. However, the need for further research has been demonstrated in the area of humor. This research can be extended by developing and testing humor as a therapeutic modality within the theoretical context of Rogers' science of Unitary Human Beings. Due to the success of the IFE in this study, a foundation has been laid for the development of a humor intervention with the IFE as an outcome measure. Consequently, the IFE has a bright future for use in gerontological research.

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INNOVATIONS COLUMN

Unitary Human Being is like Being Connected with Hula Hoops: A Student Presentation

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Endnote by Dr. Sarah Gueldner

The Science of Unitary Human Being is almost too complex to grasp at first. The words Rogerians use are not words we use everyday. For instance, as humans we are not “particulate”, but “unitary”. And Rogerian nurse scientists urge us to “bring our highest frequency to practice”. I (Mandisa) was assigned as a work study student to help one of our professors, Dr. Sarah Gueldner, and I spent some time in her office, where I learned that Dr. Gueldner was really high on Rogers—in fact, she even referred to herself as a “Rogerian”. And her office had more purple things in it than any of the other faculty offices do. I soon learned that the color purple is the highest frequency that is visible to the human eye – the next higher color is ultraviolet, which is not visible to the naked eye. And prominently displayed on her wall there was a framed poster of a smiling, playful Martha Rogers wearing a billed black cap that had, stitched across the front, *Just Visiting this Planet*. (Dr. Gueldner smiled and told me she had purchased the cap at a truck stop, then gave it to Martha.) I thought that

was unusual at the time, but I later came to understand that it was a classic poster that captured the fun loving side of the theorist, Martha Rogers. Dr. Gueldner also pointed out her collection of *Visions the Journal of Rogerian Nursing Science* on her bookshelf.

So when we were assigned to do a group presentation in our graduate nursing theory class, four of my classmates and I signed up to portray Martha Rogers’ Science of Unitary Human Beings. We certainly didn’t make it easy on ourselves, but it turned out to be a lot of fun, and now we know the Science of Unitary Human Beings better than most students do. To get an “A” on a class presentation (which my classmates and I were of course aiming for) you needed to ace your presentation, and we had a great idea. We bought 5 purple (i.e., unitary) plastic hula hoops embedded with sparkly shiny flecks - - they were awesome. And we prepared a skit to convey our interpretation of unitary human being. We didn’t actually write a script for the skit – it seemed like it would be wrong to write a script for a

Rogerian presentation, where things are supposed to just emerge. Our presentation was to be a demonstration of the unitary field, highlighting the five of us as unitary humans integral with each other and with our shared environmental field that included other human fields. After the presentation we gave the sparkly hula hoops to Dr. Gueldner, and she still keeps three of them tucked between her desk and her file cabinets – two people asked if they could have one to exercise with, so there are only three hula hoops left in her office now. You can see them through the little full length vertical window by her door.

But back to our presentation. While we did not write a script, our storyline was about a patient who was to receive bad news about her diagnosis from the physician, in her room at the hospital. The skit began as the nurse woke up and had to deal with problems at home and on the bus as she came to work, and finished as the nurse and physician gathered in the patient's room to deliver the unwelcome news that she had a serious health problem. We continually held our hula hoops around us, to convey our individual human energy fields...and as we came upon others we held one hand on the other person's hula hoop and they held ours with one of their hands, conveying that our fields were not separate, but unitary. At some points in the skit the fields of all five of us were connected in this way with each other.

Encircled by our hula hoops, we portrayed two different scenarios;

in the first scenario the nurse had encountered bothersome difficulties before she got to work, including unpleasant interactions with her family and friends, made worse by transportation problems that made her late getting to work, making her have to run up the steps at the hospital to get to her unit "on time" (as if time is a finite concept, as is presumed in most work places). She carried these problems with her, making her interactions with the doctor and her nursing colleagues curt, and the session with the patient was less effective and comforting than it might have been.

In the second scenario the nurse encountered the same problems at home and on the way to work, but she was mindful that the others who she met may have had similar experiences at home or on the way to work, so she was able to acknowledge that together they shared a unitary human field, which made her able to be with them in a different, more unitary way. She was able to accept their irritating behaviors (as well as her own) as an expression of the mutual human field that could be made better. With this insight, she was able to view her own difficulties and theirs differently, and in doing so she was able to help the group transform the negative energy within their mutual unitary field to create a more positive field. We used the hula hoops to convey that neither the patient nor the health care staff were separate entities, but cohabitants of the mutual human-environmental field, which includes all other fields.

So we came “to work” at the hospital depicting two different “field” scenarios. One scenario depicted the usual way that patients are attended when things go wrong, and the other conveyed a more unitary scenario. Since it is never all that easy to get to work, we started our wrong then unitary skits at home, with things going wrong, then a difficult commute, a bothersome co-worker and an irritable physician. In the first scenario we were still carrying that baggage with us, so we were thinking about ourselves – we rolled our eyes when the doctor made a snide remark about nurses, and paid very little attention to the patient and her family member. Rather, our attention was directed to our co-workers, who were getting on our nerves.

Then we exited the stage, and reentered portraying a Rogerian approach. And this time we held our pretty sparkly hula hoops around us, portraying our fields. The troubles at home and getting to work were the same, but as we encountered our co-workers and the patient and her family, we acted differently. We merged our field with the fields of others who we came upon – holding our own hula hoop (i.e. our individual human field) with one hand and at the same time holding the hula hoop of another person; and they held to ours, symbolic of the mutual human field that we shared. And when we got to the patient and her family member, they were included as a part of the larger mutual field. Holding our own and each others’

hula hoops, our fields became emerged in mutual process.

We symbolically connected with the human fields of each other, and together we joined and shared the field with the patient and her family, and with the still persnickety doctor. Visually and experientially connected, we acknowledged and embraced our collective energy field, and our conversation and the nursing care changed. Separateness melded into unity, and the scenario changed dramatically. We felt like one mutual energy field instead of five separate human fields, and our interactions mellowed. As unitary human beings, we were attentive to each other, and things went better. We were also more civil to those who had created problems in the first scenario, and we acknowledged the patient and her family as unitary human beings within the mutual human field. With this conscious change in the perspective of mutuality, communications improved, with a sense of increased relevance for each person. The hula hoops helped to convey the unitary connection of all humans within the mutual human field.

An editorial comment by Sarah Gueldner...

Most would agree that nursing has never been easy on its young, and I’m sometimes afraid that is especially true for Rogerian nurses. It’s not easy being a student within Rogerian Science. We expect a lot of our future generations; they must

learn and embrace the language, and we Rogerian “elders” who “knew Martha” (as she allowed us to call her) require that they “get it right”. And we learned that at Martha’s side -- she wrote “PARTICULATE !” in letters three quarters of an inch high across my diagram of Rogerian thinking – and me feeling sure that she was going to love my diagram!

She had agreed to serve as a consultant to my dissertation committee, but then had the serious car accident that left her on a pulmonary ventilator for several weeks, so I assumed that she wouldn’t be able to read it. But Martha knew how to get over things, and just a few weeks before I was scheduled to defend my dissertation proposal, she left a message on my home phone that she was better now, and would be staying at her cottage (named “Corn Pone Cottage”), near the Smoky Mountains in Tennessee, and could read the draft of my dissertation proposal. And she told me where to send it. She also extended an invitation to the members of my dissertation committee and me to join her there, where she would share her thoughts in regard to the draft my dissertation proposal. Well! What a shock – I had finished the draft of my dissertation, and had already distributed it to my

committee. None of my committee members were of the Rogerian persuasion, but fortunately all respected her highly, and were very supportive of me; and they were pleased that I had connected with Dr. Rogers so that I could “get it right”. So I sent her the draft of my dissertation proposal, and prepared to go to her place in the Smoky Mountains to receive her comments. One classmate and one member of my dissertation committee accompanied me “to the mountain”.

But when I got there I was astonished to see that she had written “*particulate*” across what I thought to be a near perfect diagram conveying my application of Rogerian theory in terms of my dissertation research; I was practically distraught. So when I got a chance, I made a long distance phone call to my doctoral classmate back in Alabama to ask her to retrieve the copies of my dissertation proposal that I had just distributed to my committee members – because I could see that I wasn’t nearly ready to defend in the special Rogerian language just yet. So, long story short, it’s not easy being Rogerian, but it is a noble thing to do. And my dissertation proposal only took a couple of months longer that it would have if I hadn’t “gone to the mountain” to “get it right”.

IMAGINATION COLUMN

MARTHA ROGERS AND *ONE HUNDRED YEARS OF SOLITUDE* WHERE BLACK AND WHITE ENDS AND PURPLE BEGINS

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Abstract

Transcending the confines of the purely physical, Rogerian theory elevates the possibilities of nursing practice. By its inclusion of that which cannot be explained empirically and allowing for the possibility of the miraculous, a deeper truth is revealed. In the same way, Gabriel Garcia Marquez's literary style of Magical Realism in *One Hundred Years of Solitude* poignantly reveals truth through the seamless blending of the miraculous and the ordinary.

Key Words: Rogers, unitary nursing science, magical realism

I have never been very interested in the "black and white" aspects of life. The concrete has never appealed to me; the ethereal and the abstract have always seemed somehow more true than the literal. Perhaps that is how I ended up in a job where healing is intangible, and improvement can rarely be reflected in lab values. I work in a children's psychiatric hospital, and success is often most clearly reflected in a smile that comes readily where it was once reluctant, or by the ability to open up when difficult questions are asked rather than to shut down. The medical model leaves much to be desired in my line of nursing, and Martha Roger's (1992) view of nursing, and of the world, left me enchanted. The causality so inherent in traditional ideologies depicts healing as a struggle; each patient seems to be battling in an individual effort to overturn the

"natural" order with no connection to anything beyond these personal struggles. Rogers illuminates our interconnectedness and allows the miraculous to actually be commonplace, revealing a deeper reality than the physical alone can express. The literary genre of Magical Realism exemplified by *One Hundred Years of Solitude* (Marquez, 1967/2006) similarly touches upon the metaphysical elements of humanity, describing the miraculous and the ordinary with no distinction between the two, and in so doing, poignantly expressing truth as it feels.

The Rogerian model is essential to the development of nursing practice in our increasingly complex world; her theory expands the very concept of what it is to be human, and how nursing practice can be enhanced based on this expanded perspective. In our world of ever increasing speed and

diversity, nurses need creative solutions. Healing modalities that are difficult to explain or quantify (such as meditation and therapeutic touch) are gaining reluctant acceptance as evidence continues to show that they work. As Rogers (1992) states, "There are lots of things that we do not understand but which, nonetheless, have documented evidence that something goes on..." (p. 34). There is something to human existence that extends deeper than the medical model will allow, something that extends beyond the physical and concrete.

Rogers (1992) identifies four postulates that accommodate this extension: energy fields, openness, pattern, and pandimensionality. Her vision of unitary human beings provides a framework for looking at people and their environment as not just a sum of parts, but as irreducible wholes, each part inseparable from the other (Rogers, 1992). This broadened vision of humanity allows for the exploration of new modalities and new ways for nurses to enhance health and well-being using methods that stretch our conception of the possible, past that which can be explained physically. As Rogers (1992) writes, "What may be quite valid in describing biological phenomena does not describe unitary human beings, any more than describing a molecule tells you about laughter" (p. 30). Evolving healing modalities utilize the vast expanse of our unitary selves that is left out when only the molecules are given consideration.

Under a Rogerian lens, a research study was recently conducted exploring garden walking as a healing modality for individuals who are depressed (Hanson, McCaffrey, & McCaffrey, 2010). The study was designed using garden walking followed by reflective journaling to change pattern manifestation through enhanced perception of integrality in a sample of forty adults diagnosed with depression. Assessment scales measuring depression showed a significant reduction in depression following a six month period of regular garden walks (Hanson, McCaffrey, & McCaffrey, 2010). The authors note that "reflective writings often identified human patterns and pattern changes on the basis of the connectedness of the participant to the garden. Beauty, peacefulness, a sense of the wholeness of the world, and a sense of being a small part of a larger whole were examples of patterns identified and changed" (Hanson et al., 2010, p. 258). The difficulty we have describing in words or quantifying in numbers exactly how this type of healing takes place does not alter the truth that healing is, in fact, happening. If we as nurses are to act as patient advocates, our uncertainty of what we feel but cannot explain should never stand in the way of providing care.

Just as Martha Rogers' work has redefined the possible in nursing, Magical Realism has redefined what the impossible can reveal about reality in literature. As author Daniela Giosefi explains,

Magical Realism “contains surreal or fantastical elements that happen within a realistic setting or circumstance... Magical events happen that represent an emotional truth. Properties of the fantastic and realistic are blended into one” (as cited in Corso, 2007, p. 21). In this way, the writing is not bound by observable reality. Through the blending of the fantastic and the realistic, that which is felt intrinsically, (easily felt but hesitantly believed) is expressed, often defying the confines of the physical.

The Nobel prize-winning *One Hundred Years of Solitude* (Marquez, 1967/2006) is the embodiment of this style, interweaving the miraculous and the mundane to tell the story of the Macondo family. The fantastical picks up where reality ends and feeling takes over, creating a poetic fantasy that feels more real than reality. The beauty and simplicity of the writing lies in the recognition of the void that is left in reality alone. Marquez uses magical depictions to fill this void. In *One Hundred Years of Solitude* a narrative is created that is more real because of its fantasy, in its inclusion of the ethereal to speak in a language our souls understand but our minds often do not.

Love and hate, war and peace, innocence and corruption are all encompassed throughout the novel. Remedios the Beauty is a child of simple purity, and her exit from Macondo foreshadows the village’s peace coming to an end. Marquez (1967/2006) writes:

She watched Remedios the Beauty waving goodbye in the midst of the flapping sheets that rose up with her, abandoning with her the environment of beetles and dahlias passing through the air with her as four o’clock in the afternoon came to an end, and they were lost forever with her in the upper atmosphere where not even the highest-flying birds of memory could reach her (p. 236).

The tragedy of innocence lost is illustrated using fantasy to transcend reality, and ultimately reveals truth.

Through Rogerian theory, nursing practice is unfettered by the inclusion of possibilities that transcend the empirical. In the same way, *One Hundred Years of Solitude* has affected readers worldwide through its blending of reality and fantasy, using fantasy to describe what we feel but cannot explain in the framework of the physical realm. Seeing ourselves as unitary human beings allows for the enhancement of a whole self, incorporating the intangible with the tangible, creating a depth of self and a connection to the cosmos we feel but cannot touch, creating boundless possibilities for improved nursing practice. In Rogers (1994) own words, “I think very often we’re accustomed to wanting to put everything into a kind of reality that we can pick up... The

science of unitary human beings provides the knowledge for imaginative and creative promotion of the well-being of all people” (p. 35).

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PRACTICE COLUMN

A UNITARY VIEW AT END OF LIFE NURSING

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Martha Rogers' theory of Unitary Human Beings was the first to define humans as energetic beings that should be treated in an all-encompassing manner (Rogers, 1970). While simply stated, this theory is quite complex and abstract. According to de Chesnay (2005), Rogers' theory of Unitary Human Beings can effectively be divided into three components of pattern appraisal, mutual patterning, and evaluation.

Pattern Appraisal

When formulating the pattern appraisal, one should identify the patterns that encompass the whole person because the life process reflects its own unity intermingled with the surrounding environment. This comprehensive assessment involves cognitive and sensory input, types of language familiar to the patient, and intuition. The nurse's use of feeling and sensing can be quite valuable in understanding the patient more fully. This understanding should encompass the past, present and future. One's appraisal can be validated by correctly identifying the patterns and rhythms of the patient. "The goal of the nursing action is to bring and promote symphonic interaction between human and environment" (de Chesnay, 2005). The purpose

of this interaction is to strengthen the coherence and integrity of the human field and adjust the patterning of the human and environmental fields as needed. This is an organic process and should continue to be so while caring for the patient.

Mutual Patterning

Mutual patterning between the nurse and patient is multi-directional. It can include medication administration, therapeutic touch, visualization and imagery. These are to be used in the evaluation process to resolve the dissonance often found in those needing medical attention. This ongoing process of evaluation of pain, fear, and tension with caregivers and family should be addressed regularly in that the dynamics of each will often be in a state of change. The nurse can then share her assessment with the patient so that mutual patterning can continue and a more harmonic state can be present within the patient (de Chesnay, 2005). Cobb expands the understanding of this theory as a transformative process in a unitary system that is infinite and irreversible (Cobb, 2006). Every experience of a person impacts his or her level of health. The totality of the human is a "biopsychosocioculturalspiritual being" that is much more than the sum of the parts (Wright, 2007).

Evaluation

Evaluation centers on the process of determining if the actions taken through mutual patterning activities have rendered harmony in place of dissonance. The nurse should also assess the fear, pain, and tension of the patient's loved ones. This is an ongoing process with changes in dynamics. Therefore the nurse should be aware of these variables and continue to address those issues that cause an interruption in the patient's energy field. These issues often will manifest in discomfort, fear, and pain (de Chesnay, 2005).

My Patient

I am writing about an experience with a patient who has forever impacted me. I had the honor and privilege of providing nursing care for my father in his last days and being witness to and integrated with his transition from this life. I was not expecting to have such an intense and hands on experience this early in my nursing career, but I was put to the test in August of this year. My father was one of the most intuitive people I have ever known. He taught me to know and trust my own intuition. In some ways this made working with him in his altered state rather simple. In other ways it was very difficult in that the high emotion and pain that accompanies the loss of a parent can easily cloud judgment and hinder clear decision making.

Theory Applied

On Friday July 31, 2009, I received a message from my sister that my father had been put in the

last stages of hospice care. He had been courageously fighting Alzheimer's disease and its comorbidities for about 14 years. My family had witnessed the slow deterioration of his abilities to perform activities of daily living. After assessing the new needs of my father and being determined to keep him at home if at all possible, we had rearranged the master bedroom of my parents' home to accommodate a hospital bed, a twin bed, and newly needed supplies. At this stage he was able to ambulate with much assistance and was sporadically aware of his surroundings. When taking him into the newly arranged bedroom, he displayed a look of surprise at the condition of the room where he has slept for the past 30 years. I kiddingly told him that he had once again sold the furniture from their bedroom. He just chuckled and then a sense of calm familiarity came over him. As a middle aged man, he was owner/operator of a successful home furnishings business and more than once he and my mother had words as she would come home from work and find her bedroom suite had been sold and removed. This exemplifies the portion of Rogers' theory of integrating the past with the present to put one's energy field in a harmonic state (Rogers, 1970). Also vital to addressing the Unitary Being is the use of innovative and creative responses to the interaction between the person and their environment. This is said to reinforce harmony within a dissonant situation (Allgood, 1991). By suggesting a familiar

reasoning to an unfamiliar situation, my father was put at ease.

His first night in the hospital bed was somewhat restless. We realized by his fidgeting that he must be uncomfortable. Also, the pillows used to cushion the metal rails were making him hot. We remedied this by adding an egg crate pad to the mattress and used a swimming noodle (a long, round floatation device made from styrofoam) we measured and cut to fit the rails. His restlessness ceased and his temperature became more normalized.

Another main goal for us was to keep the situation one of dignity. I instructed and reminded everyone when in the room to not refer to his adult briefs as diapers. I knew that he had always been a modest man. I asked everyone not directly involved in his care to leave the room when it came time for bathing, cleaning etc. When one of my sisters had a rather difficult time with some of the cleaning duties, I assessed this and would gladly trade duties with her. We all were focused on what was best for my dad, happily asked for help when we needed it, and allowed each other to use their own strengths. By addressing this, the overall environment of the room remained calm. My mother reminded us that in my dad's more active years he had always been very aware of good hygiene and personal care. We arranged for daily bathing and shaving with hair washing every two to three days. These grooming sessions left him pleasant and arousable for about

one hour. The family relished these times of communication.

My father was a man who always enjoyed being outdoors. While still ambulatory, he would take a cup of coffee and sit out side in the sun with his dog. Daily, after he became bedridden, we moved the bed in front of the picture window. I bathed and dried the dog brought him in to be with my father. My dad reached up to touch him and puckered his lips as if to give a kiss. This was a sign he was comforted.

Throughout the time I was providing nursing care for my father, I was careful to use jargon familiar to him. I would refer to him by a silly nickname he used his whole life, Ellibow, when having to move him or give instruction for taking medication. He responded to this very well. When lifting him or turning him, I would tell him to give me a big hug. If we needed him to stand he would hug me and then we would sway slowly as if to dance. I would remind him to not try to jitterbug. Often he would pat my back and kiss my cheek. All of these actions, which integrated past behaviors, proved to bring harmony to the situation.

I was under hospice orders to administer medication based on my father's behavior. He had recently begun having seizures when his Seroquel was increased. At first the seizures were so brief that I questioned if they were true seizure activity or other neurological issues associated with Alzheimer's. But my mother, who has been his caretaker for the past ten years, later stated she knew something was just not

right. The Alzheimer's specialist was called and told us that no one had ever reported having seizures from Seroquel. So going against her intuition, she continued the administration of the increased amount. Within 24 hours he had body stiffening and jerking and a bit of emesis that was undoubtedly a true seizure. The hospice nurse was called and we had new orders to stop the Seroquel and use an appropriate dosage of Ativan instead. In the first week, my father was able to swallow. I would crush the Ativan and mix it with applesauce for easy administration. I would gently hold his face, call him either Ellibow or daddy, and tell him I needed him to swallow just one time; this was the medicine that made him feel better. He would rouse slightly and concentrate on taking the medication. This proved successful as long as he could swallow. Once he was no longer able to swallow, I made a milky paste of the Ativan and water and told him what I was doing before I applied it to his buccal membrane. I would hold his face gently, rub his hair, and kiss his forehead. Even when he could barely muster the energy for movement, he would oftentimes pucker his lips as if to kiss me and occasionally stroke my face with his hand. He knew I was caring for him.

The hospice service gave us liquid morphine to use as his dehydration status increased and muscle pain intensified. My mother had dreaded using the morphine. I think she knew that administration of this drug meant we were so close to

the end. She had always put his needs first and would never allow any of us to do otherwise. One night when I was sitting up with him through the night, I noticed he was grimacing slightly and fidgeting. I had given him his Ativan about an hour prior. When he was not resting well, I knew it must be time for the next stage. I was hesitant to administer the morphine simply due to my mother's dread. So I waited another 15 minutes and hoped he would become calm. When no relief was evident, I awoke her and we agreed together it was time for the narcotic. I felt it was important to have her at peace with this process and knew she would not hesitate.

Often reported at the end of life are visions of loved ones who have already died. My father was not different. When he would speak it was often unintelligible with the exception of select words. When my family or I would understand one of these words we would latch onto them to try and engage him. The hospice workers had told us that he would need our permission to die. I used visualization and imagery to assist with this process. When we could understand he was addressing his deceased mother and two of his deceased brothers, I was able to use this to talk about the party that was waiting for him on the other side. This was in line with his belief system and seemed to add to his comfort. I told him it was okay to go whenever he needed to and they were most likely looking forward to him getting there because he was always the life of the party. I would

use the names he had just mentioned and address the specific things about them that I could remember. I reminded him we would all be fine and care for each other. I told him that I loved him and that we would all miss him but would be okay: he had taught us well. My sisters, mother and I all learned from each other how to do this.

My father died on August 14, 2009 at the age of seventy nine. I was with him and at the time of death I was helping him into an adjusted position to aid his comfort. I had been with him for the majority of the past three weeks. I had expected to feel his spirit leave. I did not. Each day prior, I could see a noticeable decline in his energy field. The transition to death for him was one of seemingly fading away. The day after his death, I was expecting a sign of some sort, but I saw nothing. On day three I was alone in my car, retuning from an errand for my mother. I spoke out loud to him telling him he was changing my view of the other side. No bird, no rainbow, nothing. Later that day, my sister told me that she had seen a yellow bird that made itself very obvious to her. "Yellow bird" is a song he frequently sang to us as children. Before nightfall, my nephew told us to come outside. Over the sky out of the front door was a vibrant full rainbow. While getting ready for his viewing, we saw a baby deer feeding from its mother a few feet in front of the window. The first weekend I was visiting my mom, a yellow bird was at the feeder. It was the first visit we had

seen from this type of bird. The day the death certificates arrived in the mail, another rainbow was in the sky. Some may contribute all of this to coincidence. But intuitively we knew it was some sort of sign. Intuition, which is so valued in concrete circumstances, is often disregarded in areas that are more ethereal. Though often times Rogers' ideas and theories are viewed as "quackery" I can't help but give validity to much of it. I think we may get caught up in the jargon and fail to see that what she describes is really all around us. The idea of holistic nursing is as old as nursing itself. As humans in relatively good health we can endure some dissonance. In fact I think that is what different forms of stress are. But once our health is compromised, we can often become hypersensitive to those things we might not otherwise notice. We need more quiet and calm than usual. We need our energy and environment to be in harmony. We need loved ones to be sure we are cared for and comforted. It seems at the end of life it was so important to have children and spouse near and to be sure that the work of a father was done. Rogers' theory is more poignant today than ever. I have no doubt that we are unitary beings. As Unitary Beings, the human energy transforms and only the physical body changes in death (Malenski, 2006). Nothing in nature is ever lost; it only changes form. It has been said that healthcare providers should use Rogers' theory to be inspired to go beyond the ordinary line of vision and embrace the esoteric in order to

more fully serve the individuals unique potential (Tordar-Francheschi, 2006). By going to a place that many may have found uncomfortable, I was able to focus on my dad and talk about painful things in order to assist him. I often cried and at times had to leave the room unnoticed when talking about his passing. The physical aspect was easier in that I was able to teach my family what I knew as a woman about to be a nurse how to care for him physically. He had absolutely no skin breakdown. I could slightly elevate the head of the bed to aid his breathing. I could float his heels and put a pillow between his knees. I taught my family how to log roll him and use a draw sheet. I followed his cues on how to deal with him emotionally. He reinforced what I have always believed: little things make the biggest differences in patient care. And he was gracious enough to be the first patient I have ever had to die. The relationship with my dad is not gone, only changed. Those we love always live in our hearts.

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IMAGINATION COLUMN

EXPERIENCING ROGERIAN THEORY FROM A BACCALAUREATE PERSPECTIVE: A NURSING STUDENT'S WINDOW TO WELL-BEING

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Cedar Crest College

Abstract

The purpose of this paper is to describe the acquisition of emerging knowledge of Rogerian Theory from one baccalaureate student's perspective. The learning process regarding nursing theory and its correlation to evidence-based practice will be discussed, and the importance of exposure to nursing theory at an undergraduate level will be explored. Personal examples of nursing practice from a Rogerian perspective and its impact on patient well-being will be highlighted.

Key words: "nursing theory", "baccalaureate", "theory-based", "Martha Rogers", Science of Unitary Human Beings

Introduction

Current research indicates that in order for nursing to complete its move from vocation to practice, theory needs to be taught at an undergraduate level (Flanagan & McCausland, 2007). Students in a profession as diverse and complex as nursing need to be taught in a theory-based manner in order to prepare for the intellectual challenges that will be faced in practice (Flanagan & McCausland). The author of this paper completed the Baccalaureate Degree in Nursing

at Cedar Crest College in Allentown, Pennsylvania in December 2008. Curriculum content included not only instruction in clinical competency and content mastery, but also nursing theory and its practical application. While nursing theory was not taught as a specific class, concepts relating to nursing theory were interspersed throughout the author's educational process. It was during this process that the author conceptualized the foundation of Rogerian theory. Because it is a personal story, I will

report the rest of my experience in the first person.

Timeline of Learning Process

The first two years of my four year education consisted of pre-requisite classes. These classes were required to complete the degree, but were not part of the nursing curriculum. When these classes were completed, access to nursing courses was granted. The introductory course of the nursing program provided an overview of the nursing profession including its history, education, ethical and legal concerns, and cultural issues. During this course, students were assigned to groups that would research a specific topic then write a paper and present it to the class.

Students were then exposed to the process of nursing research, including the functions of the professional nurse in designing and conducting research. Knowledge obtained through prior course work and life experience was incorporated to enhance comprehension and application of nursing research as an essential facet of nursing practice. Students critiqued a sample of nursing research for statistical and functional validity, formulated research questions and performed comprehensive literature searches. During the clinical component, each student nurse was assigned placement in an on-going research study with an experienced nurse preceptor. My work, under the supervision of the nurse preceptor, was continued during the Leadership in Nursing class, which emphasized the management process of the

professional nurse in the delivery of healthcare.

In addition to mandatory assignments, students were encouraged to further develop and present projects initiated during the educational process. Again, students worked in small groups. My group partner and I were given the opportunity to present a report of the baccalaureate dissemination of the research explored throughout the educational process. The presentation took place at the Health and Wellness Conference on campus. The work was further refined and submitted as a poster presentation at the 20th Rogerian Nursing Conference at Case Western Reserve University in Cleveland, Ohio. (see Figure A).

Process

My emerging knowledge of Rogerian Theory and its application was gained through a gradual process which spanned the two-year nursing portion of the curriculum of baccalaureate preparation (see Figure A for the flow of course work). During the introductory concepts course, students were group-assigned various topics relevant to the nursing profession. The topic assigned to my group was nursing theory. Each participant in the group selected one theory and expounded on it during the presentation to the class, and also prepared a paper on their topic to turn in at the end of the semester. Although Rogers' Theory was not selected at this time, understanding of the importance of nursing theory and its applications to nursing care was gleaned from

writing this paper. This early experience laid the foundation for the introduction of Rogerian Theory, because it demonstrated to me that the nursing profession is built upon a theoretical framework.

The next step in the process of acquiring knowledge regarding Rogerian Theory occurred when I was completing the curriculum's research component. I learned how to analyze research findings to determine validity, as well as how to perform a literature search. These skills were subsequently employed when I participated with a faculty preceptor on a nursing research project. The project to which I was assigned involved data collection at Cedar Crest College using Gueldner's *Well-Being Picture Scale* (Gueldner et al., 2005). In addition to compiling data, I was afforded the opportunities to develop a site-specific consent form and to contact the Institutional Review Board for permission to obtain the data on campus. In order to complete this assignment, rudimentary understanding of Rogerian Theory was essential.

In my senior year of the baccalaureate program, during the Leadership in Nursing class, I was approved to continue working with a faculty advisor (preceptor) on the *Well-Being Picture Scale* I should just note that the theme of the conference was well-being, which coincided very well with the presentation). It was at this point that I began to explore Rogerian Theory at a deeper level. Leadership students were encouraged to

participate in the college's annual Health and Wellness Conference and a classmate and I developed a power point presentation on the *Well-Being Picture Scale*. In order to understand the conceptual base of the scale, I found it necessary to study the theoretical framework from which it was derived, which is based on the tenets of Rogerian Science. Being able to connect Martha Rogers' Science of Unitary Human Beings (Rogers, 1992) with the *Well-Being Picture Scale* gave the concepts of the theory new depth and clarity, and I began to consider health as a multi-dimensional dynamic process. Rogers' principles of helicy, resonancy, and integrality became easier to grasp when applied to patient assessment using the picture scale.

The power point presentation on Gueldner's *Well-Being Picture Scale* was well-received at the conference. In fact, my faculty advisor recommended that a poster based on the power point presentation be constructed and submitted for presentation at the 2008 Society for Rogerian Scholars Conference at Case Western Reserve University in Cleveland, Ohio. The abstract was accepted, and during the poster presentation at Case Western, I had the opportunity to discuss Rogerian Theory with nursing experts from diverse backgrounds and specialties. This experience fostered further understanding of Rogers' Science of Unitary Human Beings, as well as adding an important theoretical

dimension to my professional and personal growth.

The exploration of nursing theory from my perspective as a baccalaureate nursing student took place during each course, in a different way. According to Chickering and Gamson, high quality undergraduate education urges students to become active participants in the progression of intellectual development (1987). The American Association of Colleges of Nursing (AACN) holds that baccalaureate students need to understand the correlation between theory, practice and research (AACN, 2008). For me, hands-on involvement was a cornerstone in each step of the learning process. By participating in nursing research and presenting both my experience and the findings of that research in different forums, I was able to recognize the connection of various concepts and the application of those concepts to nursing practice. The AACN has also stated that critical thinking and reasoning are essential to high-quality evidence-based nursing practice, suggesting that a nursing education which includes theory can help foster these skills (2008). For me, being exposed to nursing theory and seeing its practical application as an undergraduate student was an exercise in critical thinking.

Reflections on Homeodynamics:
Nursing from a Rogerian Perspective

Rogers' concepts of helicy, resonancy and integrality provided a multi-faceted framework for my pursuit of the concept of well-being

both personally and professionally. According to Rogers, helicy is defined as an on-going, progressive process within the human and environmental field pattern that is evidenced as increasing diversity (1992). Helicy has been noted to correspond with moving toward and fulfilling an individual's potential (Gueldner et al., 2005). For me, the journey of nursing education and the genesis of a nursing career have produced multiple interfaces within the human and environmental energy fields that have elicited progression toward fulfilling my individual potential. I now think of well-being as an experience that is impacted by more than just physical condition and essential knowledge.

Resonancy is defined as the ebb and flow of energy in human and environmental fields, with amplification of the flow of energy being tantamount to enhanced well-being (Gueldner et al.). In my personal experience, low (negative) energy and high (positive) energy have impacted my well-being at many points throughout my still-evolving life process. At times, fatigue and fear of failure have resulted in depression, lower productivity, and an ensuing decline in well-being. Conversely, encouragement, positive personal interactions and relaxation techniques such as communing with nature and practicing breathing exercises have resulted in a higher state of well-being.

Integrality describes the process as one and whole (Rogers, 1992). To me, the quintessence of

this concept can be stated as the whole being different than the sum of its parts. It was not one experience, individual, or class that lead me down this path. Rather, it was the summation of all and the dynamics of the connecting and communing energy fields that wove the tapestry that has become my life experience to this point.

Coming to “know” Rogerian Theory has had an influence on the author’s nursing practice in many ways. I currently work on a medical/surgical intensive care unit. The environment in a critical care unit can often be cold and impersonal. Because of my exposure to Rogerian Theory and specifically, the Rogerian-based conceptualization of well-being, I am able to perform my nursing care in a more holistic manner. When ventilated patients appear agitated, I use relaxation techniques such as soft music and lighting, in conjunction with medication. When unstable patients are experiencing a crisis, I attempt to exude calm, positive energy while reacting, in order to increase the patient’s feeling of well-being. In my work, I sometimes have the opportunity to provide comfort care to dying patients. At these times, therapeutic touch and spiritual care seem especially helpful.

Conclusion

Perhaps grasping the concepts of Rogerian Theory cannot be achieved at a baccalaureate level by taking one class in nursing theory. Inclusion of nursing theory in each course of the undergraduate

program has the potential to assist students in understanding the often obscure theoretical concepts and in improving critical thinking skills. Not all of my nursing classmates were afforded the opportunity to study nursing theory for independent projects; therefore, my educational experience with Rogerian Theory was the culmination of a fortunate chain of events. This chain of events has resulted in my deeper understanding of Rogers’ homeodynamics and how they can impact one nurse’s personal and professional growth. Because of my unique experiences as a baccalaureate student, Rogerian-based theory has become a part of my daily nursing care. I would have liked to have met Dr. Rogers in person.

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SRS NEWS

PRESIDENT'S MESSAGE APPRECIATING ORGANIZATIONAL WHOLENESS

I bring greetings to readers from the Society of Rogerian Scholars (SRS). In the first year of my term as president, it has been wonderful to work with the board and committees as they cocreate day-to-day expressions of the SRS given the visionary path sketched by our founders and members. The path emerged from the 2010 appreciative inquiry process of strategic planning that the SRS membership participated in and affirmed at our 2010 General Assembly meeting in Florida.

Our Vice President and Membership Chair, Dr. Nelma Shearer, has been coordinating the membership renewal process. I encourage you to renew your membership and encourage others to join. Our major activity of the year will be our 2011 Conference. The Conference Planning Committee (Co-Chaired by Drs. Richard Cowling and Pam Reis) has been hard at work to assure a successful annual conference. They have raised SRS Conference Planning to new heights with a systematic plan for sponsorship, resort location, and web-enhanced support/resources. Of course, they also have honored the traditions of the many SRS Conference Planning Committees before them by selecting outstanding presenters and sessions that promise to stimulate thinking and future knowledge development. I would like to take this opportunity to publically thank Dean Pearcey, of the University of North Carolina - Greensboro for hosting the Dean's Reception on Friday, October 7, 2011.

The Nominations Committee (Dr. Michele Kramer, Chair) has worked diligently on SRS leadership succession. They have been able to gather a slate of candidates to provide experienced and innovative leadership for our organization. At this writing, a ballot is being prepared for mailing and the election results will be announced at the General Assembly to be held in Greensboro, NC in conjunction with our 2011 Conference. I hope there will be a strong voter response and fabulous attendance at the conference and General Assembly.

Our ever committed and faithful treasurer, Dr. Jacqueline Fawcett, drafted a proposed budget that has been reviewed by the board and the board will vote on approval at our next board meeting (September, 2011). We are trying, in fiscally responsible ways, to weave in support for activities in our strategic plan. Dr. Jane Flanagan, our Secretary, keeps us together with instructions for meetings, agendas, and minutes. In addition to the operations of our vibrant organization, there are varying correspondence and proposals that come up throughout the year that the board discusses at the quarterly meetings. For example, items related to our publications, archival materials, follow-ups to our conferences, correspondence with members, discussions with other organizations, etc.

Our co-editors, Dr. Sonya Hardin and Dr. Martha Bramlett, have provided members, readers, and visitors a window on Rogerian Science through their tenure as editors. Please be sure to thank them personally when you see them at the Conference and consider submitting your work for review. Being aware of their years of service makes the news that Dr. Hardin will be stepping down as editor, sad, yet joyful in that she has fulfilled years of honorable and invaluable service to the SRS. We are looking for someone to take Sonya's editorial and leadership position. This is an opportunity for another member of the organization to bring new ideas and innovations to our Journal.

I could say more about the work of our Directors, who serve on various committees and provide consultation as needed. Our founders are also a source of counsel and encouragement. Individual members provide tangible and existential support that is treasured. Look at the work that Dr. Howard Butcher has contributed with the WIKI (just one recent contribution). It is a work in progress and needs our attention, please look at it and see what you can contribute. Dr. Thomas Cox has long supported the SRS with his hosting of our listserv. I could go on and on.

My key point is that I want you to know the SRS is alive and active.

The brief examples I have shared manifest the vibrant nature of our organizational, group field wholeness. The SRS is a living breathing field that continually requires voluntary mutual patterning. It is our "integrated awareness" (Phillips & Bramlett, 1994, p. 22), which is essential to the well-being of the SRS.

In closing, it is really an honor to be able to serve the Society of Rogerian Scholars as President. My hope is to honor the work that others have done to preserve, grow, and nurture the organization in the almost 25 years the SRS has been in existence. There are special transitions that will be unfolding within the next five years – 25 years of being an organization, 100 year anniversary of the birth of Martha E. Rogers, to name just two milestones. We hope you will journey with us along the many exciting and innovative adventures before us!

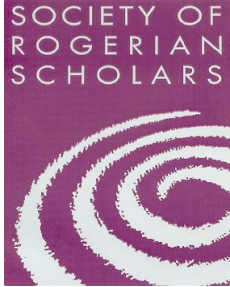
In appreciation,

Arlene T. Farren, RN; PhD, AOCN, CTN-A

President, Society of Rogerian Scholars

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Visions: Journal of Rogerian Nursing Science

Call for Co-Editor

The Society of Rogerian Scholars is seeking a co-editor for *Visions*. Since the Fall of 2002, Drs. Sonya R. Hardin and Martha Bramlett have been co-editing the journal. Dr. Hardin has made the decision to step down as co-editor, while Dr. Martha Bramlett will be continuing on with the Journal to ensure continuity. Time commitment is estimated to be 5-10 hours a month.

Interested applicants should submit their curriculum vitae to:

Dr. Arlene Farren, President SRS

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MEMBER NEWS

Promotions and New Positions:

Congratulations to all those who have been promoted. Effective July 1, 2011, both Dr. Jane Flanagan and Dr. Danny Willis received promotions to associate professor with tenure at Boston College, William F. Connell School of Nursing. Additionally, effective July 1, 2011 Dr. Sonya R. Hardin was promoted to full professor at the University of NC at Charlotte.

We have members who have accepted new positions. Dr. Nancey France has accepted a position at Florida Atlantic University in Boca Raton, Florida as an Associate Professor. Dr. Richard Cowling has accepted a position at Chamberlain College of Nursing as Vice President of Academic Affairs. Congratulations to both.

Awards and Grants:

Dr. Danny Willis received funding (2010-2012) from the National Institutes of Health/National Institute of Nursing Research (NINR) as principal investigator for his R15 research grant (R15NR011353-01A1) entitled, Adult Male Survivors Healing from Childhood Maltreatment.

Dr. Danny Willis received the Eastern Nursing Research Society (ENRS) "Rising Star" award at the March 2011 conference held in Philadelphia, PA.

Certifications:

Congratulations to Dr. Mary Guadron who recently received her Certified Nurse Educator Certification.

Resignation as Editor

It is with regret that we announce the resignation of Dr. Sonya Hardin as Co-editor of *Visions*. She served as Co-Editor of the journal since 2003, working with Dr. Martha Bramlett for the last nine years to bring a yearly journal to the membership. While Dr. Hardin will be directing her efforts in other directions, her presence as co-editor will be greatly missed.