Visions: The Journal of Rogerian Nursing Science

Volume 19 Number 1 2013

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Guidelines For Authors

1. Content must reflect some aspect of Rogers’ Science of Unitary Human Beings (research, theoretical issues, etc.)
2. The manuscript must not be submitted elsewhere for consideration.
3. Manuscripts will not be returned.
4. Authors will follow the format of the Publication Manual of the American Psychological Association (6th Ed.).
5. Manuscripts should be submitted electronically in Microsoft Word, prepared on a Windows compatible or Mac computer.

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.

Each manuscript will be reviewed by three members of the Review Panel. Final decision rests with the editors. Manuscripts are accepted for review at any time during the year. Submissions should be submitted electronically in Microsoft Word to martha.bramlett@pfeiffer.edu or howard-butcher@uiowa.edu.

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1. There are seven potential columns – Innovations, Controversies, Imagination, Emerging Scholars, Media review, Instrumentation/Methodology and Human-Environmental Field Patterning Practice – that will appear as submissions are received and accepted.
2. Selections for columns are editorial decisions. Submit manuscripts electronically in Microsoft Word to Martha.bramlett@pfeiffer.edu or howard-butcher@uiowa.edu. Please specify the column for which you are submitting the manuscript.
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Welcome to New Co-Editor

*Visions* welcomes Dr. Howard Butcher as the new Co-Editor of *Visions*. He previously served as editor of the Imagination column of *Visions* and takes the Co-Editor position previously held by Dr. Sonya Hardin. He is a charter member of the Society of Rogerian Scholars, as well as member of numerous other professional organizations including Sigma Theta Tau International.

Dr. Butcher is Associate Professor of Nursing at the University of Iowa College of Nursing. He received his Master of Science in Nursing degree from the University of Toronto, majoring in psychiatric/mental health nursing. He received his PhD in Nursing Science from the University of South Carolina. Both his masters thesis and dissertation were conceptualized within the science of unitary human beings. His dissertation research focused on the creation of the Unitary Field Pattern Portrait research methodology and he used the method to create a unitary field pattern portrait of dispiritedness in later life. He has published 21 journal articles and 11 book chapters focusing on the science of unitary human beings as well as 50 other journal articles and book chapters on a wide range of topics including depression and dispiritedness in later life, family caregiving, and nursing interventions. He is the co-editor of the Nursing Intervention Classification, now in it's 6th edition, and has a funded program of research focusing of the health benefits of written expressive emotion as a way to decrease the stress and burden in family caregivers.

**Editorial**

Curiosity as the Engine of Scientific Discovery and the Advancement of Rogerian Nursing Science

Howard Karl Butcher, RN; PhD

In late 2011, scientists at CERN, the Geneva-based European Organization for Nuclear Research, found tantalizing hints of something that looked like the Higgs boson. The physicists, concerned about unintentionally introducing biases to their analysis, agreed to remain completely unaware of the results while performing blind analysis until June 2012. On July 4, 2012, CERN announced cautiously, at the opening of the 36th International Conference on High Energy Physics in Melbourne, Australia, that they observed a new particle
consistent with Higgs boson properties. Remaining uncertain, they stated that they needed to go through the data and rule out the possibility it wasn’t something else. Two separate teams at the Large Hadron Collider, a 17 mile around 500 feet underground tunnel on the French-Swiss border, consisting of 3000 scientists each independently reviewed the data for months. Finally on March 14, 2013, scientists from CERN confirmed that they had indeed discovered the long sought elusive Higgs boson subatomic particle.

Finding it wasn’t easy. In 1964, Peter W. Higgs of the University of Edinburg along with two other groups of physicists, one in Brussels and the other at Harvard and MIT, all virtually simultaneously and independently suggested the existence of a particle that provides mass to elementary particles. It took more than three decades, thousands of scientists and the analysis of massive amounts of data from trillions of colliding protons to find because the Higgs boson is so elusive that only about one collision per trillion will produce one of them in the collider. It is a highly unstable particle that is visible only through its decay products and, once created, the particle only exists for less than a billionth of a trillionth of a second before changing into other subatomic particles.

I am writing about the Higgs boson particle for two reasons. First, the long search for the Higgs boson is an exemplary example of the role of curiosity in scientific discovery. Carroll (2012), in his book “The Particle at the end of the Universe: How the Hunt for the Higgs Boson Leads us to the Edge of a New World” states, “particle physics is the purist manifestation of human curiosity about the world in which we live” (p. 7). The Higgs discovery represents the triumph of human passion for discovery. Second, the search for the Higgs particle demonstrates how theory-testing research leads to discovery that can have profound implications by providing support for new understanding of the nature of reality and the universe.

The discovery of the Higgs boson particle is important, not for what it is but for what it does. The Higgs arises from a field of pervading space know as the Higgs field, and everything in the universe moves through the Higgs field. As all particles move through this field, they acquire mass. If there were no such process, everything would be mass-less. According to our new understanding of the Higgs field, the universe is made of fields, and substances are noticed because of their vibrations as they pass through the Higgs field. The vibrations, which appear are the subatomic particles that make the atomic particles. I imagine Martha would be thrilled about the verification of the Higgs field, since her view of energy is grounded in the notion of energy fields and pattern as vibrational manifestations of the energy field.
Second, the “Standard Model” is the reigning theory of particle physics and quantum theory, and all 61 particles predicted in the Standard Model describing the weak, strong and electromagnetic nuclear forces have been discovered, except one, the Higgs boson. More importantly is the role the Higgs boson plays in the Standard Model. It is the building block of all the other particles that have mass. Now that the Higgs boson has been discovered, the Standard Model is complete and the proposed theories based on the Standard Model have a new level of confirmation. The discovery of the Higgs boson has profound implications forever changing our understanding of the nature of the universe. For example, we now have a deeper understanding of the origin of mass. The Higgs boson also now helps us see how two of the four fundamental forces in the universe, the electromagnetic and weak forces, can be unified, and the discovery has implications of our understanding of what appears to be the symmetry in nature as proposed in theories of supersymmetry.

Philip Ball (2012) in his new book, “Curiosity: How Science Became Interested in Everything,” illustrates how, through time, great advances in human innovation were fueled by curiosity. Curiosity is the engine of knowledge and drives our compulsion to understand. In the sense that the modern definition of curiosity more often refers to the eagerness to know or learn something, there are many ways to be curious. Thomas Hobbs (1651/1985), the English philosopher, believed that curiosity, the desire to know why and how, was one of the defining characteristics of humankind that motivates the “continual and indefatigable generation of knowledge” (p. 124). Interestingly, the term “curious” derives from the Latin cura, which means “to care.” Curiosity is an essential component of any theoretical and scientific endeavor. Curiosity alone is not a sound basis for a program of research, but rather “it must be disciplined, for example by coupling it with methods for establishing reliable ‘facts’ empirically and using them to formulate hypotheses and interpretations” (Ball, 2012, p. 397). CERN Director General Robert Aymar also referred to the role of curiosity in the search for the Higgs boson when he stated CERN’s “research programme has the potential to change our view of the universe profoundly, continuing a tradition of human curiosity that’s as old as mankind itself (Aymar, September 10, 2008, CERN Press Release).

Curiosity was the major energy fueling Martha Rogers’ profound and continually revolutionary vision of nursing science, education, and practice. The accounts written describing Martha, especially those published in Malinski and Barrett’s (1994) text, Martha E. Rogers: Her Life and Her Work,” clearly illustrate how curiosity or the “thirst for knowledge” (Hector, 1994, p. 13) for the purpose of helping others was the fuel and major driving force behind Rogers’ life and work. Reading all 20 volumes of The Child Book of Knowledge by the 6th grade and waking up at 5 AM for most of her adult years so she could reach her goal of
reading at least 5 books a week (Malinski, 1994) are just a some of the illustrations of her insatiable thirst of knowledge. As Barrett and Malinski (1994) so clearly illustrate, “For her, curiosity and compassion spearheaded the need to know that ‘mankind’ may benefit” (p. 44). Like the discovery of the Higgs Boson, Rogers’ vision of nursing and the universe, based on a synthesis of the most contemporary scientific theories as articulated in the Science of Unitary Human Beings, offers a profoundly new vision, reality and understanding of the nature of nursing with radically different implications for the way nurses practice.

This is the 25th year since the founding of the Society of Rogerian Scholars, and 2013 is the 20th anniversary of this journal. This issue, as all the issues since 1993 when Visions: The Journal of Nursing Science first appeared, comprises examples of research and theoretical works that all originated from the relentless questioning, searching, and seeking for answers to questions driven by the curiosity of the authors. Each and every work published over the last 20 years in this journal has furthered our understanding and the profound implications of Rogers’ nursing science. In this issue, Kirton and Morris examined whether power as knowing participation in change is associated with adherence to prescribed antiretroviral medication regimen. The authors offer a new understanding of adherence conceptualized within Barrett’s theory of power as knowing participation in change, thus, adherence is a process of being aware, making choices, feeling free to act on intentions and involving one’s self in creating change. Kim and Smith used Barrett’s power and knowing participation in change theory to examine the effectiveness of a breast health education program. Consistent with Rogers’ new worldview, the authors conceptualize an educational initiative “as a health patterning modality whereby a person experiences pandimensional awareness of integrality of human-environmental mutual process.” Thus, participants used their awareness to make choices, freedom to act on their intentions, and involvement in themselves to create change. “Participating in screening mammogram is one way a person manifests change to enhance breast health.” Fuller, et al. used Butcher’s unitary field pattern portrait research method to create a vivid portrait of adult substance users and family pattern in rehabilitation. The researchers provided a new transformative understanding of substance use by transforming the portrait into the language of Rogerian science using the concepts in Barrett’s theory of power as knowing participation in change and Rogers’ postulates and principles.

Einstein (1955) reminded us “the important thing is not to stop questioning… Never lose holy curiosity” (p. 64). The advancement of the Science of Unitary Human Beings rests on the continual curiosity of a community of Rogerian researchers and scholars and may the manifestations of their work never become elusive and transitory as the Higgs boson.
References


KNOWING PARTICIPATION IN CHANGE AND PATIENT ADHERENCE TO ANTIRETROVIRAL THERAPY IN HIV INFECTED ADULTS

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Abstract

The purpose of this study was to examine the relationship between perceived power and adherence to prescribed antiretroviral medication regimen in a sample (n=66) of HIV infected adults. HIV is a major chronic illness, and successful treatment depends on the ability of the patient to maintain nearly perfect adherence to a combination of life-long antiretroviral therapies. The high pill burden, often unpleasant side effects, lifestyle choices and social stability all undermine the capacity of people living with HIV to take these medicines consistently for the rest of their lives. Power was measured by the Power as Knowing Participation in Change Tool (PKPCT), and adherence was measured using a visual analogue scale. The study sample had an overall adherence rate of 68% and a mean power score of 282 out of a possible score of 336. Point biserial correlation coefficient was used to examine the relationship between these two variables. No significant relationship was found between power and successful adherence to the treatment regimen.

Key Words: HIV, Science of Unitary Human Beings, Power, PKPCT
Introduction

Approximately 1.2 million people in the United States are living with the human immunodeficiency virus (HIV), the virus that causes AIDS (Centers for Disease Control and Prevention, 2007). The main effect of HIV disease is the destruction of the immune system, resulting in severe immune deficiency. With a severely compromised immune system, the host is subject to a wide array of life-threatening opportunistic infections that, without treatment, usually result in death within 10-15 years after HIV infection. Clinical management of HIV disease is complex and involves significant life style changes, frequent clinic visits to monitor disease progression, and continuous pharmacological therapy with antiretroviral therapy medications.

Although HIV infection cannot be cured, its effects can be abated through a combination of antiretroviral (ARVs) drugs designed to decrease viral replication or inhibit the entry of the virus into its cellular targets. However, nearly perfect medication adherence to ARVs is essential to curb viral replication (Paterson et al., 2000). Treatment interruptions and inconsistent drug intake by the patient can lead to inadequate suppression of the virus, deterioration of the immune system, spread of resistant viral strains, and progression of the disease. Despite the known benefits conferred by HIV therapy, patient adherence to antiretroviral therapy remains problematic. It is estimated that as many as half of the individuals being treated with combination therapies have serious problems related to adherence in terms of dosage, time, and/or dietary instructions (Nieuwkerk et al., 2001).

Four categories of factors have been identified which contribute to low treatment adherence: (1) patient characteristics such as substance or alcohol use, age, sex, or ethnicity; (2) medication related factors, such as dosing complexity, number of pills, or food requirements; (3) the patient–healthcare provider relationship; i.e., a poor relationship may be associated with reduced adherence, and (4) circumstances within the system of care, such as having no insurance or being under insured (Ammassari et al., 2002; Crespo-Fierro, 1997; Simoni, 2007; Molassiotis, 2007).

Adherence Viewed within the Rogerian Perspective

Despite a large number of studies examining adherence, demographics, and behaviors, no one idea has yet emerged that fully explains why some patients with HIV have low treatment adherence while others are able to adhere to the treatment regime. Rather, adherence is a complex behavior that is poorly understood and remains difficult to achieve. While a variety of sociological, psychological, clinical and systems based theories have been used to predict, explain, and understand the concept of
adherence, none has satisfactorily demonstrated any consistent correlate of adherence. This failure to achieve clarity may be due in part to the fact that approaches to understanding this phenomenon have been based primarily on mechanistic underpinnings. In previous attempts to understand this construct, individuals have generally been reduced to the biological person, physical person, psychological person, social person, spiritual person, or other compartmentalized attributes. In contrast, the Rogerian concept of mankind as a unified phenomenon, more than and different from the sum of his parts, provides an alternative view of personhood (Rogers, 1970). Within Rogerian science, humans are not viewed as extricable from nature, but rather are integral with it. What may be needed to fully understand why some individuals have low treatment adherence is a perspective that sees the individual as a unified whole in mutual process with his or her human-environmental field. This unique view of people and their world is the foundation of the Science of Unitary Human Beings (SUHB), a paradigm for nursing practice. The SUHB is an organized abstract system that describes individuals in continuous mutual process with the environment, where both change together continuously in a dynamic way. This thinking assumes that human beings are capable of becoming aware of their choices, and are free to use awareness and freedom to orchestrate and create change; in doing so they pattern their own field (Phillips, 1997). Within this system Barrett (1986) developed a construct of power to describe the person’s capacity to participate knowingly in change. The observable manifestations of power proposed by Barrett are awareness, making choices, feeling free to act on intentions and involving one’s self in creating change.

In summary, this study is based on the premise that sense of power, as described by Barrett, may be related to adherence, with the potential to help the nurse identify which patients with HIV are prone to low adherence to treatment. Then, through mutual patterning, nurses can develop ways to assist those with lower sense of power to move to higher power, thus improving their treatment adherence.

Methods
Sample

In order to determine the required sample size, a power analysis was performed according to Cohen’s (1992) recommendation, using a power of .80 and a significance criteria of \( \alpha = .05 \). It was determined that 63 individuals under treatment for HIV were needed to achieve power = .80 and \( \beta = .20 \), but 66 subjects were enrolled to allow for possible attrition of study subjects, and to be able to eliminate subjects
with incomplete or missing data on any of the data collection tools.

Inclusion criteria were as follows: (a) adult male and female patients 18 years of age or older with HIV infection or AIDS; (b) currently undergoing prescribed antiretroviral therapy with drugs from at least two different drug classes at the time of data collection (which is consistent with the standard of HIV care); (c) able to read English (as the study tools are only available in the English language) (d) clinically stable, that is, the participant has not had any new opportunistic infections occurring within one month prior to enrollment. Participants were recruited from an infectious disease clinic in a borough of New York City. Procedures were reviewed and approved by the institutional review boards of North General Hospital and Case Western University, and participants provided voluntary consent prior to participating in the study.

Measures

Medication adherence is generally defined as “the extent to which a client’s behavior coincides with the healthcare regimen as determined through a shared decision-making process between the client and the health care provider” (Garcia & Cote, 2003, p. 37). In this study adherence was measured using a visual analogue scale (VAS) developed by the investigator. The literature supports the use of a VAS as a simple, valid measure of adherence, even when compared to other more complex measures (Giordano et al., 2004; Oyugi et al., 2004). The VAS measurement is simple to execute, free of examiner factors that might affect the patient’s responses and is easy to analyze. The scale is numbered from 0% to 100%, representing the percentage of the prescribed drug that the respondent has taken during the last month. Participants were asked to read the directions and mark on the VAS how much of their prescribed medication they have taken within the past month. Between 95% and 100% was considered to be high adherence, and any amount below 95% was categorized a nonadherent.

Power was measured using Barrett’s (2003) Power as Knowing Participation in Change Tool (PKPCT), a semantic differential instrument with four subscales: awareness, choices, freedom to act intentionally, and involvement in creating changes. Each subscale is composed of a list of 12 bipolar adjectives and one retest reliability item; each subscale item is scored from 1 to 7, with total subscale scores ranging from 12-84 on each concept. The tool can also be scored as a total power score summing the total score on each subscale. The total power score can range from a minimum score of 48 to a maximum score of 336; higher scores indicate
relatively more power and lower scores indicate lower power.

**Statistical Data Analysis**

Descriptive statistics were used to describe the sample, and demographic differences between the adherent group and the non-adherent group were examined using $\chi^2$ tests. The Mann-Whitney U Test was used to examine differences in power scores between the adherent and non-adherent groups. To answer the primary research question, bivariate correlation analysis was used to determine the relationship between the continuous variable (power) and the categorical variable (adherence). The *Statistical Package for the Social Sciences* (SPSS) Release 16 was used to enter and analyze all data.

**Findings**

**Demographics**

Data was collected from the sample of sixty-six subjects. One subject’s data was excluded in the final analysis due to the extent of the missing data on the Likert scale. Therefore, the final sample consisted of sixty-five subjects, 41 (63%) males and 24 (37%) females. More than 90% (n=63) of the sample was minority, with African-Americans representing 74% (n=48) of the sample. Forty-eight percent of the sample was between the age of 40-49 (n=31) and 69% (n=45) of the sample were educated at the high school level or less (Table 1).

The majority (81%) of the study subjects (n=53) had an annual income of less than $19,000. Only four subjects had an annual income of greater than $29,000 and one subject did not answer the income question. All but two subjects reported having some type of health insurance. The majority (69%; n=45) received Medicaid as their primary health insurance.

**Risk Factor for HIV infection**

Subjects were asked to determine their own personal risk factor for contracting HIV. Twenty-four subjects (37%) reported their risk factor for HIV to be heterosexual sex. Fifteen (23%) of the subjects were men who have sex with men. Of particular note is that 29% of the subjects (n=19) reported that they did not know how they acquired HIV infection.

**Level of adherence in the study cohort**

About one-third (32%) of the sample (n=21) was found to be non-adherent to their antiretroviral therapy, and about two-thirds (68%; n = 44) of was adherent. Of the 41 men in the sample, 28(68%) were adherent; similarly, 16 of the 24 women (67%) were adherent. Thirty percent of the men and thirty-three percent of the women were non-adherent.

A chi-square test for independence indicated that there
was no statistically significant difference between those who were adherent and those that were not adherent with respect to ethnicity, age, education or personal risk factor for HIV (Table 2).

Power in the study cohort

The mean power score for all subjects regardless of adherence was 282. The mean power score for adherent subjects was 287 and the mean power score for non-adherent subjects was 17 points lower, at 270 (see Figure 1). The median power scores for adherent subjects was numerically higher than the median power scores for non-adherent subjects (Median = 293 versus 273). Upon visual inspection the distribution revealed a histogram that was negatively skewed. This finding was confirmed by statistical analysis in the descriptive summary (PKPCT Total skew = -.68; kurtosis = -.38). Normality of the distribution of scores was assessed, Kolmogrov-Smirnov = .112 (df =65, p = .04), indicating a departure from normality. Thus, an independent –samples Mann-Whitney U Test was conducted to compare the median scores on the total power scores between adherent subjects and non-adherent subjects.

No statistically significant difference in total power scores for adherent subjects (Median = 293, n = 44) and non-adherent subjects (Median = 273, n= 21) was found; U = 333, z = -1.88 p =.069 (two-tailed).

It was found that the mean power score for African American was lower than the mean power score for all other ethnic groups (M = 277) (see Figure 2); however, the small number of study subjects in the white group (n=2) and the other group (n=2) limits the interpretation of this finding. It was also noted that the mean power score was numerically higher for younger subjects, and that this score tended to decline with age. Adults between the age of 20-29 had a mean power score of 324; adults between the age of 30 -39 had a mean power score of 300; and adults between the age of 40 – 59 had mean power scores of 277.

The Kruskal-Wallis test was conducted to explore the impact of age on total power score as measured by the PKPCT, but no statistically significant difference at the p <.05 level was found in power scores for the five age groups $\chi^2 = (df \ 4, \ n = 65) = 2.765, \ p = .598$. 
TABLE 1: Characteristics of the Sample (N =65)

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<td>3</td>
</tr>
<tr>
<td>Medicaid</td>
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<td>69</td>
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<td>6</td>
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<td>Medicare &amp; Medicaid</td>
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<td>14</td>
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<tr>
<td>ADAP</td>
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<td>6</td>
</tr>
<tr>
<td>Missing Data</td>
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<td>2</td>
</tr>
<tr>
<td><strong>Risk Factor for HIV Infection</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSM *</td>
<td>15</td>
<td>23</td>
</tr>
<tr>
<td>Heterosexual</td>
<td>24</td>
<td>37</td>
</tr>
<tr>
<td>IDU **</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Unknown</td>
<td>19</td>
<td>29</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

*Men who have sex with men
**Intravenous Drug Use
TABLE 2: Comparison of adherent group vs. non-adherent groups on descriptive variables

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>ADHERENCE</th>
<th>$P$ value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>ETHNICITY</td>
<td></td>
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</tr>
<tr>
<td>Black</td>
<td>33</td>
<td>15</td>
</tr>
<tr>
<td>Hispanic/Not Black</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>AGE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-39</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>40-49</td>
<td>21</td>
<td>10</td>
</tr>
<tr>
<td>&gt;50</td>
<td>17</td>
<td>6</td>
</tr>
<tr>
<td>EDUCATION</td>
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<td></td>
</tr>
<tr>
<td>11th Grade or less</td>
<td>13</td>
<td>8</td>
</tr>
<tr>
<td>High School Grad or GED</td>
<td>15</td>
<td>9</td>
</tr>
<tr>
<td>Two years college or grad</td>
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<td>4</td>
</tr>
<tr>
<td>INSURANCE</td>
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<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td>31</td>
<td>14</td>
</tr>
<tr>
<td>All other insurances</td>
<td>13</td>
<td>7</td>
</tr>
<tr>
<td>HIV RISK FACTOR</td>
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<td></td>
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<tr>
<td>**MSM</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>Heterosexual</td>
<td>16</td>
<td>8</td>
</tr>
<tr>
<td>All other risk factors</td>
<td>17</td>
<td>9</td>
</tr>
</tbody>
</table>

* with Yates Continuity Correction  
**Men who have sex with men
Finally, a point biserial correlation was used to determine if a relationship existed between the total power score and adherence. Pearson product-moment correlation between the two variables \( r = -0.187 \) (\( p=0.13 \)) was not found to be significant. Therefore the null hypothesis could not be discarded in favor of the alternative hypothesis.

Discussion

The purpose of this study was to determine if a relationship exists between power and adherence in an HIV infected adult population. Ensuring adherence to HIV medications is a critical domain in the nursing care of patients with HIV/AIDS, yet the reasons why some patients adhere to antiretrovirals and others do not remains elusive. Crespo-Fierro (1997) identified four factors that affect adherence in patients with HIV: psychosocial factors such as mental health problems, internal conflict, and ineffective communication; factors related to medications and treatments such as complex regimens, inconvenient dosing schedules, and skepticism; ethnocultural factors such as a differing worldview or lack of understanding by the provider of cultural influences; and factors such as continued substance use, lack of social
support, and a negative view of addiction on the part of the patient. While sense of power was not found to be an indicator of adherence in this study, it seems possible that our tendency as health care professionals to use one-dimensional approaches to understanding patient adherence may undermine our ability to work with patients as partners in their care.

Using Rogers’ unitary nursing model, one can hypothesize that power, a unitary concept, may be a factor linked to medication adherence. Power is being aware of what one is choosing to do, feeling free to do it, and doing it intentionally (Barrett, 2000). It has been demonstrated in non-unitary investigations that self-efficacy and readiness (concepts that would appear to be related to Barrett’s conceptualization of power) are associated with higher antiretroviral therapy adherence (Reynolds et al., 2003; Enriquez et al., 2004). It has also been found that characteristics associated with lower belief in one’s ability to adhere (i.e., lower self efficacy) can be identified in individuals naïve to antiretroviral therapy (Reynolds et al., 2004).

In the current study almost one-third (32%) of the participants were non-adherent to their antiretroviral therapy (n = 21), while approximately two-thirds (68%) were adherent. In a large sample (n=17,573), a recent meta-analysis of adherence level in North America combining adherence data for investigators report an overall adherence rate of 55% (95% confidence interval (CI) 49% - 62%) (Mills et al., 2006). Because the current study had an adherence rate outside of the range of the 95% confidence interval, one interpretation is that this sample is not representative of the population of HIV infected adults and study findings may be a result of a type II (sampling) error.

The findings of the current investigation did not confirm the power score on PKPCT to be a measure of adherence. These results are puzzling, since anecdotally it has been observed that individuals who are active participants in their own care and have greater self efficacy have better outcomes in HIV. Therefore, given the urgent clinical need to find a way to assess potential for adherence among individuals who have HIV, it does not seem unreasonable to replicate this study in a larger and perhaps more varied sample.

Limitations and Future Directions
Several limitations are acknowledged in this study. First, patient adherence was measured at the point of data collection and it is known that adherence is not a static measure. Rather, patients have been known to be both highly adherent and non-adherent during the course of their disease. Thus there is no summary measure that adequately measures adherence throughout the duration of the disease. Second, the power dimensions are dynamic and power is a non-linear phenomenon. Barrett & Caroselli (1998), although
supportive of empirical investigations to advance theoretical concepts, have acknowledged the limitation posed by use of statistical linear models to explain non-linear phenomenon. Further, these authors suggest that qualitative methodologies may be the best to explain non-linear phenomenon.

Implications for Nursing Knowledge

While disappointing in some ways, the findings of this study hold important implications for nursing knowledge development, nursing clinical practice and nursing research. In the current investigation the hypothesis positing a relationship between power and adherence was not supported. However, the relationship may not have been detected because both power and adherence were measured one day during the course of the individual’s experience. Both power and adherence are dynamic phenomena, and thus using quantitative, reductionistic methodologies to elucidate continuous changing phenomena may impose limitations. Rather than viewing the negative findings with pessimism, one could argue that the negative finding supports the notion that evolutionary concepts based in the Science of Unitary Beings cannot be wholly explained by the chosen linear model. Thus one could say that the study findings are not surprising, and that they are in fact consistent with the Science of Unitary Being. Viewed within this perspective, this study contributes to the further development of nursing knowledge by engaging the educator, clinician and researcher in the development of a variety of methodologies to validate unitary concepts such as power and adherence.

Nursing Practice

For the practicing nurse, few empirically tested and validated tools exist in clinical practice to support staff and advanced practice nurses in assessing the capacity for adherence. We anticipated that the PKPCT could perhaps be used as a tool to identify which patients would be most in need of specific adherence interventions by nursing staff. Although the PKPCT’s role in identifying medication adherence was not established in this study, the PKPCT has been established as a pattern appraisal tool for both individuals and families (Barrett, 2000; Butcher, 2006; Malinski, 1994). Through the process of pattern appraisal, nurses care for individuals with the goal of actualizing their potentials for change. The PKPCT reliably quantifies the changes in potentials. Nurses at all levels of educational preparation should be taught the value and usefulness of this tool at the individual, family and community levels. And while the reasons as to why patients adhere and do not adhere remain elusive, it is important that nurses with clinical research preparation continue to monitor for phenomena that explain adherence and support continued investigation.

Toward that goal, it is recommended that the current investigation be replicated using
repeated measures of power and adherence within a longitudinal study design. It is further recommended that subsequent investigations expand the sample so that individuals with more varied socioeconomic status and educational preparation are included to determine if there is indeed a difference in power among specific groups.

In this study, the majority of participants were educated at less than a high school education. The PKPCT’s author recommends that subjects have a minimum of a high school education as the complexity of the language used in the tool may affect study results. However, it should be noted that several investigators have included subjects with less than a high school education in their sample and have not reported difficulty with language of the tool (Davis, 1989; Phillips & Bramlett, 1994; March, 1989; Morris, 1991). Future investigations should examine the impact of education level on the ability to understand the words in the tool.

Lastly, it was noted that Blacks/African Americans in this study scored considerably lower on the power tool, compared to white subjects in this study (n=2). Although there are too few subjects to make inferences about this finding, it does raise the question as to whether or not there could be racial differences in the level of power. In her work on power and well-being in the elderly, Morris (1991) found a statistically significant difference in awareness and choice scores between Black/African Americans and Whites, with Black/African Americans having a higher score. The notion of racial differences on power scores or any of its subscales needs further exploration with larger and more diverse cohorts. As the American culture becomes more diverse and the collective experiences in life are less homogeneous, it is inhere

References


EDUCATIONAL INTERVENTIONS TO ENHANCE EMPLOYEE BREAST HEALTH:
A PROGRAM EVALUATION USING THE BARRETT POWER THEORY

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  St. Joseph’s College

Anne Sullivan Smith, RN; PhD
  Health Care Consultant

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  Manager, Community Health
  Oakwood Healthcare System

ABSTRACT:

The purpose of this study was (1) to evaluate the effectiveness of a breast health education program to increase the participation of women employees with regard to screening mammogram and (2) to examine how employee participation with breast health education program relates to power. A mixed design was used at the end of the entire initiative to collect data. Two hundred fifty-eight individuals attended educational sessions ranging from one to seven sessions. Employees who participated in educational session significantly increased obtaining a mammogram ($p < .01$) and choices dimension of power ($p < .01$). Women who obtained a mammogram exhibited significantly greater overall power ($p < .01$).

Acknowledgement

This study was supported by the Healthcare System who received a grant from Ford Motor Company Fund.

KEY WORDS: Breast health education program, screening mammogram, power as knowing participation in change, PKPCT
Breast cancer is the most common cancer in women in the United States with 120.4 incidences per 100,000 woman of all races, and the second leading cause of cancer deaths among women accounting for 22.8 deaths per 100,000 (U.S. Cancer Statistics Working Group, 2010). It is generally accepted that mammograms are the best way to find breast cancer early (National Center for Health Statistics, 2010) and screening mammography reduces breast cancer mortality (Nelson et al., 2009). However, the rate of women who are having screening mammogram has been generally low. According to the National Center for Health Statistics (2010), the percentage of women aged 40 years and older who had a mammogram in the last two years averaged 63.7% in 2005. In 2006, the mammogram rate in the state of Michigan was 64.3% (Michigan Cancer Consortium, 2009, p. 36). Similarly, claims data of a regional Healthcare System in Michigan indicated 64.8% of women received annual mammograms in 2007.

To address this generally low rate of screening mammogram several innovative learning series centered around women's wellness, including breast health and family health history were developed and offered exclusively to women who worked at the Healthcare System’s corporate location. The primary goal was to increase annual screening mammograms by Healthcare System’s female employees in alignment with the Michigan Cancer Consortium (2009) goal of 80% by year 2011. The purpose of this study was (1) to evaluate the effectiveness of a breast health education program to increase the participation of women employees with regard to annual screening mammogram and (2) to examine how employee participation with breast health education program relates to power.

Theoretical framework

This program evaluation is guided by Barrett’s Theory of Power as Knowing Participation in Change. Using Rogers’ (1970) postulate of knowing participation, Barrett created the theory of power as knowing participation in change. As such, knowing participation is the key in Barrett’s theory (Barrett, 2010). Barrett (1986) defined knowing participation as “being aware of what one is choosing to do, feeling free to do it, and doing it intentionally” (p. 175). Barrett’s power theory is consisted of four dimensions, namely, awareness, choices, freedom to act intentionally, and involvement in creating change. These dimensions are dynamic, nonlinear and inseparably associated (Barrett, 2010).

The theory describes power in individuals as well as in groups (Barrett, 2010). A person’s or a group’s power profile can be made from the inseparable association of the four power dimensions in mutual process with environment. The changes in power profile indicate the: 1) nature of the awareness of experiences; 2) type of choices.
Visions

made; 3) degree to which freedom to act intentionally is operating; and 4) manner of involvement in creating specific changes (Barrett, 1986, 2010). From Barrett’s (1986, 2010) theory of power, educational initiative is conceptualized as a health patterning modality whereby a person experiences pandimensional awareness of integrality of human-environmental mutual process. People use their awareness to make choices, feel free to act on their intentions, and involve themselves in creating change. Participating in screening mammogram is one way a person manifests change to enhance breast health. In this study annual mammogram is defined as obtaining a mammogram in the last 13 months.

The four dimensions of power profile are measured by the Power as Knowing Participation in Change Tool (PKPCT). The PKPCT uses semantic differential technique where 12 power characteristics are randomly ordered in opposite adjective pairs (Barrett, 1990). The PKPCT has documented construct validity and high internal consistency reliability for the total power as well as for its four dimensions (Barrett, 1990). The most recent review of PKPCT literature showed Cronbach’s alpha for the total PKPCT ranged from .93 to .99. Cronbach’s alpha ranges for the four subscales were: .81 to .97 for Awareness; .58 to .96 for Choices; .79 to .97 for Freedom to Act Intentionally and; .86 to .98 for Involvement in Creating Change (Kim, 2009). Internal consistency reliability of the PKPCT by Cronbach’s alpha for the current study remained high, showing consistency with the previous findings. They were .97 for the total power (n = 233); .86 for Awareness (n = 244); .91 for Choices (n = 240); .92 for Freedom to Act Intentionally (n = 236) and; .93 for Involvement in Creating Change (n = 233).

Methods

My Health: A Female Focus program: Design and implementation

The goal of the program was to provide comprehensive interventions to enhance breast health for women employees. Objectives were to increase knowledge and motivation, overcome fears, and provide tools to ensure convenient access to services including screening mammogram. Comprehensive program of innovative new learning series which provided practical tips centered around women’s wellness with specific focus on breast health was designed in 2008 based on an extensive review of relevant literature, which included recent journals and national websites. Some examples of the website sources used were research-tested intervention programs from National Cancer Institute, cancer screening guide to preventive services from Centers for Disease Control and Prevention and 2008 national breast cancer awareness survey from National Women’s Health Research Center. Three core educational activities having the largest influence
on motivating annual mammogram screening were designed first. They were “Breast Health: Throughout Your Life,” “Family History: It’s Important to Your Health,” and “Breast Care Center Tour.” Four additional educational classes developed included “Lifestyle Choices and Cancer Prevention,” “Family History: Computer Lab,” “Feeding the Body and Soul,” and “Reading E-mails or Online Articles.” The three core educational activities and “Lifestyle Choices and Cancer Prevention” were offered both in-person/class and online. Each of the educational sessions averaged one hour in length.

Educational classes were offered between October 2008 and November 2009. Communications, online participation and data collection occurred via a secure, external “My Health” web portal hosted through a proprietary website, with content developed and updated by My Health Steering Committee. This innovative and secure website was designed to provide online classes and tours, mammogram appointment reminder calls, education articles and links to website resources which included note tabs to enroll in educational classes and view videos, features such as “Ask the Doctor or Nurse,” and online mammogram scheduling help. The website also provided detailed participation management and reporting. In addition to educational emails, direct mailings were used. Prior to offering educational classes, employee’s preferred learning modalities and class time were determined by conducting a survey where 52% of employees responded. Meals were provided for the in-person activities. Participants who attended both in-person and online activities received participation gifts.

**Target population**

Primary target population was women over 40 years of age, enrolled in the Healthcare System’s health plan and working at the corporate location (n = 246). This population was chosen for its measurability through aggregate claims data and because research has shown that there has been a decline in annual mammogram rates in recent years among women of similar demographic characteristics. While the main focus was the target population, the program was open to all female employees who work at the corporate location (N = 470) since all women would benefit.

**Survey Instrument**

SurveyMonkey™, an online survey tool was used at the end of the entire initiative to collect both quantitative and qualitative data. Group discussion among the program planners led to the conclusion that this process would be most efficient and cost effective as staff were accustomed to online communication efforts. It was also decided that the online process would minimize alternative in-person instructions and respondent requests for additional definitions of terms beyond the standard information.
provided in the structure of the instrument. The key leadership in Women’s Services, Community Health, Marketing and Information Technology at the Healthcare System, and two nurse researchers, one a local healthcare consultant and the second a member of the nursing faculty in New York collaborated to design and implement a program evaluation process with the intention of identifying strategies that were affecting knowledge and behavior and to measure the impact of these strategies on the likelihood of women having annual screening mammograms.

The initial steps of the process included review and editing of the survey document, already in early stages of development, by the Healthcare System staff. The local consultant approached the Healthcare System key project leaders to consider enhancing the program evaluation process by adding the PKPCT measures. The consultant provided PKPCT literature and the Barrett website access information to assure an understanding of the value of the measures to the project. The leadership team expressed interest and approval to proceed. After receiving a permission to use the PKPCT from Dr. Barrett, the local consultant nurse researcher drafted the introduction to the survey, the bridge to the PKPCT and concluding message to those who completed the process. In addition, the two nurse researchers reviewed the survey instrument recommending changes to minimize complexity and risk of respondent fatigue and drop out from process. The survey tool was pre-tested with eight of ten persons completing the process in a timely fashion. One person completed the process in part and one dropped out early in the process. The survey tool was consisted of five sections: (1) demographic information (age category and health plan status); (2) mammogram (had or scheduled); (3) education session (participation and its effectiveness at positively impacting receiving annual mammogram); (4) reasons for attending the education session; and (5) PKPCT to measure participation in change. In addition, the survey tool had two qualitative response items asking participants to share reasons for not attending the education program, and ideas or changes in the education program to increase its effectiveness.

The primary goal of the My Health: A Female Focus program was to enhance participant’s annual screening mammogram rates. Additionally, to guide in developing future educational programs, participants completed evaluations, after each educational session, describing overall satisfaction with each class. Another component of the online evaluation tool was the Power as Knowing Participation in Change Tool (PKPCT), which measures the nuances of behavior change. The researchers believed that the measurement of subscales power components: awareness, choices, freedom to act intentionally and involvement in creating change,
could elucidate the nuances of behavior change along the spectrum from intention to behavior, comparing those who did and did not participate in the education sessions, as well as those who attended one or more sessions and had not yet had or scheduled their annual screening mammograms. The utilization of the survey instrument and the PKPCT also afforded both quantitative and qualitative method scoring with numerics and fruitful narratives explaining behaviors.

**Data Collection Procedures**

The decision was made to survey all program invitees: those who attended sessions and those who did not, to assure an adequate sample to make appropriate correlations between and among contributing factors and power scores. Both classroom and online participants were surveyed. On January 15, 2010, as planned, the complete survey, including the PKPCT, was sent online to the 470 women eligible to participate in the program. A steady response was noted with the vast majority responding within the first week. Two gentle reminders were e-mailed: one midway in the two week period designated, the second two days before the survey deadline of January 28, 2010. All response data were immediately accessible to the nurse researcher in New York, who transformed the data into SPSS for analysis as planned.

**Data Analysis**

Data analysis was performed with Statistical Package for the Social Sciences (SPSS) version 17. Data regarding age group, health plan status, educational session participation and power scores are presented as frequencies, percentages, means and standard deviations as relevant. Inferential statistics used were Chi-square test, independent t-test and correlations. A statistical significance was determined by a p-value < .05 (two tailed).

**Ethical considerations**

Voluntary participation and anonymity of the feedback provided by participants were assured. Employee confidentiality was ensured by approval from the Institutional Review Board (IRB) program so their personal information was protected and participation was not a requirement of employment.

**Findings**

**Respondents:**

Of the total population of all female employees who worked at the Healthcare System’s corporate location (N = 470), 273 women responded to the survey (58%). Of the 246 target population of female employees over 40 years of age, enrolled in the Healthcare System’s health plan and working at the corporate location, 186 women responded (75.6%). Respondents by age group included 45 (16.5%)
who were less than 40 years of age, 77 (28.2%) were between 40 and 49, and 151 (55.3%) were 50 and over. This included 186 (81.6%) who were covered and 42 (18.4%) who were not covered by the Healthcare System's health insurance.

**Mammogram status**

One hundred eighty-six (81.9%) individuals who responded to their mammogram status had their mammogram in the last 13 months, and 204 (90.3%) individuals either had their mammogram in the last 13 months or scheduled their mammogram in the next few weeks.

**Education session participation**

Two hundred fifty-eight individuals (94.5%) attended educational sessions ranging from 30 (11.6%) each attending just one or two, 33 (12.8%) attending three, 34 (13.2%) attending four, 46 (17.8%) attending five, 45 (17.4%) attending six, and 40 (15.5%) attending all seven sessions. Eleven people did not attend any sessions. One hundred eighty participants (83.7%) who attended educational sessions more than once and four individuals (44.4%) who did not attend any educational sessions had their annual mammogram.

Educational session participation (Yes: n = 184, 82.1%; No: n = 40, 17.9%) is significantly related to annual mammogram ($\chi^2 = 9.085, df = 1, p = .003$). As seen in Table 1, when individual educational session attendance and mammogram status were examined, attending the “Breast Health: Throughout your Life,” “Breast Care Center Tour,” “Lifestyle Choices and Cancer Prevention,” and “Feeding the Body and Soul” were significantly related to annual mammogram. Table 2 displays a comparison between the classroom/in-person and online attendance on its effectives on receiving or continuing to receive annual mammogram. Of the four educational sessions that were provided by both classroom/in-person and online format, “Breast Health” and “Breast Care Center Tour” showed significant differences between the classroom and online format with the respondents more positively regarding the classroom or in-person format. The effectiveness of individual education session in affecting participants’ decision to have their annual mammogram was measured from 1 (Strongly Disagree) to 5 (Strongly Agree). The mean effectiveness was high for all education sessions, which ranged from 4.36 ($SD = .69$) for “Reading emails or online articles” to 4.71 ($SD = .52$) for “Feeding body and soul.”

**Ranking reasons for attending educational sessions** One hundred eighty-one individuals (91%) stated that “Topic” presented was the most important reason for participating the educational sessions, followed by “Friends or Coworkers” (n = 98, 55.1%), “Incentive gifts” (n = 85, 45.2%), and “Lunch” (n = 75, 44.1%).
Table 1. Educational session participation and mammogram status

<table>
<thead>
<tr>
<th>Educational Session</th>
<th>N</th>
<th>Yes: n (%)</th>
<th>No: n (%)</th>
<th>$\chi^2$</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family History: It’s Important to Your Health</td>
<td>269</td>
<td>185 (68.8)</td>
<td>84 (31.2)</td>
<td>.277</td>
<td>.599</td>
</tr>
<tr>
<td>Breast health: Throughout Your Life</td>
<td>269</td>
<td>186 (69.1)</td>
<td>83 (30.9)</td>
<td>6.719</td>
<td>.010</td>
</tr>
<tr>
<td>Breast Care Center Tour</td>
<td>267</td>
<td>173 (64.8)</td>
<td>94 (35.2)</td>
<td>4.567</td>
<td>.030</td>
</tr>
<tr>
<td>Lifestyle Choices and Cancer Prevention</td>
<td>265</td>
<td>176 (66.4)</td>
<td>89 (33.6)</td>
<td>7.230</td>
<td>.007</td>
</tr>
<tr>
<td>Family History: Let’s Draw Yours (Computer Lab)</td>
<td>264</td>
<td>85 (32.2)</td>
<td>179 (67.8)</td>
<td>2.084</td>
<td>.149</td>
</tr>
<tr>
<td>Feeding the Body and Soul</td>
<td>262</td>
<td>96 (36.6)</td>
<td>166 (63.4)</td>
<td>8.470</td>
<td>.004</td>
</tr>
<tr>
<td>Reading Emails or Online Articles</td>
<td>261</td>
<td>208 (79.7)</td>
<td>53 (20.3)</td>
<td>1.440</td>
<td>.230</td>
</tr>
</tbody>
</table>

Table 2. Comparison between Classroom/In-person vs. Online educational session attendance on effectiveness at positively impacting receiving or continuing to receive annual mammogram.

<table>
<thead>
<tr>
<th>Educational Session</th>
<th>N</th>
<th>Classroom: n</th>
<th>Effectiveness</th>
<th>t</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Online: n</td>
<td>M</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family History: It’s Important to Your Health</td>
<td>185</td>
<td>119</td>
<td>4.50</td>
<td>.275</td>
<td>183</td>
<td>.784</td>
</tr>
<tr>
<td>Breast health: Throughout Your Life</td>
<td>184</td>
<td>117</td>
<td>4.70</td>
<td>-</td>
<td>182</td>
<td>.001</td>
</tr>
<tr>
<td>Breast Care Center Tour</td>
<td>173</td>
<td>120</td>
<td>4.73</td>
<td>-</td>
<td>84.69</td>
<td>.001</td>
</tr>
<tr>
<td>Lifestyle Choices and Cancer Prevention</td>
<td>176</td>
<td>164</td>
<td>4.62</td>
<td>-</td>
<td>3.538</td>
<td>.547</td>
</tr>
</tbody>
</table>

Note: Range of effectiveness = 1 to 5
**Power correlations**

Individuals over 50 years of age scored significantly higher on the subscale of involvement in creating change compared to those women under 40 years old. No other significant findings were noted for other age groups or health plan status or the remaining subscales and total power scores. Power scores were significantly higher for “Awareness,” “Choices,” and “Involvement in creating change” subscales, and total power scores for those who did have mammogram in the past 13 months compared to those who did not have a mammogram. Scores for “Freedom to act intentionally” subscale were not significantly different (Table 3). Attending educational sessions had a significantly positive relation to PKPCT dimension, “Choices” \( (p < .01) \). It did not significantly relate to the three remaining dimensions (awareness, freedom to act intentionally, involvement in creating change) or the total power score. As individuals attended more educational sessions, their scores on

<table>
<thead>
<tr>
<th>PKPCT Dimension</th>
<th>Mammogram:</th>
<th>PKPCT</th>
<th>t</th>
<th>df</th>
<th>p</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>n</td>
<td>M</td>
<td>SD</td>
<td></td>
</tr>
<tr>
<td>Awareness</td>
<td>20/4</td>
<td>Yes = 168</td>
<td>72.30</td>
<td>9.43</td>
<td>-3.574</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No = 36</td>
<td>65.94</td>
<td>10.82</td>
<td></td>
</tr>
<tr>
<td>Choices</td>
<td>20/0</td>
<td>Yes = 164</td>
<td>73.57</td>
<td>9.62</td>
<td>-2.355</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No = 36</td>
<td>69.28</td>
<td>11.15</td>
<td></td>
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<tr>
<td>Freedom to Act Intentionally</td>
<td>19/6</td>
<td>Yes = 160</td>
<td>72.91</td>
<td>10.60</td>
<td>-1.869</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No = 36</td>
<td>69.17</td>
<td>11.89</td>
<td></td>
</tr>
<tr>
<td>Involvement in Creating Change</td>
<td>19/3</td>
<td>Yes = 158</td>
<td>71.98</td>
<td>11.22</td>
<td>-2.171</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No = 35</td>
<td>66.46</td>
<td>14.10</td>
<td></td>
</tr>
<tr>
<td>Total Power</td>
<td>19/3</td>
<td>Yes = 158</td>
<td>291.02</td>
<td>36.82</td>
<td>-2.772</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No = 35</td>
<td>271.54</td>
<td>41.06</td>
<td></td>
</tr>
</tbody>
</table>

Note: PKPCT = Power as Knowing Participation in Change

three components (awareness, choices and involvement in creating change) of PKPCT and the total power scores were significantly higher. This was not true for the “Freedom to act intentionally” component (Table 4). Individuals who rated higher on the effectiveness of all educational sessions for having annual
mammogram had higher scores on all components (awareness, choices, freedom to act intentionally and involvement in creating change) of PKPCT and the total power scores. The only exception was the “Feeding Body and Soul” educational session (Table 4).

Attributes favored by respondents on semantic differential scales of PKPCT

Valuable, expanding and informed were the descriptors that scored high on all four subscales, all scoring 6 or greater of a possible 7. In three of the four subscales, the respondents also favored the adjectives pleasant and important, scoring 6 or greater. The descriptors seeking, intentional, and orderly, were selected strongly (6.0 or greater) on the subscale choices only. Free was favored third among five attributes scoring 6.22 or greater on the subscale involvement in creating change (Table 5).

Thematic analysis of qualitative data responses to questions 19 and 20

Responses to Question 19: If people did not attend any sessions offered, why not?

Thirteen people listed diverse issues related to communication, such as lack of awareness, did not recall receiving information, would forget to sign up or attempted to sign up but discovered registration was closed. One person could not navigate the links. Seven individuals experienced scheduling difficulties; ten had time constraints; four said too busy. Other reasons cited by seven included not eligible; only did online activities; lack of interest; already knowledgeable; no explanations; saw nothing listed on previous screen and finally a question mark.

Responses to Question 20: suggestions for program improvement:

Many employees made positive comments regarding the program, its planners and presenters (n = 28). They said that they learned a lot and that new knowledge will influence their behavior. They viewed the program as an effective, informative, phenomenal, and an asset to the Healthcare System employees. Examples of comments included: prevention was a key message for some, in particular regarding lifestyle choices, diet and routine testing (n = 7); influence of family members and friends made a difference (n = 10); email reminders as prompts that they are due for their annual screening mammograms were appreciated (n = 11); already have been committed to annual screening mammograms and will continue to do so (n = 16); would continue as long as her insurance continues to to pay (n = 1).
Table 4. Correlations among the Number of Educational Sessions Attended, the Effectiveness of Educational Sessions at Positively Impacting on Annual Mammogram with PKPCT Dimensions.

<table>
<thead>
<tr>
<th></th>
<th>Awareness</th>
<th>Choices</th>
<th>Freedom</th>
<th>Involvement</th>
<th>Total Power</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of Sessions Attended</strong></td>
<td>.168**</td>
<td>.158*</td>
<td>.093</td>
<td>.145*</td>
<td>.151*</td>
</tr>
<tr>
<td></td>
<td>N = 244</td>
<td>N = 240</td>
<td>N = 236</td>
<td>N = 233</td>
<td>N = 233</td>
</tr>
<tr>
<td><strong>Family History Effectiveness</strong></td>
<td>.25**</td>
<td>.267**</td>
<td>.33**</td>
<td>.287**</td>
<td>.314**</td>
</tr>
<tr>
<td></td>
<td>N = 172</td>
<td>N = 170</td>
<td>N = 168</td>
<td>N = 167</td>
<td>N = 167</td>
</tr>
<tr>
<td><strong>Breast Health Effectiveness</strong></td>
<td>.317**</td>
<td>.311**</td>
<td>.342**</td>
<td>.348**</td>
<td>.363**</td>
</tr>
<tr>
<td></td>
<td>N = 172</td>
<td>N = 171</td>
<td>N = 168</td>
<td>N = 167</td>
<td>N = 167</td>
</tr>
<tr>
<td><strong>Breast Center Tour Effectiveness</strong></td>
<td>.342**</td>
<td>.297**</td>
<td>.305**</td>
<td>.356**</td>
<td>.355**</td>
</tr>
<tr>
<td></td>
<td>N = 167</td>
<td>N = 165</td>
<td>N = 163</td>
<td>N = 161</td>
<td>N = 161</td>
</tr>
<tr>
<td><strong>Lifestyle Choices Effectiveness</strong></td>
<td>.201*</td>
<td>.180*</td>
<td>.213**</td>
<td>.300**</td>
<td>.252**</td>
</tr>
<tr>
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<td>N = 165</td>
<td>N = 163</td>
<td>N = 161</td>
<td>N = 161</td>
</tr>
<tr>
<td><strong>Family History Com. Effectiveness</strong></td>
<td>.250*</td>
<td>.282*</td>
<td>.321**</td>
<td>.339**</td>
<td>.325**</td>
</tr>
<tr>
<td></td>
<td>N = 83</td>
<td>N = 81</td>
<td>N = 80</td>
<td>N = 80</td>
<td>N = 80</td>
</tr>
<tr>
<td><strong>Feeding Body &amp; Soul Effectiveness</strong></td>
<td>.144</td>
<td>.012</td>
<td>.068</td>
<td>.158</td>
<td>.107</td>
</tr>
<tr>
<td></td>
<td>N = 93</td>
<td>N = 92</td>
<td>N = 92</td>
<td>N = 92</td>
<td>N = 92</td>
</tr>
<tr>
<td><strong>Reading Online Effectiveness</strong></td>
<td>.196**</td>
<td>.159*</td>
<td>.172*</td>
<td>.225**</td>
<td>.204**</td>
</tr>
<tr>
<td></td>
<td>N = 195</td>
<td>N = 193</td>
<td>N = 189</td>
<td>N = 188</td>
<td>N = 188</td>
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</tbody>
</table>

Note: *p < .05; **p < .01.

Table 5. Favored PKPCT Attributes (M > 6)

<table>
<thead>
<tr>
<th>Awareness</th>
<th>Choices</th>
<th>Freedom to Act Intentionally</th>
<th>Involvement in Creating Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valuable (6.55)***</td>
<td>Important (6.67)***</td>
<td>Valuable (6.54)****</td>
<td>Informed (6.54)****</td>
</tr>
<tr>
<td>Important (6.53)***</td>
<td>Valuable (6.42)****</td>
<td>Important (6.33)***</td>
<td>Valuable (6.33)****</td>
</tr>
<tr>
<td>Expanding (6.35)****</td>
<td>Informed (6.38)****</td>
<td>Expanding (6.22)****</td>
<td>Free (6.22)*</td>
</tr>
<tr>
<td>Informed (6.18)****</td>
<td>Seeking (6.15)*</td>
<td>Pleasant (6.16)***</td>
<td>Pleasant (6.16)***</td>
</tr>
<tr>
<td>Pleasant (6.08)***</td>
<td>Intentional (6.15)*</td>
<td>Informed (6.10)****</td>
<td>Expanding (6.10)****</td>
</tr>
</tbody>
</table>

Suggest for providing continuing information opportunities regarding radiation dosages and where to find the most effective digital mammogram and advice on (n = 24) included: information on

Note: *present in one dimension; ***present in 3 dimensions; ****present in all 4 dimensions.
technology (n = 5); reinforce screening and offer more timely information by annual updates (n = 5); provide additional times, later in the day, longer sessions or sessions at lunch time, online access to increase the program attendance (n = 1); keep a registry of classes attended to avoid duplication of registration (n = 1); include successful survivors of breast cancer treatment to reinforce significance of screening behaviors (n = 2); provide teaching self-breast exam, in depth dietary information, offering one on one meetings for comparing individual mammogram findings over time, and opening up the classes to family and friends including men (n = 4); assistance in finding a primary care physician to facilitate their plan for the mammogram (n = 3).

The respondents also noted themes that corresponded directly or indirectly to the power components: awareness, choices, freedom to act intentionally and involvement in creating change. Awareness was evident in eight women stating the program made them aware of the importance of having their annual screening mammograms. Choices were described in healthy lifestyle options. Freedom to act intentionally was implied in seven narratives noting learning more about breast health influenced them to be proactive in their behaviors. Involvement in creating change was expressed explicitly in women choosing to influence themselves, family and friends to have their annual exams when age appropriate.

There is a note of caution regarding acceptance of change in screening guidelines recently described.

Discussion

Access to Breast Health Program

Access to the program was an issue raised by some individuals. Thirteen women listed diverse issues related to communication, such as not knowing the program availability, not recalling receiving information or forgetting to sign up classes. In addition, seven women experienced difficulties in scheduling and other time constraints for their timely participation in the education sessions. Program planners need to keep in mind the most efficient and effective means of communication when planning for future education opportunities. This process could address concerns expressed, and perceived, communication gaps and scheduling difficulties by respondents. Similar to a tailored approach (Lin & Wang, 2009; Menzies, 2009), designing a structure for logging attendance that is accessible to participants so that employees can see a profile of classes in which they have participated and be aware of additional programs available to them could be also considered. Inviting friends and family to participate in select evening offerings or online opportunities might be another alternative for those who have scheduling difficulties during the work hours. Two education sessions (“Family History: It's Important to Your Health” and
“Lifestyle Choices and Cancer Prevention”) could be provided online as highly productive activities, cost effective and efficient transactions, since the online format for these two sessions were as effective as the classroom version.

Mammogram controversy

While the breast health program is in progress, in November 2009 the U.S. Preventive Services Task force (USPSTF, 2009) published new recommendation statement on screening for breast cancer in the general population, generating some controversy over mammogram interval. Based on a review of current evidences, USPSTF updated its 2002 recommendation, making a major shift in its screening mammogram interval from annually to biennially for women between the ages of 50 and 74 years only. They recommend no routine biennial screening mammogram for women between the ages of 40 and 49, and older than 75 years, and the decision to have a mammogram should be based on a consideration of the individual’s context and values regarding specific benefits and harms. The USPSTF also recommends against clinicians teaching women how to perform breast self-examination. In addition, they concluded current evidence is not sufficient to assess additional benefits and harms of either digital mammogram or magnetic resonance imaging against film mammogram as screening modalities for breast cancer.

The breast health program followed the earlier guideline by the American Cancer Society (2009), which continues to recommend annual screening mammogram and clinical breast examination for all women beginning at age 40. Reflective of these conflicting recommendations five women made suggestions for information on digital mammogram and radiation concerns, and one woman requested breast self-examination education. These concerns about the need to continue annual screening mammogram in relation to the change in USPSTF guideline could be addressed or clarified with up-to-date information on benefits and harms of screening mammogram. Annual updates on new information, periodic one on one meetings to review findings over time, particularly for those at greatest risk might be another innovative intervention.

Online Survey Instrument

SurveyMonkey was used to collect data for this study. This online survey tool made virtual collaboration among the Healthcare System personnel and two nurse researchers highly efficient and effective. All response data were immediately accessible to the nurse researcher in New York who transformed the data into SPSS for data analysis. To increase the response rate we simplified the online survey form by eliminating more detailed demographic information. Only age category and health plan status were asked. To our knowledge this is the first time
the PKPCT was used as an online format. To meet online format we made some adaptations of the PKPCT instrument by adding PKPCT subscales (My Awareness is, My Choices are, My Freedom to Act Intentionally is, My Involvement in Creating Change is) in front of each line of 13 opposite attributes for each subscale, and found it worked well in our survey. Mean subscale power score ranged from 5.85 for Freedom to Act Intentionally to 6.02 for Choices with 5.95 for the total power. The total PKPCT mean of 5.95 in this study is negatively skewed and similar to PKPCT mean ranges of 4.9 to 6.1 reported in the literature (Barrett & Caroselli, 1998).

Compared to those women under 40 years old, individuals over 50 years of age scored significantly higher on the subscale of involvement in creating change. Kim and colleagues (2008) found age was positively related to power in Korean adults. Further study is needed to clarify the relation between age and power. Employees who participated in educational session had significantly higher scores on the choices dimension of power \( (p < .01) \), and those who obtained a mammogram exhibited significantly greater overall power \( (p < .01) \). We suggest planning for periodic pre and post PKPCT measures for those newly eligible to participate in the program to clarify any changes in power profile since attending the program. In planning program promotion messages, we recommend selective use of attributes favored by respondents as measures of perceived power (i.e., valuable, expanding, informed, important and pleasant).

**Summary**

My Health: a Female Focus Program was an overall success. Participants responded that the educational sessions were highly effective in generating health behavior change as evidenced by generous improvements in having or imminent scheduling of screening mammograms. The baseline of mammogram screening behavior prior to the educational program was 64.8% of eligible employees. In the evaluations of the program, 81.9% of the study respondents, by self-report, had screening mammograms in the previous 13 months. This is reflected in the Healthcare System's claims data for annual mammogram. According to these data, the mammogram rate was increased from 64.8% in 2007 to 82.43% in 2008 (17.63% increase) and to 83.12% in 2009 (18.32% increase) thereby exceeding the goal of 80%. Educational session participation is significantly related to annual mammogram. Specifically, attending the “Breast Health: Throughout your Life,” “Breast Care Center Tour,” “Lifestyle Choices and Cancer Prevention,” and “Feeding the Body and Soul” were significantly related to annual mammogram. “Topic” being presented was the highest ranking reason for attending the education session, followed by “Friends or Co-workers”, “Incentive Gifts”, and “Lunch.”
The scores on power as knowing participation were proportionally greater for those who attended more educational sessions either online or in person. The responses to two open ended questions offered creative and impressive ideas for program enhancement and sincere appreciation for the program opportunities. Some of the responses reflected the four component of power: awareness, choices, freedom to act intentionally and involvement in creating change.

The results of the program review clearly support the continuation of the educational sessions enhanced with option and suggestions offered by survey respondents. The program website was well utilized by participants and program coordinators for online sessions, data analysis, registration and other communications. As evidenced by the outcomes of this study, program evaluation process can surely be enhanced by collaboration between academic researchers and leaders of community groups with a focus on measuring the impact of program interventions, sharing program data, and continuing development of programs of interest (Smith & Kim, 2010).

References


A Family Field Pattern Portrait of Adult Substance Users in Rehabilitation

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Abstract

The purpose of this research study was to create a vivid portrait of adult substance users and family pattern in rehabilitation using a hermeneutic phenomenological research design derived from Rogers’ science of unitary human beings. The unitary field pattern portrait (UFPP) research method developed by Butcher (1998, 2005) was used. Eleven participants, ages 21 – 54, who were identified as adult substance users, participated in this research study. Utilizing the UFPP, the researcher synthesized the participants’ experiences, perceptions, and expressions to create a unitary field pattern portrait and theoretical unitary field pattern portrait of family pattern of power as knowing participation in change among adult substance users in rehabilitation. The theoretical unitary field pattern portrait of adult substance users and family pattern in rehabilitation was as follows: An awareness of being content with rhythmical correlates of changing emotions; Experienced as resonating waves of complex living pattern of recovery with presenting choices to resist temptation; The
freedom to act intentionally is the power to control today's choices; Helicity manifested as the power to participate knowingly in change with patterning of the human-environmental fields; Involvement in creating change is being in an environment where continuous change is possible; Integrity is experienced as continuous mutual human-environmental field process of change.

Keywords: Unitary Field Pattern Portrait research method, Power as knowing participation in change, Substance Use, Rogers’ Nursing Science

Introduction

Substance use is a term used in multiple health-related disciplines, and it has been the focus of many different types of research. The use of addictive substances is a significant public health issue. In the United States, excessive alcohol consumption is the third-leading cause of preventable deaths (U.S. Department of Health and Human Services, 2008). According to Healthy People 2020, improved evaluation of community-level prevention has enhanced researchers’ understanding of environmental and social factors that contribute to the initiation and abuse of alcohol and illicit drugs, leading to a more sophisticated understanding of how to implement evidence-based strategies in specific social and cultural settings (U.S. Department of Health and Human Services, 2010). Family conflict, poor family communication, family history of substance use, disorganized neighborhoods, high community crime and substance use levels, endemic poverty, lack of employment opportunities, and use of substances by those in one’s social group are risk indicators in the human-environment relationship of an individual’s patterned behaviors. As patterns of impairment are identified and understood, researchers can focus on nursing strategies that change the patterns of human and environmental fields (West, 2002). However, there is a lack of understanding of the experience from the family’s perspective. Involvement of a family member or significant other in an individual’s treatment program can strengthen and extend treatment benefits (National Institute on Drug Abuse [NIDA], 2009).

“The evolution of nursing as a scientific discipline is predicated on the development of conceptualizations of phenomena central to its concern from a unique nursing science perspective” (Butcher, 1996, p. 41). A nursing theoretical framework that supports the study of individuals who are substance users is needed for nursing knowledge development to
help enhance efforts toward promoting change and well-being in these individuals’ lives. Rogers’ (1970; 1992) science of unitary human beings provided the nursing science-based perspective for this study. The unitary field pattern portrait (UFPP) research method was selected because it was derived directly from Rogers’ ontology and epistemology (Butcher, 1994). The purpose of this study was to enhance understanding of the experience of substance abuse by illuminating the patterns of adult substance users and their family while they are in rehabilitation from the perspective of Rogers’ science of unitary human beings.

Research Question
From the perspective of Rogers’ science of unitary human beings, the purpose of this study was to illuminate kaleidoscopic and symphonic patterns describing adult substance users and family pattern in rehabilitation. This study provides a new understanding of the experiences, perceptions, and expressions of adult substance users and family pattern in rehabilitation from a scientific perspective specific to the nursing discipline.

The research question in the language of the UFPP research method was: What is the unitary field pattern portrait and theoretical unitary field pattern portrait of family pattern of power as knowing participation in change among adult substance users in rehabilitation? Questions the researcher investigated about unitary field patterns included: 1) is family pattern an indicator for adult drug rehabilitation; 2) what are early patterns of adult substance use; 3) how can nursing find ways to improve the family relationship, if one exists; and 4) can family pattern relationship support future rehabilitation potential for adults in drug rehabilitation?

Rogerian Research on Substance Use
While there is a plethora of research on substance abuse from the theoretical perspective of other disciplines, there are few studies on substance abuse users and their families from a nursing science perspective and even fewer from the perspective of Rogers’ science of unitary human beings. Rushing (2005) conducted a research study that examined the life pattern of nine individuals in the recovery process. The researcher found the study helped to understand the unitary life pattern of persons experiencing serenity in the context of their journey of recovery and healing from addiction (Rushing, 2008). Rushing also noted that with addiction, family deviance, family disruption, and social and cultural environments, can shape the potential addict (2005). Hammond (2002) conducted a research study to explore the relationship between spirituality, power and change in women with alcohol-related problems. Three qualitative themes emerged from the study: 1) being aware of utilizing thoughts and feelings, 2) involving self and others in actions to maintain
changed behavior, and 3) being connected to part of a spiritual dimension (2002, p. 168). Hammond suggested future research should be conducted to explore how social support can be incorporated into the treatment program. Anderson (1996) developed, The Personalized Nursing LIGHT model, as a prescriptive model for nursing practice derived from Aristotle’s theory of ethics and Martha Rogers’ SUHBs. Anderson, Hockman & Smereck (1996) conducted a research study on drug users that utilized a version of the LIGHT model to assist each client with the model as a process to improve their sense of well-being, while remaining free of alcohol and drugs. The LIGHT model posits interventions that affect drug users’ well-being as a more effective means to encourage positive behavior change than more traditional drug treatment programs that try to directly change behavior. Their study found that drug use and high risk behaviors were reduced after the clients used the LIGHT model (Anderson, Hockman & Smereck, 1996). The difference in this research study compared to the other studies, is that the primary purpose of this study was to uncover patterns describing adult substance users and family pattern in rehabilitation from the perspective of Rogers’ science of unitary human beings using the unitary field pattern portrait research method.

Methodology

Butcher developed an innovative descriptive methodological approach derived directly from the science of unitary human beings that is congruent with the theory’s philosophical assumptions and the criteria for Rogerian research (Butcher, 1994, 1998, 2005, 2010). The UFPP research method is well recognized as an appropriate method for conducting research guided by the science of unitary human beings (Barrett, 1998; Fawcett & Desanto-Madeya, 2013; Malinski, 2002; Parse, 2001; Phillips, 2000). The UFPP has been used in several Rogerian science-based research studies including Butcher’s (1996) investigation of the experience of dispiritedness in later life and Ring’s (2009) study of the experience of Reiki. Butcher (1994) first developed the UFPP research method in his original dissertation work where he derived a set of criteria for Rogerian inquiry from an analysis of the ontology and epistemology inherent in the science of unitary human beings. These criteria were used to develop the method’s specific facets and processes. The UFPP is a rigorous hermeneutic-phenomenological research method that can be used to understand pattern manifestations emerging from the pandimensional human-environmental mutual process to understand human well-being (Butcher, 1998, 2001, 2005). The UFPP requires the researcher to select a significant human-environmental phenomenon in the life process associated with well-being as the specific focus of inquiry (Butcher, 2005). The method
consists of eight essential facets: 1) initial engagement; 2) a priori nursing science; 3) immersion; 4) manifestation knowing and appreciation; 5) unitary field pattern profile; 6) mutually shaped unitary field pattern profile; 7) the unitary field pattern portrait; and 8) theoretical unitary field pattern portrait. The UFPP also includes four essential processes: a) creative pattern synthesis, b) mutual processing; c) immersion and crystallization, and d) evolutionary interpretation.

Initial Engagement

The researcher conducted an in-depth literature search to discover more about adult substance users and how the relationship of the family is an indicator for adult drug rehabilitation. For over a decade, the researcher has worked as a nurse with adult populations with substance use backgrounds. In addressing the specific aims of the study, the researcher apprehended early patterns of adult substance use, such as whether or not and how friends may have a role in substance use. The researcher was interested in examining how nursing could discover patterns based upon the participants’ descriptions of family support that would improve family relationships. There was also an investigation of family pattern relationship on the future rehabilitation potential of the participants. These research aims and questions are of value in understanding how to promote human betterment and well-being.

A Priori Nursing Science

A priori nursing science means that the UFPP is a theory-driven approach to inquiry and the postulates and principles of the Science of Unitary Human Beings explicitly guides all aspects of inquiry, from identifying concepts appropriate for inquiry, to how the concept is initially defined and conceptualized, to what questions are asking of participants during data collection, and finally how the data are interpreted. Martha Rogers’ (1970, 1990, 1992, 1994) science of unitary human beings guided the research and Barrett’s (1989, 2010) power as knowing participation in change theory was used to describe the nature of change. Rogers believed nursing is the study of unitary, irreducible, and indivisible human and environmental fields as well as the study of people and their world (Rogers, 1990). According to West (2002), no one theory explains the complex phenomenon of substance use impairment. Everyday events can be used to examine the science of unitary human beings, raise new questions, and allow new explanations (Rogers, 1992). Rogers’ science encompasses the concepts of wholeness, patterning, and human and environmental fields, a mutual process occurs with people and their environment (Rogers, 1970, 1992). Rogers (1994) stated, “The Science of Unitary Human Beings provides the knowledge for imaginative and creative promotion of well-being for all people” (p. 35). Theories have been derived from
Rogers’ postulates of energy fields, pattern, openness, pandimensionality, and principles of resonancy, helicy, and integrality for the purpose of guiding research and practice. The theory of power as knowing participation in change by Barrett (1986, 2010) is one of the major theories derived from Rogers’ postulates and principles, and it was used in this study to provide an understanding of how power to participate knowingly in change is experienced in families with substance users in a rehabilitation program from the perspective of Rogers’ nursing science. According to Barrett (1989), Rogers’ paradigm can provide the theoretical basis for nursing in health patterning. The process of change as viewed in Rogers’ model is always geared toward increasing complexity and diversity, just as successful drug rehabilitation involves creating a change within the human environmental field between the adult substance user and the complexities of family pattern on rehabilitation. The expression of the substance user is integral to the environment. Through choice patterned actions, humans may be integral to environmental patterns that limit their ability to participate knowingly in the process to change their substance using behavior.

Barrett’s theory provides a way of conceptualizing pattern change based on the clients’ awareness that they have the capacity to participate knowingly in change (Barrett, 1989). Nurses can facilitate individuals knowingly participating in change by enhancing participants’ awareness of a situation, providing information so participants realize they have choices, and assisting participants in being actively involved in the change process.

Barrett (2010) recently updated her theory, power as knowing participation in change, to reflect two different views of power: power-as-control and power-as-freedom. She stated, “Living power, or power-as-freedom, is the interest of wellness and well-being for ourselves and all those whose paths we cross in life, if we make and carry out the types of choices that promote health” (Barrett, 2010, p. 52). In describing this concept, Barrett (2010) stated the following:

We can participate knowingly in changing any situation in our lives. That does not mean we can control the situation, as there is no control in an acausal view of power, but we can do what we choose to do in the ongoing mutual process with ourselves, with other people, with our immediate world and with all of the universe (p. 52).

Barrett (2010) found that “in living power-as-freedom, we seek to see relationships among things; we increasingly think analogically” (p. 52). Power-as-control is a causal worldview about the material world. Barrett (2010) found that with these
two new power views, “We can investigate to further understand the interplay between power-as-freedom and power-as-control” (p. 52).

**Manifestation Knowing and Appreciation**

The study involved 11 participants, 21 – 54 years of age, who were participating in a drug rehabilitation program in Erie, Pennsylvania. IRB approval was obtained before any research was conducted and each participant signed an informed consent form. Maintaining confidentiality and informing the participants about how confidentiality was maintained throughout the research study and beyond was important in order to protect participants and meet the requirements of the IRB. Throughout the study, the researcher followed ethical guidelines by maintaining participant anonymity and a trusting and honest researcher-participant relationship. Participants were selected using intensive purposive sampling. The researcher recruited participants through the research interview site by posting research flyers and speaking with the director of operations and a social worker. The social worker recommended that the researcher contact local residential housing operations to recruit participants who could utilize the services provided by the health center. The researcher was able to meet representatives of two agencies in Erie, Pennsylvania, which had a population of residents in recovery who met the research study criteria. At each agency, the researcher was able to speak with the director about the research study and provide contact information. Directors at each of the agencies approached residents with documented histories of substance use and gave them the researcher's contact information if they indicated they wanted to participate in the study.

When the researcher received phone calls from interested persons, she scheduled private interview sessions with each participant at the federally qualified health center. The researcher explained the research study aims and told the participants that the first interview was tape recorded for later transcription, with only the researcher listening to the tapes. The research interviews were conducted from December 2010 – January 2011.

The researcher collected data from one-on-one interviews and participant journals in a private setting at a medical office. Selecting a community medical office allowed the researcher to have a higher rate of participant retention because individuals who lived near the office were more likely to remain in the study. The participants were asked to write in a journal after the first session to reflect on their experiences and perceptions, and they were asked to express themselves by creating pictures and poetry or journaling about power as knowing participation in change. During the first interview session, specific research questions were asked of each participant, which reflected the specific aims of the
study on family pattern and the power as knowing participation in change field dimensions. The research questions were created to guide an open-ended interview style with each participant. The structured questions were asked of all participants in a particular order because of the nature of the questions. Examples of questions aimed at revealing experiences, expressions, and perceptions of family patterns of substance abuse and recovery included: Tell me about your family support system; How does your family support your rehabilitation? How do you feel your family has influenced your substance abuse behaviors? Have past family relationships influenced your use of substances? Guided by Barrett’s power as knowing participation in change theory, the researcher asked participants the following sample questions: Explain how your family influences you in recovery. Are you aware you have Power to change? Describe what Power means to you. Describe your current situation on where you are now and your well-being. Describe your awareness on your current situation in recovery. Tell me about the choices you have in your rehabilitation. How would you describe your freedom day to day to intentionally act on your recovery process? Do you feel you can change? How are you going to create your own change? What does well-being mean to you? How do you plan on obtaining well-being?

At the end of the first interview, the researcher would share with the participant an emerging joint or mutually constructed unitary field pattern profile, which consisted of a merging and synthesis of profiles from previous participants. This allowed each participant to hear what the previous research participants had to share about their own field dimensions of power and provide comments. The researcher also maintained observational, methodological, and theoretical field notes and a reflective journal to write notes about each participant’s interview session allowed the researcher to reflect on the phenomenon and later enhanced the creation of the emerging unitary themes. Interview questions were designed to find patterns and themes and discover how participants have the power to participate knowingly in change utilizing Barrett’s field dimensions of power. This allowed the researcher to describe the nature of power as knowing participation in change once the data were analyzed using the hermeneutic phenomenology research approach and Butcher’s UFPP methodology.

After the eighth participant’s field pattern profile was reviewed and emerging themes were extracted, data saturation took place. The researcher realized that there were five resonating themes that developed from all of the emerging themes, but decided to continue data collection in order to add to the richness of the data and confirm data saturation. After interviewing the eleventh participant, the researcher found there were still only five resonating themes that developed
from all of the emerging themes. This finding confirmed the complete repetition of pattern and themes. Pattern appraisal was completed at that time.

The diverse population included three females and eight males and consisted of one American Indian/Pacific Islander participant, four Black participants, and six White participants. Three of the 11 participants held a bachelor’s degree, and all but two of the participants had a high school diploma or equivalent.

The family support system of the participants included 14 different support persons for a total of 25 individuals. Most participants (63%) reported that their mother was the major source of family support. The second most reported source of family support was children (36%). Only one participant reported that the marital partner functioned as the family support system, and only one participant reported that friends served as the family support system. Individuals who were related by blood (mother, children) were more often used as a source of family support than non-related individuals (wife, friends), which could be interpreted as the human-environmental field pattern of support. This finding prompted the researcher to ask: Who is a source of encouragement versus who is not valued or is not supportive of an encouraging environmental force for these participants?

The 11 participants in the study used different substances. There were nine different categories of drugs used by these participants. The most widely used substance was alcohol (82%), followed by crack cocaine (73%), marijuana (64%), heroin (55%), cocaine (45%), amphetamines (45%), opiates (27%), hallucinogens (27%), and sedatives (9%). These findings confirm that most participants had polysubstance use addictions. All 11 participants were clean from any drug during the study and had an average clean time of 7.35 months (this excluded an outlier of 8 years, 5 months clean).

Unitary Field Pattern Profile Construction

Pattern profile construction is the process of creating a profile for each participant using creative pattern synthesis. After each interview was transcribed, the researcher created a synthesized narrative statement in order to reveal the essence of the participant’s description of the phenomena. The researcher used a selective highlighting approach, extracted the key words, phrases, sentences, and synthesized them together into a cohesive narrative. The completed unitary pattern profile was then shared with the participant so they may add to, revise, and validate the researcher’s construction of their unitary field pattern profile. This second interview was also the time when the participant brought back the journal for the researcher to review. The journal was reviewed by the researcher to illuminate the meaning of the phenomenon. The researcher recorded any meaningful journal.
entries that were written by each participant, in his or her own words (unedited), under the pattern profile. The emerging unitary themes of human-environmental pattern manifestations that were extracted from each pattern profile are listed under the pattern profile of each participant.

Findings

Presentation of an Exemplar Unitary Field Pattern Profile

An exemplar representing one of the 11 unitary field pattern profiles was selected to show how the emerging themes were derived.

*My family support system has been my mom; she’s done so much for me, throughout my entire life. I’ve been so spoiled. And then for me to come around and do this…it’s disappointed her, I’ve never disappointed her before. It tore me up. She’s back talking to me and checking on me, it just feels like everything is in order again. My life is getting back on track. It’s very important for me to have that relationship with her. My family influence on my past substance abuse is my oldest brother, I’d smoke weed with him and of course drink, what kid doesn’t. I can’t say it was mainly him, because I decided to go out and use with him. My family influence on my recovery is my mom, she is a recovering alcoholic herself, and she knows how important it is to take it one day at a time. She constantly reminds me to do that. I’m not a very patient person, but I’m working on it. It’s important for me to get my life back on track. I have a college degree, I had a very outstanding job, I can get these things back, I’m young. My mom wants me to get them while I still can. I’m aware I have the power to change, because there are certain days where I don’t want to recover at all. I’m in the nonrecovery mood, but something clicks in there, and its saying, you know you need to go to a meeting today, and I fight it. But, I get on and think I need to go to a meeting and hear what other people have to say and how they got through this. It’s not an easy thing. Power means the control I have over my entire life. Everything that I do has power in it. I choose to give it that power and I choose to take it away...that’s how I see it. I have made so many new friends in my rehabilitation program. In my well-being right now, I’m doing good, I’d like to think so, and my sponsor seems to think so. I’m getting better everyday. It’s been a tough road for me because I’ve done so many messed up things. The choices that I have are I can choose to go to work or I can choose not too. The choice is very simple, it’s either follow the rules or move on, go somewhere else. I can’t really move on anywhere else unless I get this (recovery) so that’s what I’m working on. My freedom to act intentionally on my recovery is, do I really want to live the life that I was used to leading. I never want to get into that predicament where I have nothing. Literally nothing. No one around me. That is one of those things that I fear. It keeps me going from day to day. I remember where I was at and
I never want to go back there again. I most definitely feel I can change. Do I want to change is the question. Right now, I do, I need too. I want it, it’s the most important thing in my life right now is to change. Well-being is listening to advice and advice that is given to me. Just follow the simplest instructions and work on it and keep going at it, it will all fall into place for me, what my position is in life, what I need to do to make it out in the world.

Mutually Shaped Unitary Field Pattern Profile Construction

A mutually shaped unitary field pattern profile was generated throughout pattern manifestation knowing and appreciation process by merging each of the previous unitary field pattern profiles together into a unified whole. At the end of the first interview, the emerging mutually shaped unitary field pattern portrait is shared with the participant. The process of anonymously sharing pattern profiles allows each participant to hear what other participants said during their interviews and engage in the pattern manifestation knowing and appreciation process of the study. At the participant’s second interview, the researcher read aloud to the participant his or her individual pattern profile for verification and revision. No participants requested that anything be changed about their pattern profile, but there was one participant who had an incorrect year and age listed, which the researcher changed.

After the researcher finished reviewing the pattern profile with the participant, the researcher would then read aloud the mutual unitary field pattern profile as it was created from the previous individual field pattern profiles. As each field pattern profile was completed and reviewed with each participant for verification/revision. By the time the researcher read the emerging mutually shaped unitary field pattern profile to the eleventh participant, it consisted of a synthesis of the 10 previous participant’s unitary field pattern profiles. This synthesis is achieved by eliminating any repeating patterns and maintaining the key experiences, perceptions, and expressions in each participant’s unitary field pattern profile.

Presentation of the Mutually Shaped Unitary Field Pattern Portrait Profile of Family Pattern of Power as Knowing Participation in Change Among Adult Substance Users in Rehabilitation

I feel like everything is in order again. My life is getting back on track. My family tries to keep me on track, encourage me to make right choices. It’s very important for me to have that relationship with my family. Their encouragement. My family is very supportive. They think it’s the best thing for me. The support I get from them is just being a part of that family. They talk about the Lord. They just want me to do well, do the right thing. They’re happy that I kind of pulled my life together and their kind of reaping
some of the benefits of that. My family feels what I feel. They’re there for me mentally. They also would never really tell me how much I’ve hurt them. I can’t manipulate them anymore. Everyone as a whole wants me to get clean. That’s not why I stay sober but it’s that kind of concern that reminds me that it’s not all about me. They want to understand why and understand me. They can’t do anymore than they have done.

I don’t know what happened to me. Because where I’m from is all I know. I’ll go back home and start hanging out with those same old guys and end up doing the same old thing. It’s important to take it one day at a time. I can get things back. I accepted where I’m at. I got to move on. When I’m walking the streets or whatever it could be, I always try to be aware. I’m aware I have the power to change, because there are certain days where I don’t want to recover at all. I’m in the nonrecovery mood, but something clicks in their and its saying, you know you need to go to a meeting today, and I fight it. But, I get on and think I need to go to a meeting and hear what other people have to say and how they got through this. It’s not a bad thing to try and pull yourself together. It’s not an easy thing. It slowly starts to take over as what you need or what you do and before you know it, you’re doing it everyday. Because you don’t want to be sick and you don’t know how to get rid of whatever it is hurting you inside that’s making you do it everyday. Addiction and drugs become a way of life. It’s hard; it’s hard, you have know idea how hard it is to stay clean. It’s something that I look forward too.

Power is the ability to do what I want to do. In my addiction I was powerless. It took over everything. Powerlessness is the key to surrender. Surrendering to the fact that I have a drug and alcohol issue. My power comes to understand that I have no power. Just letting go, that’s what you got to do. I think if I didn’t have some aspiration, that I wouldn’t have the power to change. I have to be vulnerable and do the things that don’t feel comfortable because it’s going to help me. Now, I’m more in control of what I want to do and where I want to go, instead of being powerless. It was putting myself into an environment where change was possible, where I could get people to help me change.

Power means the control I have over my entire life. Everything that I do has power in it. I choose to give it that power and I choose to take it away. My choices are I can either use or not use, that’s it. The choice is very simple, it’s either follow the rules or move on, go somewhere else. My awareness changes everyday. My awareness is that I still need maintenance. I have to really work to stay there. And that means I have to be in the presence of others who can understand my situation because I am a master at rationalizing myself into anything. I’m very aware of what my drug use has done. The awareness is intense. It’s like you know, I’m not ready to die. I know I have the
power to make my own decisions. You got to identify the problem and you got to deal with it. I never want to get into that predicament where I have nothing. Literally nothing. No one around me. That is one of those things that I fear. It keeps me going from day to day. I’m not going to be a statistic. Recovery means being able to make choices now. In addiction the drug was making your choices for you.

You have a lot of freedom. It pushes you to deal with a lot of things. Temptation is going to be everywhere for someone like me. It’s like what I said, what are you willing to do to stay clean? Our disease is a disease of feelings. And how we are feeling will obviously influence our next decision and that next decision will influence where we go, who we hang out with and all those different things. Just being free from the drug is a good feeling. When you use drugs there are a lot of things that go with it, as far as the after effects, like you wake up with no money in your pocket or you can’t do this or that for your child. I know that I’m free to make choices but my addiction is so strong that I don’t always feel free to make good choices because addiction takes over. I need guidance from somebody who has more time than me. I can’t do it by myself, I realize that. I can change by the people who help me.

It’s time for me to stop. I’m getting too old for that same old thing. It’s been a tough road for me because I’ve done so many messed up things. The same stuff, expecting a different result, it wasn’t working for me. I’m getting better everyday. One day at a time. I most definitely feel I can change. Do I want to change is the question. I want it, it’s the most important thing in my life right now is to change. I know that there are things that I can do and that I can’t do. The one thing I had to do was cut people out of my life. Those people that I hang out with now, I don’t hang out with them because I want something from them, we’re just friends. But, that’s the thing that I was lacking the most, having someone to look up too. Some people find that in religion. Maintaining my faith with God. Well-being means being healthy in mind, body and soul. Well-being is listening to advice and advice that is given to me. I’m content with where I’m at. It’s living right and doing the next right thing. Be a normal member of society. For me, well-being is balance, just for today. What’s going to keep me doing the right thing. Well-being means being in a position to take advantage of what life has to offer.
Table 1

*Unitary Themes of Human-Environmental Pattern Manifestations Derived from the Exemplar Unitary Field Pattern Profile:*

<table>
<thead>
<tr>
<th>it tore me up</th>
<th>tough road</th>
<th>my life is getting back on track</th>
</tr>
</thead>
<tbody>
<tr>
<td>I never want to go back there again</td>
<td>everything is in order again</td>
<td>take it one day at a time</td>
</tr>
<tr>
<td>control I have over my entire life</td>
<td>everything that I do has power in it</td>
<td>getting better everyday</td>
</tr>
<tr>
<td>keeps me going from day to day</td>
<td>keep going at it</td>
<td>fall into place</td>
</tr>
<tr>
<td>make it out in the world</td>
<td>follow the rules or move on</td>
<td>I can change</td>
</tr>
<tr>
<td>important for me to have that relationship</td>
<td>listening to advice</td>
<td></td>
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</tbody>
</table>

**Unitary Field Pattern Portrait Construction**

Unitary field pattern portrait construction begins by first identifying emerging unitary themes from each participant’s field pattern profile and sorting the emerging unitary themes into common categories. The process of identifying emerging themes from each profile occurred as the researcher reviewed each transcribed and verified field pattern profile to extract key phrases and sentences that represented the research questions of family pattern and field dimensions of power. A total of 165 emerging themes were derived from the 11 unitary field
pattern portraits. The 165 emerging themes from every field pattern profile were then categorized into common themes. These common themes were then formed into resonating themes that included the experiences, perceptions, and expressions of adult substance users and family pattern in rehabilitation.

During creative pattern synthesis, the researcher immersed in all of the emerging themes, mutually shaped unitary field pattern profile, reflective journal, and notes for an extended period of time to create the common categories (Butcher, 2005). During this phase, the researcher performed immersion/crystallization data and spent three weeks conducting pattern synthesis to create the resonating themes. The five resonating themes were created of human-environmental pattern manifestations of adult substance users and family pattern in rehabilitation. See Table 2.

The first resonating theme of adult substance users and family pattern in rehabilitation, being content with ever changing emotions, was expressed by the participants through descriptions of their emotional awareness. An example of this theme is expressed by statements from one of the participants:

I’m a big proponent that our disease is a disease of feelings….I think well-being is that there are choices that I can make that will keep me healthy in my thinking, in my spiritual life, in my emotional life, and I am free to choose those things.

This theme is supported in the literature. Rushing’s (2005) study on substance users experiencing serenity in recovery found that participants shared a spiritual experience/awakening that was pivotal in the recovery process. Those

Table 2
Resonating Unitary Themes of Human-Environmental Pattern Manifestations:

Being Content With Ever Changing Emotions:

Living Patterns of Recovery While Resisting Temptation:

The Power to Control Today’s Choices:

Being in an Environment where Change is Possible:

Enhanced by Supportive Guidance in Changing Family Patterns:
participants experienced serenity, leading them toward sobriety, healing, and wholeness (Rushing, 2005). These findings support this research study and what is known in the literature.

The second resonating theme of adult substance users and family pattern in rehabilitation, living patterns of recovery while resisting temptation, was expressed by the participants through their descriptions of their past and current life patterns. The following statements from one of the participants reflect this theme:

Addiction and drugs become a way of life. It’s hard; it’s hard, you have know idea how hard it is to stay clean. There’s crack everywhere. Everywhere. There’s people right across the street, you can get some. It’s everywhere. When you are trying to stay clean it’s very, very hard.

Rushing (2005) stated, “Addiction suggests an orientation and a lifestyle that completely engulfs a person” (p. 9). The participants in this research study were all trying to maintain their recovery and “get their life back on track.” The living patterns of their recovery are supported by each participant’s verbalizations of their desire to stay clean and “doing the right thing.”

The third resonating theme of adult substance users and family pattern in rehabilitation, the power to control today’s choices, was expressed by the participants’ statements about believing they have the power to change. The following statements from one of the participants demonstrates this theme:

I’m aware I have the power to change, because there are certain days where I don’t want to recover at all. I’m in the nonrecovery mood, but something clicks in there, and its saying, you know you need to go to a meeting today, and I fight it. But, I get on and think I need to go to a meeting and hear what other people have to say and how they got through this. It’s not an easy thing. Power means the control I have over my entire life. Everything that I do has power in it. I choose to give it that power and I choose to take it away…that’s how I see it.

The research participants in Kearney and O’Sullivan’s (2003) study found that promoting change meant controlling their environment. The finding supports this research study’s findings on the power to control today’s choices theme. Rushing’s (2005) study found “power issues for addicts revolve primarily around control of their substance use as well as control of other people and circumstances in their lives” (p. 42).

The fourth resonating theme of adult substance users and family pattern in rehabilitation was being in an environment where change is possible. Participants were asked if they could change and all responded, “Yes.” They also gave
this response in their interviews. An example of this theme was reflected in a participant’s statement:

*I’m aware that I’m the only one that can change me. I can’t do it for someone else or something else, it’s up to me. The power to change, I’m the only one that can do that. It’s all about dealing with it. You got to identify the problem and you got to deal with it. I know I got to be the one to change.*

Matto et al. (2005) conducted a study on social referents and found that those in treatment are influenced by social identity in relationship to their addiction and recovery and level of concern. This finding demonstrates that social environment is a factor and influences the substance user’s rehabilitation. Padgett et al. (2008) found that the main priorities for the participants in recovery were to make trusted, sober friends and reunite with family. This finding supports and expands on the theme that the environment (human environ-mental energy fields) is integral to the change process under investigation in this study.

The fifth resonating theme of adult substance users and family pattern in rehabilitation was *enhanced by supportive guidance in changing family patterns.* Within this theme, participants discussed their family pattern and family influences on their recovery. An example is demonstrated by statements from one of the participants:

*My biggest support is my mother. She’s a great moral support. She is someone who is always there for me. She’s always worried. I know it will crush her if I go drinking. That’s not why I stay sober but it’s that kind of concern that reminds me that it’s not all about me.*

Another participant stated, “My family is very supportive. They’ve given me a million chances. I’d be tired of me. They just be giving me one more time to get it right.” In a Craft-Rosenberg et al. (2000) study on women and support systems, the researchers found that family members and friends were the majority of those in the women’s support system. Kearney and O’Sullivan (2003) found social and environmental influences could prompt change or act as a constraint in the recovery process. Studies conducted by these researchers support this study’s findings on support and family pattern.

**Presentation of the Unitary Field Pattern Portrait**

The UFPP is expressed in the form of a vivid, rich, thick, alive, and accurate aesthetic rendition of the universal patterns, qualities, features, and themes exemplifying the essence of the dynamic kaleidoscopic and symphonic nature of the phenomenon of concern (Butcher, 2005). In this study, the UFPP of adult substance users and family pattern in rehabilitation was created and reflected the expressions of the phenomenon. The UFPP of adult substance users and family pattern in rehabilitation is stated as follows:
Being content with ever changing emotions and living patterns of recovery while resisting temptation and the power to control today’s choices while being in an environment where change is possible which is enhanced by supportive guidance in changing family patterns.

Theoretical Unitary Field Pattern Portrait Construction

The last element in UFPP research method is the development of the theoretical UFPP. This process involves transforming the unitary field pattern portrait into a set of theoretical statements grounded in the language of Rogers’ nursing science by interpreting the unitary field pattern portrait using Rogerian postulates, principles, and theories while maintaining scientific rigor of trustworthiness and authenticity. This process of interpretation is referred to as “evolutionary interpretation” (Butcher, 1998, 2005, 2010 Rogerian science, Barrett’s power as knowing participation in change, and the field dimensions of power were used to construct the theoretical unitary field pattern profile.

Presentation of the Theoretical Unitary Field Pattern Portrait

The theoretical UFPP of adult substance users and family pattern in rehabilitation is as follows: An awareness of being content with rhythmical correlates of changing emotions;

Experienced as resonating waves of complex living pattern of recovery with presenting choices to resist temptation;

The freedom to act intentionally is the power to control today’s choices;

Helicy manifested as the power to participate knowingly in change with patterning of the human-environmental fields;

Involvement in creating change is being in an environment where continuous change is possible;

Integrity is experienced as continuous mutual human-environmental field process of change.

Evolutionary Interpretation of the Resonating Themes to the Theoretical Themes

The theoretical theme, an awareness of being content with rhythmical correlates of changing emotions, evolved from the resonating theme, being content with ever changing emotions, interpreted from Rogers’ principle of resonancy, which is resonating waves of growing complexity of pattern by describing the patterns of
change as rhythmical. It also reflects Barrett’s dimension of awareness. The theoretical theme, experienced as resonating waves of complex living pattern of recovery with presenting choices to resist temptation, evolved from the resonating theme, living patterns of recovery while resisting temptation, interpreted from Rogers’ complexity of pattern and Barrett’s dimension of choices, which are living patterns. The theoretical theme, the freedom to act intentionally is the power to control today’s choices, evolved from the resonating theme, the power to control today’s choices, interpreted from Barrett’s dimension of freedom to act intentionally, which is power. The theoretical theme, helicy manifested as the power to participate knowingly in change with patterning of the human-environmental fields and involvement in creating change is being in an environment where continuous change is possible, evolved from the resonating theme, being in an environment where change is possible, interpreted from Rogers’ principle of helicy, which is continuous, innovative, and unpredictable, increasing the diversity of human-environmental fields and Barrett’s theory of power as knowing participation in change, the dimension of involvement in creating change, where change is continuous and a process of emergent change. The theoretical theme, integrality is experienced as continuous mutual human-environmental field process of change, evolved from the resonating theme, enhanced by supportive guidance in changing family patterns, interpreted from Rogers’ principle of integrality, which is the continuous mutual human field and environmental field process, and Barrett’s principle of involvement in creating change, the support of the family energy field.

Scientific Rigor

In this study, the researcher strictly adhered to Butcher’s UFPP methodology and followed each of the eight steps during data gathering and interpretation. Butcher (1994) designed the criteria for establishing scientific rigor by using Guba and Lincoln’s (1989) criteria for trustworthiness to examine the scientific rigor and authenticity of the findings. This study used the processes described by Butcher (1994) for establishing credibility, confirmability, dependability, descriptive vividness, and unitary integrity.

Discussion

By utilizing Barrett’s theory of power as knowing participation in change, the researcher reviewed the research findings and how they correlated with the field dimensions of power. Barrett (1983) stated, “Power is the capacity to participate knowingly in the nature of change characterizing the continuous repatterning of the human and environmental fields” (p. 4). All participants were asked if they were aware they had the power to change...
and if they felt they could change. All 11 participants stated they had the power to change in regard to their phenomenon of substance use, and every participant felt that he or she could change. The researcher reviewed the transcripts and field pattern profiles and the field dimensions of power: awareness, choices, freedom to intentionally act, and involvement in creating change were examined during the process of evolutionary interpretation, and all participants saw themselves as having the power to knowingly participate in change. According to Barrett (2010), “We are always participating in change, but our participation is not always in a knowing manner. When it is, that is what I call power” (p. 48).

These findings can provide a foundation for future researchers to conduct similar studies on adult substance users and family support systems. Research that focuses on substance use among humans and their environmental field pattern can advance nursing science. Nurses need to focus on improving outcomes for individuals with substance use issues. Utilizing nursing theoretical models in research studies that are consistent with the model concepts may expand nursing science. Future nursing researchers need evidence in order to utilize nursing research models and contribute to nursing philosophy by discovering knowledge about our discipline.

**Recommendations for Further Research**

This was the first known research study investigating family patterns in adult substance users that was guided by Rogers’ conceptual model and used Barrett’s theory of power as knowing participation in change by following Butcher’s UFPP methodology. There is still a lack of nursing literature on adult substance use and current family support systems during rehabilitation. Many researchers have suggested future studies need to be conducted on the environmental/support systems used by substance users undergoing the recovery process. A suggestion for further research based on this study would be to conduct research with similar participants in focus groups in order to develop a shared knowledge of the phenomenon. Further research could also be conducted with a similar study using a different Rogerian theory and incorporating other dimensions of the theory into research.

**References**


The Practice Column presents articles that address issues related to applying the Science of Unitary Human Beings in a practice setting. The article presented here was adapted from a paper presented at the Society of Rogerian Scholars Conference, “Advancing Rogers’ Science of Unitary Human Beings through Praxis: Theory, Research, and Practice,” Christine E. Lynn College of Nursing, Florida Atlantic University, Boca Raton, FL, October 10, 2010. It begins with a discussion of the origins of praxis and then proceeds with a commentary between the authors.

I invite you to send or email manuscripts for consideration for inclusion in this column to me. Commentaries on articles are always welcome.

ROGERS’ SCIENCE OF UNITARY HUMAN BEINGS AND PRAXIS: AN ONTOLOGICAL REVIEW

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Abstract

Development of theory, research, and practice are essential to the future of the Science of Unitary Human Beings. Understanding the relationship between the Science of Unitary Human Beings and ontology also is essential. This paper focuses on the ontology of praxis and presents answers to four questions: What is the ontology of Aristotle’s use of the term, praxis? What are the disciplinary uses of praxis since Aristotle? When did praxis first appear in the nursing literature? What has the nature of praxis been in publications about the Science of Unitary Human Beings? The paper concludes with a dialogue between the two authors.
The concept of praxis has appeared in an increasing number of nursing publications in recent years. One might ask, what is it that has fueled nursing interest in the concept of praxis? One possible answer is that the philosophy of science expansion and embrace of qualitative approaches led to new understandings of the relationships among theory, research, and practice. Literature supporting that view was reviewed in an earlier publication (Alligood & Fawcett, 1999). It has become obvious that literature about the methods debates that positioned qualitative and quantitative approaches as competitors shifted to a position of complementarity and an understanding of the value of each approach for nursing theory development (Alligood, 1994; Ford-Gilboe, Campbell, & Berman, 1995; Silva & Sorrell, 1992). Praxis then began to be referred to in the nursing literature and was used to describe an expanded understanding of nursing practice in relation to theory and research (Conner, 1998, 2004; Holmes & Warlow, 2003; Thorne & Hayes, 1997). For the purposes of this paper, we define praxis as “A dynamic process informed by the reciprocal relationship of theory and practice.” (Alligood, 2010, p. 519). To expand our own and others’ understanding of praxis, we decided to look back to its origin with Aristotle and forward to how the term has been used in the nursing literature, with particular attention to its use within the context of the Science of Unitary Human Beings (SUHB).

Given our commitment to the advancement of the SUHB, we asked, How can praxis help build the SUHB? The specific questions that guided the content of our paper are:

- What is the ontology of Aristotle’s use of the term, praxis?
- What are the disciplinary uses of praxis since Aristotle?
- When did praxis first appear in the nursing literature?
- What has the nature of praxis been in publications about the SUHB?

**What is the Ontology of Aristotle’s Use of the Term Praxis?**

Our review of praxis was conducted from an ontological perspective. Why ontology? We selected ontology because this branch of philosophy addresses the question of existence or what it means to be (Blackburn, 1996; Reed, 1997). For the purposes of this paper, we used Blackburn’s (1996) definition of ontology: “From the Greek word for being...concerns what exists” (p. 269).

Aristotle focused on ontology as the nature of being; he was interested in human motivation and action (Blackburn, 1996) and believed that philosophy dealt with the whole of being, whereas the sciences dealt with the particulars of the whole (Blackburn, 1996; Bernstein, 1971). Aristotle’s observations of human behavior led to identification of three types of knowledge, which are associated...
with three types of human activity (Blackburn, 1996; Bernstein, 1971, 1983):

1) **Theoria** is theoretical and concerns knowing that aims to answer “why”?

2) **Praxis** is practical and concerned with doing that is aimed at voluntary or goal directed action for the purpose of doing good or for its own sake rather than action done because a person is compelled to act as in slavery.

3) **Phronesis** or **Techne** is productive, is concerned with making, and aims at knowing how to do something, such as skillful manufacture.

**What are the Disciplinary Uses of Praxis since Aristotle?**

Gadamer’s (1976) concept of the “fusion of horizons” was used to understand the hermeneutic interpretation of the concept praxis by various authors. Fusion of horizons refers to a hermeneutic approach that is philosophically inclusive of turns-of-meaning texts take over time. Linge (1976) observed that Gadamer focused his attention directly on what a text says to successive generations of interpreters, stating that “Gadamer succeeded in transforming the past into what appears as an inexhaustible source of possibilities of meaning rather than as a passive object of investigation” (Linge, 1976, p. xx). Use of fusion of horizons leads to new meaning and understandings as the horizon of a historically situated author’s text is interpreted and fuses with the historically situated horizon of the interpreter (Blackburn, 1996). Linge (1976) states, “The task of philosophical hermeneutics… is ontological rather than methodological (p. xi)...The aim of Gadamer’s philosophical hermeneutics is to illuminate the human context within which scientific understanding occurs and to account for the necessity for repeated attempts at critical understanding” (p. xviii). Thus, Gadamer provides an understanding of how fusion of the horizons of interpreters has fused with the horizons of the text of writers regarding praxis, which has taken several turns of meaning that have resulted in the term being used in different ways over the last 2000 years. Yet, most agree that Aristotle’s root meaning of praxis exists contemporarily (Blackburn, 1996; Bernstein, 1971, 1983; Gadamer, 1976; Linge, 1976; Magee, 2006).

Within the discipline of philosophy, the meaning of praxis evolved from Aristotle’s (384-322 BC) use of the term to describe action and moral custom of free men in contrast with the compelled activity of slaves. Praxis surfaced again during the renaissance in the 17th century when philosophers returned to the perspective of Greek philosophy. Successive generations of philosophers continued to work within the context of that perspective (Brightman & Beck, 1964). For
example, **Kant** (1724-1804) who focused on analysis of reason, discussed praxis in terms of action based on application of theory (Blackburn, 1996; Magee, 2006). **Hegel** (1770-1831) dialectically combined thinking and being, building on Aristotle's idea of wholeness. He maintained that the whole is true, which was a solution to the theory-practice debate (Bernstein, 1971; Blackburn, 1996; Brightman & Beck, 1963; Magee, 2006). **Marx** (1818-1883) drew from Hegel's solutions and the flurry of interest in praxis, along with the acceptance and growth of science, for his own understanding of the nature of praxis. Inasmuch as science was becoming popular because it was useful, Marx wanted to make philosophy useful by applying it to the problems of the day, which he identified as poverty, powerlessness, and domination by the aristocracy. Marx's theory of praxis is regarded as the first to make praxis a central theme of a theoretical proposal (Bernstein, 1971).

**Heidegger** (1889-1976) was called an ontologist because he focused on being as separate from thought in the existential perspective. He interpreted Aristotle's focus on being and called it 'Dasein,' that is, what the world is for a person in time (Blackburn, 1996). **Gadamer** (1900-2002) maintained that “What we call literature has acquired its own contemporaneity [is contemporaneous] with every present time...a communication in what the text says to us...present participation in what is said” (Gadamer, 1976 as translated from German by Linge in the introduction, p.xx). Bernstein (1983) pointed out that Gadamer was noted for “his fusion of hermeneutics and praxis and the claim that understanding itself is a form of practical reasoning and practical knowledge—a form of phronesis” (p. 174).

**Arendt** (1906-1975) returned to the Aristotelian meaning of action. For Arendt, praxis is the “life of action,” and the theorist’s task is to interpret the meaning of action hermeneutically with a backward glance to recall, recover, and round out the meaning of human deeds (Bernstein, 1971, 1983). Habermas(1929- ) has focused on consciousness and causation of social action. His 1963 book, *Praxis and Theorie*, when translated became *Theory and Practice* (Blackburn, 1996).

Within the discipline of **education**, praxis is used primarily in relation to Praxis I and II, which are examinations for primary school educators that are prepared and administered by the Educational Testing Service. Praxis I and II examinations are required for teacher licensure in 39 of the United States. Development of high quality teachers is based on a system that calls for reflectivity of personal practice as a teacher. Praxis is regarded as individual teacher development of practical expertise. The examinations lead the teachers through a cyclical process of learning experiences for their development as school teachers.
Two areas of the discipline of sociology have produced considerable literature on praxis. In critical social theory, which is based on Marx’s work, praxis is used as epistemology for deconstruction of systems for social change (Freire, 1970). In general social work literature, praxis is used to describe the reflexive relationship of theory and action in practice and the cyclical process that guides delivery of social work practice (Lee, 2001).

In medicine, the term, praxis is used in the names for commercial business systems that organize the complexities of medical practice. Examples of such business systems are Praxis Medical Management, Praxis EMR Software Solutions, and Praxis Technology-titanium for medical devices.

When Did Praxis First Appear in the Nursing Literature?

Holmes and Warelow (2001) noted that praxis in Greek terminology referred to the action of free men, who could behave in a voluntary manner, in contrast to slaves, whose behavior was dictated by their masters. They proposed that this broad understanding of praxis led many to link praxis to nursing. It is true that nurses have a history of human concern that compels them to help others, and that nurses are generally viewed as good citizens. Evidence of this view of nurses and nursing by the public is the repeated Gallup poll ranking of nurses. For example, on December 10, 2010, the Gallup website announced that nurses were ranked at the top of their survey of the public’s view of ethics and honesty among professionals for the 11th year. Inasmuch as the ontology of praxis emphasizes actions that are for doing good (moral, ethical, political), nurse scholars have found praxis to be a useful concept to expand the nature and meaning of the practice of nursing (Conner, 1998; 2004; Holmes & Warelow, 2001; Newman, 1990; Thorne & Hayes, 1997). However, as noted earlier in this paper, there were different interpretations of the nature of praxis among philosophers whom nurse scholars would have referenced.

Early references to praxis in the nursing literature were found in German nursing journals of the 1970s. Praxis was usually translated from German to English as practice or process. However, some nurses now use praxis to refer to practice; others, to refer to research approaches; and still others, to refer to the modus operandi of the nursing profession. Differences in meaning may be traced to differences in translations. Early references to praxis in nursing publications by American nurses include Moccia (1986 as cited by Thorne, 1997, p.xi), who used praxis to describe the relationships among theory, practice, and research. This was at the time when nurses were beginning to articulate the relationships among theory, practice, and research with proposals that these three activities were more closely related than previously understood. Munhall (1989) later used the term praxis to emphasize the benefits of qualitative research methods as a way for
nurses to better understand lived experiences of patients with diverse health conditions.

Praxis now is a prevalent topic in nursing literature worldwide, with varied uses in research and practice (Conner, 2004). For example, praxis is used in reference to nursing ethics (McKeown & Mercer, 2010), mental health (Hewitt, 2009), nursing education (Moss, Grealy, & Lake, 2010), community nursing (Jenkins, Mabbett, Surridge, & Warring, 2009), gerontology (Molony, 2010), oncology (Charalambous, 2010), and emancipation (Chinn & Kramer, 2011; Kagan, Smith, Cowling, & Chinn, 2009). Praxis also is used to refer to qualitative research processes (Cowling, 2004; Newman, 1990). In addition, praxis is found in the title of the book, Nursing Praxis (Thorne & Hayes, 1997) and as the title for the New Zealand nursing journal, Praxis. Doane and Varcoe (2008) pointed out that praxis can be considered “a way of being in which the interconnection of theory, evidence, and practice is lived” (p. 294). They contend that it is not sufficient to know about and believe in the efficacy of a theory (or conceptual model); instead, that knowledge and belief must be translated into a way of being a practicing nurse. Their concept of praxis is consistent with Aristotle’s use of the term.

**What Has the Nature of Praxis Been in Publications About the SUHB?**

Praxis is most explicit in the SUHB literature in publications by Newman and Cowling. Newman (1990) used the term, praxis, to describe her approach to research within the context of her theory of health as expanding consciousness, which was derived directly from the SUHB. Newman’s research approach—the research as praxis protocol—emphasizes the close relationships among theory, research, and practice. She based her idea of research as praxis on the work of Lather (1986) from sociology for his "process of identifying pattern" (p. 38). The focus of the research as praxis protocol is pattern recognition by the nurse researcher/clinician and a client. More specifically, the focus is on the authentic involvement of the nurse with a client in a mutual relationship of pattern recognition. The client’s responses to the basic request to “Please tell me about the most meaningful persons and events in your life,” provide the data for pattern recognition.

Cowling developed the method of unitary appreciative inquiry (UAI), which is based in the SUHB. Cowling and Repede (2010) explained that “The process of UAI was intentionally developed to provide flexibility in uncovering life patterning through innovative approaches in a praxis context” (p. 69). They went on to explain that UAI is praxis “because it is an active synthesis of theory, research, and practice. As praxis, UAI creates opportunities for participants to open themselves to new unitary understandings of their lives in process with an appreciative stance toward what is, rather than what
should be” (p. 69). The process of UAI encompasses three essential elements: appreciation, participation, and emancipation (Cowling & Repede, 2010). Appreciation involves both researcher and client becoming aware of the client’s life patterning. Participation involves assumption by both the researcher and the client of the role of active inquirer-participant. Emancipation involves evolution from illumination, discovery, and understanding of the client’s life patterning to new perceptions and visions of the wholeness of life.

UAI was specifically developed “to offer a method for researchers interested in generating and testing theories derived from [the SUHB]” (Cowling & Repede, 2010, p. 72). One can argue that using UAI is praxis at its best.

Dialogue

The remainder of this paper is adapted from a dialogue by the two authors at the 2010 Society of Rogerian Scholars conference, held in Boca Raton, Florida.

MRA Epiphany: As I worked on this paper, I made an effort to empathize with Martha Rogers about her nursing thoughts and ideas in a free thinking way. As I did that exercise, it struck me that she was a public health nurse who had learned much about aggregate patient data from her education and practice days in public health. This led me to wonder about her thinking, which arrived at a strong emphasis on a view of human beings as unitary and unique in light of her many community nursing experiences. I am fortunate to have had many personal conversations with Martha (like some others in the room today) but I wish I had asked her to talk about the contrast between the community health nursing perspective and her life work in the unitary perspective. It would have been a rich discussion.

JF: I owe a debt of gratitude to Martha Rogers and Margaret Newman, who taught me a way of thinking about research and practice that I have articulated in the form of conceptual-theoretical-empirical (CTE) structures. I owe a debt of gratitude to Martha Alligood, who has helped me to understand the connection between praxis and CTE structures.

Thus, I now understand that praxis contributes to the development of SUHB-guided CTE structures for research and practice (Fawcett, 2005; Fawcett & Garity, 2009). The components of CTE structures are a conceptual model (the C component), a middle-range theory that is generated or tested through research or refined in practice (the T component), and the empirical research or practice methods (the E component). The conceptual model is, of course, the SUHB. The middle-range theory is any phenomenon of interest to the nurse researcher or clinician. The empirical methods encompass the methodology of unitary appreciative inquiry.

MRA: Aristotle was concerned with the right estimation of the role of reason in moral action (Bernstein, 1983). The balance between reason
and action is an important consideration for Rogerian scholars with regard to nursing practice. Aristotle and those who have built on his ideas through the years have shined a light on his area of content (ethical, moral, or political) as well as the role of reason in moral action (Cody, 2006). His concern about the role of reason is one that Rogerian Scholars can relate to—not just the content of what he said but his structure of thinking about the meaning of human action. Praxis may be seen as a model of reason and action that has helped to move the SUHB to practical applications.

**JF:** More than four decades ago, in 1966, Martha Rogers explained the movement of her nursing science to applications in practice. She said, “Nursing’s story is a magnificent epic of service to humankind. It is about people: how they are born, and live and die; in health and in sickness; in joy and in sorrow.” She went on to tell us that nursing’s story is a mission of translating nursing knowledge into human service. Clearly, this is praxis.

**MRA:** In closing, I offer a quote from John Muir: “When one tugs at a single thing in nature, [s]he finds it attached to the rest of the world.”

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linkages and shifts in the evolution of praxis. *Nursing Philosophy, 5*(1), 54-66.


Educational Testing Service (ETS) http://www.ets.org/praxis


Gallup, http://www.gallup.com


SRS NEWS

PRESIDENT’S MESSAGE

EXPLORATIONS AND OPPORTUNITIES

The Society of Rogerian Scholars (SRS) proposes to foster an understanding and use of the Science of Unitary Human Beings (SUHB) as a basis for theory development, research, education, and practice. One of the ways we do this is through our conferences. In 2012, our conference entitled *Opportunities for Human Betterment: Exploring the Role of Unitary Science* contributed much to the purpose of our organization. The program was designed to disseminate nursing knowledge of unitary science and practice for human betterment through applications in research, practice, aesthetics, education, and leadership. We engaged in remembering, challenging, researching, considering and suggesting, educating, practicing, and preparing.

*Remembering* began when we remembered our former president, scholar, and friend, Fran Biley with healing energy and old fashioned hand written notes sent on to him. We learned that he was open to our energy and enjoyed receiving the loving notes; soon after the conference, he died with his family at his side surrounded in peace and love. At the conference we were *challenged* by Jacqueline Fawcett and Martha Raile Alligood to consider our own work in terms of the perspective that theories are evidence. The participants heard about *research* such as that presented by Dorothy Dunn (lived experience of unpaid caregivers of persons with mild dementia) and Danny Willis (exploring men’s healing from childhood maltreatment). Cowling asked us to *consider* the interconnectedness of three theoretical perspectives and Bramlett and colleagues suggested cultural relevance within the SUHB. *Educating* from the perspective of Arcari, Willis, and Flanagan provided fertile discussion about an emerging construct, living awareness. Joyce Perkins’ educating focused on expanding the perceptive ability of the nurse through a variety of ways of knowing. Sessions in the program focused on *practicing*. Smith and colleagues found evidence of pan-dimensional awareness in the stories of healing (self and other) as shared by nurse participants. Eckert-Norton told us about the labyrinth of care and how nurses practicing within an authentic nurse-person relationship can facilitate movement through the labyrinth of care. Finally we were *preparing*, Wright, Schneider, and Kramer provided a presentation on preparing for boardroom skill enhancement. Conference participants shared their stories of leadership. In summary, it was a wonderful conference with all seeking to discuss ways to contribute to nursing science for human betterment. The implications for the future relate to farther reaching dissemination, theory development, and exploring new constructs. Presenters and others who are working on projects...
may consider sharing their work in larger circles. Our own journal, *Visions* is one way to disseminate work. SRS scholars can consider the new perspectives on theory as evidence and be more explicit regarding theory development in their own work. Exploring new concepts and constructs is needed. One such construct was pandimensional nursing education. The conference was a real celebration of the SUHB and nursing science. We agreed to meet in New York City in 2013 to celebrate the 25th Anniversary of the SRS.

As we move forward to our 25th Anniversary, I invite you to reflect upon the purposes of the SRS and our strategic plan. We must renew our commitment to the plan and mobilize and capitalize on our tremendous resources so that our mission and vision can continue to be realized. One basic step is to remain connected and active in your membership. Please take the opportunity to renew your membership. I ask you to support the activities of our organization and to continue your great work toward human betterment. I hope to see you and your colleagues at the 25th Anniversary Conference in 2013.

Respectfully,

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

IN MEMORY:

It is with great sorrow that we say goodbye to two colleagues who have transitioned to other dimensions of being. Dr. Francis Biley and Dr. Julie Schorr will be greatly missed.

Remembering Francis Biley

Fran Biley was a long time member of the Society of Rogerian Scholars, serving as a board member and president of the Society. In addition he served on the editorial board of Visions, and as a reviewer. His unique perspectives were always thought provoking and inspired us to open our view of the world. The following Tribute to Fran Biley was written by Richard Cowling and was originally published in the Journal of Holistic Nursing. It is reprinted here with their permission.

A Tribute to Francis Biley

W Richard Cowling III, RN, PhD

Time is meaningless in the face of creativity. —Bill Owens, American Artist

That was the quote on the tee-shirt I wore that summer during the Rogerian Conference in New York City where I always enjoyed being with other folks who loved and respected the work of
Martha Rogers. Fran was a regular participant in all-things Rogerian. He traveled often from the United Kingdom to engage in spirited dialogues challenging us to be expansive and innovative in our thinking. Fran loved that tee-shirt so much that he ended up having one too. That phrase had special meaning for both of us who embraced so acceptingly the notion that time really was much more malleable than most would admit. It is especially poignant to me now as I learned only a very short time ago that Fran was ill. I let myself believe, in spite of his descriptions of the gravity of his condition, that Fran would be around for quite a bit longer in this physical world. Since his death, people asked me how old he was, and it is fitting, I suppose, that I do not know—that is also compatible with our shared beliefs about the meaninglessness of chronological age and the amount of clock time one had spent on Earth. I would say Fran was young—regardless of how many years he actually had lived. Fran was diagnosed with cancer in August and died peacefully in the presence of his most beloved on November 3, 2012.

Fran Biley was an editorial board member and an active reviewer for the Journal of Holistic Nursing. I relied heavily on Fran to review those manuscripts that were particularly “out-of-the-box” with the potential to push the boundaries of holistic nursing science and practice. Fran had a strong understanding and knowledge of what was credible and creative in the most profound sense. He was a strong proponent of divergence and expansion of knowledge in the service of humankind; that is to say, Fran sought to embrace the possibilities of broadening knowledge to include all the senses to understand the human condition. Art, music, images, photography, stories, and poetry were essential to deepen our understanding of nursing, those we served, and the pursuit of human betterment. This was reflected in his own work and in his appreciation and affirmation of others—those who were well-established and those who were beginning to shine. He was perfect for the Journal of Holistic Nursing because he embodied the aims and scope of the journal in his own work and his intellectual attraction to the integrative and innovative in the work of others.

Fran lived in a small village near Dorchester, England, enjoying countryside living, keeping his small woods for the benefit of wildlife and his young boys, woodturning as an expression of his exceptional creative connection to nature and a practice of mindfulness, and keeping chickens who were never to be eaten, only adored for what they had to give him and his family. Fran shared his life with his very lovely wife, Anna, and his two sons, Mathew Jack and James. Recently, 10-year-old James participated in a bicycling challenge benefit to raise
400 pounds for a local cancer trust. He described being inspired by his dad to do this while Fran was receiving chemotherapy at a clinic.

Professionally, Fran was a nurse, qualified in adult and mental health nursing, and employed by Bournemouth University as an associate professor in the Centre for Qualitative Research and as an adjunct professor, Seton Hall University, New Jersey, USA. He had specific interests in inventive methodologies such as historiography, autoethnography, unitary appreciative inquiry, and using the arts and humanities in health care. Fran was involved in the built care environment for clinical purposes, the service user movement in mental health and adult care, and mindfulness practice. He was particularly dedicated to supporting the work of graduate students who sought to explore deeper dimensions and broader understandings through unitary and holistic inquiries. He had many years of experience with establishing, leading, and teaching courses in countries as diverse as the United States, Wales, Germany, Greece, Sweden, and the Netherlands Antilles. Fran was also a Governor of Dorset County Hospital NHS Foundation Trust. Fran established the first university-accredited Therapeutic Touch modules in the United Kingdom.

Fran’s scholarship exemplified imaginativeness and expansiveness that is so in tune with the nature of human experience and well-being. An example of the type of scholarship that he created that pushed the boundaries of knowledge for practice was an article published in the Journal of Holistic Nursing, titled “My Life: My Encounters With Insanity,” which detailed his early practice experiences in mental health nursing, personally rejecting reductive-pharmacologic approaches in favor of more holistic ideologies focused on human-centered activities. He coauthored a book with similar themes that was described as having great benefit to those interested in the pedagogy of suffering. Additionally, it was noted that this book distinguished itself from others in the genre because its narratives were unmediated—not sanitized by professional, psychobiological, medical commentaries. Fran practiced this in his life—what you got from a relationship with Fran was certainly unmediated in the way he approached communications and relations—what you got was the pure and genuine honesty of his presence.

Fran translated his ideals and his theoretical leanings into action. He initiated a project called “Digging for Health” in which he took a community allotted, rundown, and overgrown space and returned it to a fully functioning and productive resource. It not only produces vegetables, it produces social capital. Fran and his team engaged with volunteers, primarily men in later life, many
retired, and who wished to become more involved in community life. By engaging in the development of the allotment activities, they also have an opportunity to avoid losing contact with friends and acquaintances. In addition, the men benefit from light exercise as part of recovery from an array of illnesses. This project enhances healthier communities by providing the means for these men to meet up with others and engage in meaningful, productive, social, and physical activity.

In a tribute on the Cardiff University website where he previously worked, it was said of Fran that he caused many staff and students to learn to think differently. In the best sense of the word Fran was a maverick; sometimes misunderstood, sometimes infuriating which he enjoyed being told with that chuckle of his, and challenging to those he knew, worked with and taught to consider the ways of the world and academia from different perspectives (http://www.cardiff.ac.uk/for/staff/obituaries/profiles/biley-francis.html)

Those few lines capture Fran’s unmediated, pure nature in relating to others. In the same way that Fran lived his intellectual, professional, scholarly life, he lived his personal life as well. He has caused his boys to think differently, also in the best sense of the word—and the world is, and will be, better for that.

One of Fran’s most extraordinary joys was the annual experience of the Glastonbury Festival of Contemporary Performing Arts that was initiated in the 1970s. It is a festival that takes place in Pilton, Somerset, England, featuring contemporary music as well as dance, comedy, theatre, circus, cabaret, and other arts. The festival retains vestiges of its hippie tradition such as the Green Fields area, which includes the Green Futures and Healing Field. The festival has grown in size since the 1970s, now attended by around 150,000 people experiencing performances in open air venues large and small. The majority of staff is volunteers, helping the festival to raise millions of pounds for good causes. The last time I visited Fran in England, he was basking in the afterglow of having come from that experience. Interestingly, there was no festival in 2012, but tickets are already being sold for the June 2013 event. Fran won’t need a ticket—I know he will be there again—dancing and laughing and cavorting freely in those healing fields.

—W. Richard Cowling III, RN, PhD

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The online version of this article can be found at: http://jhn.sagepub.com/content/31/1/4
Remembering Dr. Julie Schorr

Julie Kay Anderson Schorr, originally from Marquette Michigan, passed away on July 28, 2011. She received her BSN from Northern Michigan University and her Ph.D. in nursing from Wayne State University. She was on faculty at the schools of nursing at the University of Nevada, Reno and Northern Michigan University for many years. Dr. Schorr’s research and publications addressed the relationships between consciousness and health as well as perceived duration of time, perceived control, and perception of time. Additionally, Julie served as a reviewer for *Visions* for many years. She is survived by her husband, Robert Schorr of Supply, N.C and her daughter, Marisa Schorr, of Wilmington, NC.

Promotions and New Positions:

Dr. Martha Bramlett accepted a position as assistant professor at Pfeiffer University Department of Nursing in Misenheimer, North Carolina.

Dr. William Richard Cowling accepted the position of Vice President of Academic Affairs at Chamberlain College of Nursing.

Dr. Marlaine Smith, was appointed Dean & Helen K. Persson Eminent Scholar, Christine E. Lynn College of Nursing at Florida Atlantic University

Awards and Grants:

Dr. Sonya Hardin is one of nine health care researchers in the United States representing various disciplines selected by Stanford University School of Medicine to participate in a one year program on ethnogeriatrics. She will be focusing on the health care needs of elderly of diverse populations including their perceptions of home care robots.
SAVE-THE-DATE

Society of Rogerian Scholars
2013 ANNUAL CONFERENCE
Newman Conference Center, Baruch College
151 E. 25th Street, New York, NY
October 9-11, 2013 (Note: Wednesday to Friday)

Celebrating the 25th Anniversary of the
Society of Rogerian Scholars

Rhythms of Life:
The Symphony of Rogers’ Science of Unitary Human Beings

MER Scholars Fund Lectureship:
Founders’ Panel: John Phillips, RN; PhD; Elizabeth Barrett, RN; PhD;
FAAN, & Violet Malinski, RN; PhD
Keynote Speaker:
Pamela Reed, RN; PhD; FAAN
Call for Manuscripts

The editors of Visions are seeking manuscripts for future editions. Visions, a peer-reviewed, biannual publication that is indexed in CINAHL (Cumulative Index to Nursing and Allied Health Literature) is focused on content that reflects some aspect of Rogers’ Science of Unitary Human Beings (clinical practice, research, theoretical issues, etc.).

Organization of Manuscript:

1. Identification page (name, address, phone number, affiliation and professional title and running title, and email address.
2. Title page (no author identification.
3. Abstract followed by 3-4 key words for indexing.
5. Manuscript should be emailed to the editors or 4 hard copies may be mailed to the addresses below. Electronic copies are preferred:

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Call for Columns

The editors of the Columns are seeking columns of 1500 words or less for the future editions of Visions. Columns include: Innovations, Instrumentation/Methodology, Emerging Scholars, and Human-Environmental Field Patterning Practice. Selections for columns are editorial decisions. Only two copies need to be submitted by mail or please send by email to mhbramlett@gmail.com.

Call for Photographs

The editors are seeking photographs of Martha Rogers or other artwork for upcoming editions of the journal. Please send photographs to: mhbramlett@gmail.com or mail to Dr. Martha Bramlett, Society of Rogerian Scholars, College of Nursing, New York University, 246 Greene Street, 8th floor, NY, NY, 10003-6677. If you send actual photographs please DO NOT SEND your original. Send a copy of the photograph since we cannot promise to return them.
Call for News

The editors are always seeking news about members for inclusion in the SRS News section of the journal. This news can include publications, promotions, retirements, or significant life events. Please email any news to Dr. Martha Bramlett at mhbramlett@gmail.com or Dr. Howard Butcher at howard-butcher@uiowa.edu.

Call for Reviewers

The editors of Visions are seeking qualified individuals to serve on the panel of reviewers for manuscripts. Interested individuals should submit their resume to Dr. Martha Bramlett at mhbramlett@gmail.com or Dr. Howard Butcher at howard-butcher@uiowa.edu.

Call for Column Editors

The editors of Visions are seeking individuals to serve as column editors for the Practice Column and for the Media Review Column. The Practice Column highlights manuscripts that emphasize the utilization of the Science of Unitary Human Beings in practice environments. The Media Review Column highlights articles reviewing a variety of media including, but not limited to, print, audiovisual, and electronic media. Individuals interested in serving as column editors should contact Dr. Martha Bramlett at mhbramlett@gmail.com or Dr. Howard Butcher at howard-butcher@uiowa.edu.
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