The Caregiver's Experience of Deliberative Mutual Patterning with Pain-Ridden Substance Users

Gaile Hausaman Nellett

Loyola University Chicago

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DEDICATION

To my father, Edwin Edward Hausaman: a man who was born in the "old" country, who didn’t learn or speak English until he went to 1st grade, and who only graduated from 8th grade; yet he instilled in me a love of learning, never failing to ask me daily, from kindergarten through high school graduation, "What did you learn today?".

To my father-in-law, Chester Nellett, who asked me in 1989 what I wanted to do more than anything else in life. When I replied "Go back to school and get a doctorate in nursing", he said, "Well, what’s holding you back?".

To my husband, Henry Herman Nellett, who said to me in the Fall of 1991, "I’ll give you five years, go get it".

And here I am.
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ABSTRACT

The purpose of this research study was to expand nursing science through the investigation of the caregiver's experience of deliberative mutual patterning with pain-ridden substance users, thus providing knowledge enrichment through use of the science of unitary human beings (Rogers, 1970, 1980, 1987, 1990, 1992, 1994) as the theory-base. A qualitative descriptive exploratory research design with 15 participants was used. Data analysis-synthesis yielded summary statements for each objective in the language of the participants which were then transformed into themes in the language of the science of unitary human beings. These themes were synthesized into the hypothesis: The caregivers' experiences of deliberative mutual patterning with pain-ridden substance users manifest as innovative, unpredictable, and increasingly diverse field patternings of deeper understanding, clearer evaluation of impediments, and multiple promises, with a uniquely integral continuously supportive mutual process with arduous contradictions in irreversible lifestyle and worldview changes. The hypothesis answered the research question: What is the caregiver's experience of deliberative mutual patterning with pain-ridden substance users in relation to: mutual field patterning process; innovative,
unpredictable diversity; and continuously changing patterning?. The hypothesis generated from this study may be useful in application to nursing practice and future research, thereby expanding the theory-base and nursing science.
CHAPTER I

INTRODUCTION

During her many years in administration and management of psychiatric and substance abuse treatment services, the researcher has developed a strong interest in how nurses care for persons who are substance users and in pain. This strong interest has been fostered by her deep concern and regard for the well-being of patients and the processes that nurses experience. Throughout the process of reviewing the literature on nurses' attitudes toward substance use, substance abusers, and pain management aimed at substance users and abusers, as well as the process of investigating pain management in an Emergency Department, it became clear that pain management for substance users is often suboptimal (Coyle, 1989; Cross & Urbanski, 1994; Kemp, 1995; Koo, 1995; Lisson, 1989; McCaffery, 1991; Miller, 1994; Payne, 1989; Portenoy, 1989; Von Gunten & Von Roenn, 1994; Waldrop & Mandry, 1995).

Since the terms "substance abuse" and "substance abuser" are laden with negative connotations in the context of current thinking, the researcher has chosen to use "substance use" and "substance user" to be more congruent with acausal values. Nurses' attitudes, for the purpose of
this study, are conceptually defined as field pattern manifestations of the mutual process of human and environmental energy fields characterized by the nurses’ perceptions of the experience of caring for pain-ridden substance users. Field pattern manifestations are not viewed as either negative or positive, but rather as significant in the process of change (Rogers, 1992b). Nurses’ attitudes as field patterning change are in mutual process with field pattern manifestations of the others and their environments.

Some nurse researchers have studied the issue of the nurses’ perceptions of caring for substance users (Johnson, 1965; Long & Gelfand, 1995; Moody, 1971; Weschler & Rohman, 1982), while other researchers and authors have examined the manifestations of the nurses’ perceptions on the way pain is managed (Kemp, 1995; Koo, 1995; Lisson, 1989; McCaffery, 1991; Miller, 1994; Nash, Edwards, & Nebaurer, 1993; Pritchard, 1988; Ryan, Vortherms, & Ward, 1994; Taylor, Skelton, & Butcher, 1984; Von Gunten & Von Roenn, 1994; Wakefield, 1995; Waldrop & Mandry, 1995). While Cross and Urbanski (1994) reported on implications of nurses’ perceptions of pain management for substance users, nurses’ experiences of deliberative mutual patterning with substance users who are reporting pain have not been investigated in the nursing literature and minimal information regarding this phenomenon has been published.
The Phenomenon Of The Caregiver’s Experience Of

Deliberative Mutual Patterning With Pain-Ridden Substance Users

The phenomenon explored was the caregiver’s experience of deliberative mutual patterning with pain-ridden substance users. This phenomenon was expressed as a pattern manifestation emerging from the human-environmental field mutual process in continuously innovative diversity when the nurse is caring for a pain-ridden substance user. The deliberative mutual patterning of caregiver and substance user manifests in the nursing care delivered. Examples have shown that there is the potential for substance users to receive inadequate attention to their pain. To illustrate this, the following four examples illuminate how, in caring for patients identified as substance users, the nurse’s perception of the patient’s pain manifests in the care given.

In the first example, a young man recovering in the Intensive Care Unit (ICU) from an automobile accident that occurred while he was using drugs, told the nurse that he was in excruciating pain. The nurse questioned why the morphine injection given to him less than an hour previously was not keeping the pain at a tolerable level and she asked whether his pain was really "excruciating". In the second example, an AIDS patient, cared for by a Home Health nurse who was aware of his history of substance use, told her that he was experiencing a lot of pain; yet the nurse was not sure if he was "really in pain" or if he was simply
trying to get something to get "high". In a third example, as an Emergency Department (ED) patient grimaced in pain (with no pain relief measures offered), the nurse said to another healthcare worker, "He doesn’t need anything; he’s just a druggie and druggies don’t feel pain". In still another setting, the sickle-cell patient, being treated for an addiction problem, requested an injection for pain during an exacerbation of her illness; the nurse questioned, "Is she really in pain or is she just wanting more drugs?".

The preceding examples express several myths about pain and substance use, such as: the substance user needs the same dosage of pain medication as other persons; the caregiver can assess a patient’s pain better than the patient; substance users do not "really" experience pain; and providing a narcotic pain-reliever will contribute to a substance user’s habit. These myths play an adverse role in nurses’ assessment processes and, ultimately, the nurses’ delivery of pain care to substance users (Cross & Urbanski, 1994). It was this perceived concern, a question as to whether substance users were receiving adequate pain relief, that motivated the researcher to examine the phenomenon of the caregiver’s experience of deliberative mutual patterning with pain-ridden substance users, a phenomenon which has not been investigated.

Nursing Perspective

In the process of discussing qualitative research, Bunkers, Petardi,
Pilkington, and Walls (1996) suggest that the investigator must look at two areas when deciding what type of research is best to use: "(a) the specific question the investigator seeks to answer, and (b) the values and assumptions concerning the nature of reality and the nature of knowing held by the investigator" (p. 33). A researcher's worldview or paradigm guides the understanding of a phenomenon and directs the research question, thus the answers flow from that research question. Therefore, this research was guided by the nursing perspective of Rogers' (1970, 1980, 1987, 1988, 1990, 1992b, 1994b) science of unitary human beings which is congruent with the researcher's worldview and the research question.

The Science Of Unitary Human Beings

Rogers (1970) proposes that nursing is a basic science, and the human being, whom nursing strives to serve, is a unitary whole different from the sum of the parts, a unitary system which cannot be explained by a knowledge of parts. Rogers (1970, 1980) further describes the human field and the environmental field as two different energy fields in mutual process with each other, negating cause-and-effect processes. It is important to note that the environmental energy field for any given human
field also includes other human energy fields. Over the years, Rogers has refined and elaborated her initial exposition of the theoretical basis of nursing into the science of unitary human beings. Rogers (1970) was the first to propose a nursing science base with the human being and environment viewed in what is now called the simultaneity paradigm (Parse, 1987). The simultaneity paradigm, explicated by Parse in 1987, views humans as unitary beings in simultaneous, mutual process with the universe (Parse, 1987).

Existing within the simultaneity paradigm, Rogers’ (1990) science of unitary human beings is unique to nursing. Possessing postulates of energy fields, openness, pandimensionality, and pattern, the science of unitary human beings is consistent with the identity of nursing as a science (Rogers, 1992b, 1994b). The unitary human being, or human field, is "an irreducible, indivisible, pandimensional energy field identified by pattern and manifesting characteristics that are specific to the whole and which cannot be predicted from knowledge of the parts" (Rogers, 1992b, p. 29). Energy fields are "the fundamental unit of the living and the non-living. Field is a unifying concept. Energy signifies the dynamic nature of the field. A field is in continuous motion and is infinite" (p. 29). Openness reflects acausality and specifies continuously open energy fields which are integral with one another in continuously innovative and creative change (Rogers, 1992b). Pandimensionality is a way of perceiving reality,
expressing the idea of a unitary whole as "a non-linear domain without spatial or temporal attributes" (p. 29). Environment, or environmental field, is "an irreducible, pandimensional energy field identified by pattern and integral with the human field" (p. 29). Pattern is defined as "the distinguishing characteristic of an energy field perceived as a single wave" (p. 29). It is an identifying abstraction, not directly observable, that gives identity to a continuously changing energy field. Observable events in the ordinary world are manifestations of field patterning (Rogers, 1992b).

Expressed as manifestations of the mutual process, caregivers' deliberative mutual patterning experiences with pain-ridden substance users are examined through the principles of homeodynamics, namely integrality, helicy, and resonancy (Rogers, 1970, 1990, 1992b). Continuous change is considered the unifying concept in these principles, even though the principles are mutually exclusive (Barrett, 1988). It is the goal of nurses to participate in this process of change for the benefit of humankind (Rogers, 1988).

**Integrality**

Integrality "is the continuous mutual human field and environmental field process" (Rogers, 1992b, p. 31). The caregivers' experiences with pain-ridden substance users as field patterning reflect the integralness of energy fields in mutual process, with the manifestations of mutual field
patterning revealing the integrality of both fields. The human energy field and the environmental energy field are integral with one another while being different by definition (Rogers, 1980); thus, changes in the patterning of one will manifest changes in the patterning of the other. Examining the phenomenon of caregivers’ experiences of deliberative mutual patterning with pain-ridden substance users is a way of investigating the continuous changes in the pattern manifestations of the caregivers that have evolved through this mutual process. Integrality "provides a key to understanding human feelings, thoughts, and actions" (Horvath, 1994, p. 164). Obtaining descriptions by caregivers on their field manifestations as emergents from the continuous deliberative mutual patterning, and examining those manifestations within the science of unitary human beings, will assist in the clarification of nursing knowledge concerning this continuous process.

**Helicy**

While the principle of integrality disavows causality in the universe, thus affirming the continuous mutual human field and environmental field process, the principle of helicy specifies that there are creative and unpredictable outcomes of change (Rogers, 1992b). The human and environmental fields change together in mutual process; thus these changes are not an adaptational adjustment to the others’ field. The
creative and unpredictable outcomes of change described in the knowledge-based nursing care provided by caregivers of pain-ridden substance users, may be manifested as field patterning that is substantiated through currently identified major health concerns about substance use (Cross & Urbanski, 1994; Kopstein, 1992; Rassool, 1996; U.S. Bureau of the Census, 1995).

Helicy "is the continuous, innovative, unpredictable, increasing diversity of human and environmental energy fields" (Rogers, 1992b, p. 31). This continuous unpredictable change surfaces out of nonequilibrium and is rapidly, not gradually, accelerating (Rogers, 1992b), with change postulated as a process of emergence. The caregivers' experiences of deliberative mutual patterning with pain-ridden substance users are viewed as field pattern manifestations reflecting innovative, unpredictable, and increasing diversity. These manifestations are revealed as the innovatively diverse patternings of caregivers' experiences of integral, evolutionary emergence, through the continuous mutual process. The increasingly diverse patterning of caregivers' experiences of deliberative mutual patterning with pain-ridden substance users, reflects the openness of human and environmental energy fields in mutual process, revealing changes manifested through choices, freedom, humanness, and individually innovative wholeness.
Resonancy

Resonancy is "the continuous change from lower to higher frequency wave patterns in human and environmental energy fields" (Rogers, 1992b, p. 31). The caregivers' experiences of deliberative mutual patterning with pain-ridden substance users in their continuously changing life process can be examined in light of resonancy. "The whole of [the human] senses, feels, perceives, and reasons" (Rogers, 1970, p. 101) in a continually resonating and changing wave patterning with the environmental energy field. The mutual process of one's energy field with the environmental energy field's ebb and flow of events manifests this continuous change in unique ways (Rogers, 1992a, 1992b). The history of human beings is replete with manifestations of human energy fields resonating with environmental energy fields. These are revealed as societal value changes and cultural acceptance or the sanctioning of substance use choice variations, methods, and innovations (Musto, 1987, 1989, 1991). The caregivers' experiences of deliberative mutual patterning, with pain-ridden substance users whose wave frequency patterning may be chaotic and intensely turbulent, may or may not manifest similar continuous wave frequency patterning changes. As these wave frequency patterns evolve, the caregivers' desires, feelings, values, and perceptions resonate with the pain-ridden substance users' desires, feelings, values, and perceptions, manifesting as continuously changing life processes.
Research Objectives

The three objectives in this study, which flow from Rogers' (1992b, 1994b) science of unitary human beings, reflect the principles of homeodynamics: integrality, helicy, and resonancy. They are:

1. To describe the caregivers' experiences of deliberative mutual patterning with pain-ridden substance users as a field patterning process;

2. To describe the caregivers' experiences of deliberative mutual patterning with pain-ridden substance users as manifesting innovative, unpredictable, and increasing diversity; and

3. To describe the caregivers' experiences of deliberative mutual patterning with pain-ridden substance users in continuously changing irreversible life processes.

Purpose Of This Study

The purpose of this study was to expand nursing science through the investigation of the caregiver's experience of deliberative mutual patterning with pain-ridden substance users, thus providing knowledge enrichment related to the science of unitary human beings. Rogers (1970) asserts that further understanding of the human being in mutual process with the environment is derived from basic research in nursing directed toward advancing nursing science knowledge. "There must be an advance
before there can be application" (p. 103); thus, it is understood that applied research, used in practice, must be underwritten by basic research. Although "science is concerned with meanings rather than facts" (Rogers, 1970, p. 83), it is also concerned with the formulation of meaningful propositions and hypotheses, and as such, is a repository of experiential observations to enrich and expand nursing knowledge and practice (Rogers, 1970).

Investigating the caregivers' experiences of deliberative mutual patterning with pain-ridden substance users provided additional affirmation of nursing as a science with principles and theories. Substance use may have profound adverse resonation with other pattern manifestations of field change (Compton, 1989), both human and environmental, including that of the caregiver. The investigation of the caregivers' experiences of deliberative mutual patterning with pain-ridden substance users by nurse scientists then, provides knowledge to enhance nursing science and to guide the practice of nursing.

**Research Question**

What is the caregiver's experience of deliberative mutual patterning with pain-ridden substance users in relation to: mutual field patterning process; innovative, unpredictable diversity; and continuously changing patterning?
Significance Of The Phenomenon Of The Caregiver's Experience Of Deliberative Mutual Patterning With Pain-Ridden Substance Users

According to Rogers (1987), "research in nursing is the study of unitary human beings and their environments" (p. 140). This study expands the science of unitary humans through the investigation of caregivers' experiences of deliberative mutual patterning with pain-ridden substance users. It yields descriptions by caregivers of what the experience of caring for pain-ridden substance users is like.

Caregivers' perceptions, thoughts, and feelings manifest in ways that reflect mutual process with substance users. The use of substances (drugs and alcohol) has been a significant social and health field pattern manifestation in the last part of the 20th Century and promises to continue at the forefront in the 21st Century (Kopstein, 1992; Rassool, 1996; U.S. Bureau of the Census, 1995). The deliberative mutual patterning of caregivers and pain-ridden substance users reflects the nature of change which is "unpredictable and increasingly diverse" (Rogers, 1992b, p. 31). While caring for substance users in pain has been problematic for nurses (Cross, & Urbanski, 1994), scant, if any, research concerning the caregiver's experience of deliberative mutual patterning with pain-ridden substance users has been completed, although there is an abundance of published nursing literature regarding substance use, substance users, and pain management as separate issues. Investigating this phenomenon...
assists in the explication of the deliberative mutual patterning of caregivers and pain-ridden substance users.

Using Rogers' (1987, 1988, 1990, 1992b, 1994b) science of unitary human beings as the nursing framework for this proposed study contributes to the expansion of nursing science, by providing a means to further the ongoing discovery of nursing knowledge. Rogers (1994b) believes that as nursing moves into the future "we are going to have to look at what it is that people need and where is the role of nursing in providing it" (p. 35). "The science of unitary human beings provides the knowledge for imaginative and creative promotion of the well-being of all people" (p. 35). Increased knowledge of the manifestations of the caregiver's experience of deliberative mutual patterning with pain-ridden substance users assists caregivers in providing care that facilitates appropriate pain relief.

Summary

The phenomenon introduced in this chapter is the caregiver's experience of deliberative mutual patterning with pain-ridden substance users. Both the purpose and significance of the study were explained explicitly. The science of unitary human beings (Rogers, 1970, 1987, 1988, 1990, 1992b, 1994b) which underpins the nursing perspective was presented as were the research objectives which flow from the
homeodymanic principles of that science. The next chapter focuses on critically reviewing the extant literature from various disciplines relevant to this phenomenon.
CHAPTER II

REVIEW OF RELEVANT LITERATURE

A broad multidisciplinary review of relevant literature laid the groundwork for studying the phenomenon of the caregiver's experience of deliberative mutual patterning with pain-ridden substance users. Fruits of this review, from change, mutual process, deliberative mutual patterning, and substance use and pain literature, are examined in this chapter, along with literature on the Rogerian perspective of care and caring. Because the term "care" is used in the data collection guide questions which flow from the objectives derived from the homeodynamic principles, it is important to assure that care is used congruently with the theoretical base of this investigation.

Change

As noted in chapter one of this dissertation, continuous change is considered the unifying concept of the homeodynamic principles (Barrett, 1988). The goal of nurses is to participate in this process of change for the benefit of humankind (Rogers, 1988). The Random House Dictionary of the English Language (1987) defines the term "change" as either a noun
or a verb. Change, the noun, is defined as "... act or fact of changing; fact of being changed ... a transformation or modification; alteration ... " (p. 344), while change, the verb, is defined as "... to make the form, nature, content, etc. of (something) different from what it would be if left alone ... to transform or convert ... to become different ... " (p. 344). Although linearity is a problem in both definitions, the definitions, "to transform" and "to become different", are most congruent with the science of unitary human beings. Thus, change is used in this study as a continuous, dynamic process of transformation manifested in the homeodynamic principles.

The concept of change has been rigorously discussed in both Western and Eastern cultures. The majority of Western literature on change is based upon the Enlightenment tradition, focusing on Lewin’s (1951) model of change, and is consistent with that worldview (Marshak, 1993; Tarnas, 1991). Lewin’s model consists of three stages: unfreezing, moving, and refreezing; and is based upon the following assumptions as described by Marshak (1993). Change is linear, moving forward through time; change is also progressive, moving forward from a lesser to a greater state. Change is destination or goal oriented, moving forward to achieve a set goal; it is based upon the creation of disequilibrium, as in the unfreezing phase that alters the force field. Change is planned and managed by people who exist separate from and act to achieve their goals. Change is
unusual; everything is normally in a static state and "unless something is done proactively, things tend to stay in the same place or condition" (Marshak, 1993, p. 401).

Interestingly, Greek philosophers have differed in their views of change. Parmenides (c. 510-450 B.C., as cited in Mahoney, 1991) asserted that there is no change in either humans or the universe, while his contemporary, Heraclitus (c. 535-475 B.C., as cited in Mahoney, 1991), argued that stability and permanence are illusory, that humans and the universe are continually changing, and that everything is in constant flux. Heraclitus' view tends more towards the eastern philosophy of change (Lee, 1994); he posed the paradox that "one cannot step into the same river twice" (as cited in Mahoney, 1991, p. 9).

Change, as viewed in the Eastern literature, is fundamental to existence (Lee, 1994; Marshak, 1993; Wilhelm, 1973; Wilhelm & Wilhelm, 1995). Confucian and Taoist models are based on the following assumptions as described by Marshak (1993). Change is cyclical with a constant ebb and flow to the universe. Change is processional, constantly moving from one condition to the next in an orderly sequence. Change is journey-oriented, following the right path or "Way". Change is based on maintaining or restoring equilibrium or balance, naturally, harmoniously, perfectly, since everything in the universe is in flux. Change is "observed and followed by people who are one with everything and must act correctly
to maintain harmony in the universe" (Marshak, 1993, p. 401), constantly striving to be in harmony with the natural order of the universe. The last assumption is that change is "usual, because everything is normally in a continuously changing dynamic state" (Marshak, 1993, p. 402); change is the continual process of everything in the universe (Marshak, 1993).

"Thus being long lasting does not mean being in a fixed and definite state. Being fixed and definite, a thing can not last long. The way to be constant is to change according to the circumstances" (Ch‘eng I, as cited in Chan, 1963, p. 571).

Prominent in the Eastern view is the I Ching, a book about change; the character "I" means "change" in the Chinese language, while "Ching" means "classic" or "book" (Lee, 1994; Wilhelm, 1973; Wilhelm & Wilhelm, 1995). The I Ching depicts the universe as a dynamic whole with change being the key to understanding the cosmos (Lee, 1994). Change is understood as the power that transforms and guides the universe (Lee, 1994).

While both the Western and Eastern views of change are interesting and have their place in science and philosophy, Rogers' (1988, 1990, 1992b) view of change is different and unique to the science of unitary human beings. "The nature of change is unpredictable and increasingly diverse (Rogers, 1990, p.9); it is relative (Rogers, 1990). The nature and direction of change is described through manifestations of patterning:
"There is continuous change from lower to higher frequency wave patterns in human and environmental fields" (Rogers, 1990, p. 8). The direction of change, which is tied in with the homeodynamic principles, is not meant in a linear way, but rather as a means of representing growing diversity in field patterning (Rogers, 1988). Continuous and unpredictable change surfaces out of nonequilibrium with change postulated as a process of emergence (Rogers, 1992b). Wave frequency patterning evolves as continuously changing life processes.

**Mutual Process Literature**

Although a dictionary definition of mutual process as a single term was not found, mutual and process as separate definitions were located. Mutual means "... possessed, experienced, performed, etc., by each of two or more with respect to the other or others; reciprocal" (Random House Webster's College Dictionary, 1995, p. 893; The Random House Dictionary of the English Language, 1987, p. 1270). "Mutual indicates an exchange of a feeling, obligation, etc., between two or more people, or an interchange of some kind between persons" (The Random House Dictionary of the English Language, 1987, p. 1270). Process is defined as "... a continuous action, operation, or series of changes taking place in a definite manner" (Random House Webster's College Dictionary, 1995, p. 1075; The Random House Dictionary of the English Language, 1987, p. 1542).
While combining the two definitions does not truly express the meaning of mutual process as it has emerged from the science of unitary human beings, certain points of each definition do describe aspects of mutual process. For example: it is "experienced" by two or more in respect to the other or others (although they may be unaware of it occurring); it is reciprocal (or reciprocity); and it is a continuous change. "The mutual process of human and environmental energy fields is a continual process of dynamic, subtle action" (Hanchett, 1997, p. 107).

A rigorous search uncovered published literature about mutual process only in the nursing discipline, specifically, in literature concerning the science of unitary human beings. The concept of mutual process has evolved from 1970, when Rogers initially used the terms mutual interaction, mutual simultaneous interaction, and mutual change. By 1980, the concepts, mutual interaction, and mutual change, within the context of the science of unitary human beings, are described in this way: "Unitary man and his environment are in continuous, mutual, interaction, evolving toward increased differentiation and diversity of field pattern and organization. Change is always innovative" (Rogers, 1980, p. 333). Rogers first uses the term mutual process in 1983, referring to the process from which human and environmental field pattern manifestations emerge; this usage has continued through her writings of 1986, 1990, 1992b, and 1994b.
Rawnsley (1985) uses the concept and process of "conceptual motion" to provide an interpretation of healing logically consistent with the science of unitary human beings. A technique (behavior) or field pattern manifestation of healthcare workers (healers), therapeutic use of self, is interpreted "as the directed involvement of the field patterns or healing behaviors of a professional in continuous mutual process with clients" (p. 26). Rawnsley uses the homeodynamic principles to explain the intent of healing behaviors in these ways: through helicy, "the nature and direction of healing patterns are toward harmony of human and environmental fields" (Rawnsley, 1985, p. 26). Although Rawnsley uses the term "harmony," Rogers does not use harmony since she believes it represents a value judgment and prefers to simply say diversity (E. A. M. Barrett, personal communication, July 30, 1997). Resonancy describes the "field motion toward harmony and health as the continuous change of wave pattern from lower to higher frequency" (Rawnsley, 1985, p. 26), while the continuous mutual process, integrality, focuses "on field patterns that can be logically explained as facilitating motion toward harmony of human and environmental fields" (p. 26).

A lack of clarity regarding mutual process surfaces in the literature; at times, mutual process, as it relates to all three homeodynamic principles, becomes "blurred" with, or veiled by, the homeodynamic principal of integrality which "is the continuous mutual human field and environmental
field process" (Rogers, 1992b). For instance, Compton (1989), in the course of writing about drug abuse and implications for nursing through her interpretation of a Rogerian perspective, suggests that integrality describes the mutual process of change while helicy asserts the characteristics of mutual process occurring between energy fields. Manifestations of the mutual process are described as "different interconnections" (p. 101) with the environmental energy field. Helicy is more clearly explained as asserting the characteristics of field patterning occurring in the mutual process between energy fields. The term, different interconnections, is incongruent with the science of unitary human beings, implying particulate separations that are connective. Compton (1989) further suggests that by "utilizing Rogers' principle of integrality, one would expect to find increased diversity in both the drug user and the environmental fields with the mutual process" (p. 101). Perhaps the principle of helicy would better clarify the diversity issue. Continuous change is the unifying concept subsuming the three homeodynamic principles (Barrett, 1988).

Research Issues Of Mutual Process

To study human and environmental fields in mutual process, research methods must be consistent with the science of unitary human beings (Rogers, 1992b). Although the development of tools reflecting the unitary and irreducible nature of human beings as expressed by the science of
unitary human beings has been a challenging dilemma, at least ten authors have created and used research instruments to measure different manifestations of the pattern of human-environmental mutual process. These instruments measure a wide range of mutual process pattern manifestations. Some of these tools have been utilized by other researchers in subsequent investigations, and in at least one instance, was the impetus for creation of another instrument (Gueldner, 1986).

The first tool was developed by Ference (1979, 1986). Ference created the Human Field Motion Tool (HFMT) in 1978, specifically as an indicator of the human energy field which was understood to be four-dimensional, and to measure the principle of resonancy (H. M. Ference, personal communication, September, 15, 1997). At that time, the human energy field was postulated to be four dimensional (Rogers, 1980). The human energy field correlates positively with other indicators to confirm the direction of the human field wave form that substantiated Rogers' principle of resonancy (H. M. Ference, personal communication, September 15, 1997). Ference developed the HFMT for her doctoral research, pilot testing it with N = 43 subjects. The HFMT consists of 23 scales (Osgood & Suci, 1955; Osgood, Suci, & Tannenbaum, 1957), and nine additional bi-polar words regarding wave frequency taken from Rogers' (1977) postulated correlates of unitary human development (Ference, 1986). Face validity was confirmed by five judges, and also by the relative direction of
the bi-polar descriptors (Ference, 1986). Four per cent of the items were measured to establish the item re-test reliability of 0.77, and internal consistency for the scales, by concept, was determined (Ference, 1986). Although two concepts, "my motor is running" (MR) and "my field expansion" (FE), and 13 scales were retained to measure human field motion, a total of 20 independent scales resulted because some scales were rated on both concepts (Ference, 1986).

The HFMT was used, with a sample of $N = 216$, to study the Rogerian construct of human synergistic development (Ference, 1986). For the purpose of this study, Ference (1986) defined human synergistic development "... as the interrelated sets of time experience, differentiation, and creativity traits. These indices were specified from Rogers' proposed correlates that development is in the direction of (1) time racing, (2) more differentiation, and (3) more imagination" (p. 99). In addition to the HFMT, the author used three existing tools, which were logically revalidated, to measure time experience, differentiation, and creativity as theoretically defined through the science of unitary human beings. The Knapp and Garbutt (1958) Time Metaphor Test measured time experience as the perception of time passing. Witkin, Oltman, Raskin, and Karp's Group Embedded Figures Test (1971) measured differentiation as increasing complexity, diversity, and heterogeneity, which correlates closely with Rogers' use of differentiation (Ference, 1986). Creativity
traits as attributes of a creative person were measured by a 19-adjective scale derived by Domino (1970) from the Adjective Check List (Gough & Heilbrun, 1965).

Factor analysis was used to analyze the HFMT in the main study (Ference, 1986). Three factors emerged, as is typical when the measurement tool is a semantic differential type; each scale loaded on at least one factor (Ference, 1986). Factor analysis provided factorial validity for the HFMT, demonstrating support of the principle of resonancy (Ference, 1986). Item re-test reliability of the HFMT was 0.70 for this study (Ference, 1986). While "part-whole correlations of each scale ranged from 0.51 to 0.77, ... correlation of the score of each concept to the total test score is 0.87 for both concepts of 'my motor is running' and 'my field expansion'" (Ference, 1986, p. 99). The HFMT was subsequently used by at least three authors (Barrett, 1983, 1986; Benedict & Burge, 1990; Gueldner, 1986) for their investigations.

Barrett (1983, 1986) investigated the principle of helicy by testing the relationship between human field motion and power. The HFMT was used to measure direction of change while the Power-as-Knowing-Participation-in-Change Tool (PKPCT) was developed and validated to measure the nature of change. The PKPCT, which measures or describes the way humans in mutual process with their environment actualize some potentials for unitary change (Barrett, 1990a), operationalized four human
field pattern manifestations of power: awareness; choices; freedom to act intentionally; and involvement in creating change.

Two judges’ studies, with judges knowledgeable in the science of unitary human beings, were conducted using a different three-part form for each study (Barrett, 1986). Semantic differential technique, utilizing the results of nine judges’ ratings, was used to construct the power measure for the pilot study, N = 266 (Barrett, 1986). The pilot power measure was composed of four concepts: field behaviors characterizing power; three contexts representing the human and environmental energy fields; and 24 scales which were bipolar adjective descriptors specifying field behaviors characterizing power, and which also included re-test reliability items (Barrett, 1986). In the pilot study, the human field motion concepts of MR and FE, first factor analyzed together, loaded on different factors, thereby providing evidence of construct validity (Barrett, 1986). MR and FE were then factored separately with the resultant scores providing the basis for a new scoring method for the HFMT (Barrett, 1986). Reliability (variances of the factor scores) ranged from 0.55 to 0.99 for the PKPCT and 0.69 to 0.81 for the HFMT, while reliability, as item re-test, extended from 0.60 to 0.90 for the PKPCT and 0.70 to 0.82 for the HFMT (Barrett, 1986). PKPCT validity coefficients varied from 0.57 to 0.78, while the HFMT range was 0.42 to 0.79 (Barrett, 1986).

Results from Barrett’s (1983) main study, N = 625, also supported
the theoretical position that MR and FE are two different concepts in human field motion. Reliability, as variance of the factor scores, ranged from 0.43 to 0.87, while reliability as item re-test was 0.73 for FE and 0.82 for MR (Barrett, 1986). Reliability for the four concept-contexts of power ranged from 0.63 to 0.99 (Barrett, 1986). Validity coefficients (factor loadings for power) ranged from 0.56 to 0.70 (Barrett, 1986). Power generalized across contexts (self, family, occupation) with a similarity of factor structures and congruence coefficients at 0.99 (Barrett, 1986). Barrett (1986) considered that power generalizing across contexts empirically demonstrates and verifies Rogers' principle that human (operationalized by self) and environmental (operationalized by family and occupation) energy fields are integral with each other. The PKPCT has been used in studies by several other researchers (Barrett & Caroselli, 1998; Bramlett & Gueldner, 1993; Caroselli, 1991, 1995; Caroselli & Barrett, 1998; Dzurec, 1994; Trangenstein, 1988; Woods-Smith, 1995; Wynd, 1992). Results obtained by Sullivan-Smith (1995) from a qualitative study of power among persons who had and had not participated in a cardiac rehabilitation program, revealed themes which supported Barrett's four dimensions of power.

Paletta (1990) investigated temporal patterning, developing an instrument "to measure the concept of temporal experience as a pattern representative of the developmental process of unitary human beings" (p.
Temporal experience was developed within the framework of human and environmental field process" (p. 240), recognizing the perception of time awareness as evolving continuous mutual process. The Temporal Experience Scales (TES) demonstrate validity and reliability within the Rogerian framework (Paletta, 1990). Validity was established by expert evaluation (face validity) of the tool, expert judges' ratings of metaphors according to wave frequency, item classification into patterns by judges' mean item scores, and "validation of the classification of the items included in each pattern by Dr. Rogers" (p. 243). Conceptual correlation of item analysis of total items was found by principle factors analysis (Paletta, 1990). While reliability for the TES was not delineated in any detail, it was suggested by the following statement: "The TES showed validity within Rogers' conceptual framework and had acceptable reliability" (p. 244).

Yarcheski and Mahon (1991) used six instruments, two of which were created specifically for this study, to examine what they called Rogers' "original (1980) and revised (1986) theory of correlates" in adolescents. According to the authors, "Rogers' (1980) original theory implied that as individuals evolved in the life process their correlates changed in the direction from lower to higher frequency according to their stage of human development" (p. 453). "Rogers' revised theory ... suggested that correlates manifested by a younger person could be of the
same relative frequency as those of an older person or vice versa" (p. 454).
Correlates, a term later replaced with manifestations of human patterning, emerge from the human field-environmental field mutual process (Rogers, 1986). The intent of the study was to determine whether what the authors called the original theory or the revised theory was more useful in advancing the science of unitary human beings. One of the two tools created for this study was the Perceived Field Motion (PFM) scale, a semantic differential scale, which measured perceived field motion. The second tool, the Human Field Rhythms (HFR), measured human field rhythms using a visual analogue instrument.

Three samples consisting of $N = 116$ each, one from early adolescents (12-14 years, $M = 13.01$, $SD = .64$), one from middle adolescents (15-17 years, $M = 15.99$, $SD = .80$), and the last from older adolescents (18-21 years, $M = 20.03$, $SD = .92$), were utilized to test the original theory, while a fourth sample of combined age adolescents ($N = 89$, 12-21 years, $M = 16.49$, $SD = 3.02$) was used to test the revised theory. The authors reported that data supported the original theory but not the revised theory, with results, as interpreted by the authors, suggesting that "human development, as indexed by chronological age, plays some indeterminant role in the emergence of the correlates. Thus, the deletion of terms and ideas from Rogers' conceptual system that imply linearity, such as human development, may have been premature" (Yarcheski & Mahon,
There are methodological as well as theoretical concerns regarding the Yarcheski and Mahon (1991) study. Methodological concerns centered on the ability of the measurement techniques to capture the unitary perspective of the correlates in the intended age group and the suitability of the instrument for the intended age group. However, overall reliability and validity was assumed from references to experts on general semantic differential scales (Yarcheski & Mahon, 1991); this is a major problem. While semantic differential scales may have been an appropriate tool to adequately measure the concepts in this study, the researchers are responsible for using appropriate tests to establish the reliability and validity. Sample selection appeared to be skewed; a total of \( N = 348 \) was utilized to test the original theory while only \( N = 89 \) were used to test the revised theory.

The actual design utilized for Yarcheski and Mahon's (1991) study was not mentioned except to call it "innovative". If the purpose of the design was to capture changes in adolescents, a longitudinal design may have been more appropriate to measure actual changes in the adolescents. Is it accurate to suppose that each of the samples would have changed and evolved in the same pattern and frequency? Rogers (1980) postulated that "the nature and direction of human and environmental change is continuously innovative, probabalistic, and characterized by increasing
diversity of human field and environmental field pattern ... manifesting continuous change from lower-frequency, longer wave patterns to higher-frequency, shorter wave patterns" (p. 333).

Theoretical concerns in this study are significant, centering on Yarcheski and Mahon's (1991) interpretation of Rogers' writings. The correlates were called Rhythmical Correlates of Change (Rogers, 1980) and Correlates of Patterning (Rogers, 1986); they were never called a theory as indicated by Yarcheski and Mahon. Rogers (1980) stresses that human field rhythms are manifestations of the whole and "are not to be confused with biologic rhythms or psychologic rhythms or similar particulate phenomena" (p. 335) even while referring to rhythmical developmental processes and evolutionary development. Rogers stopped using the term, human development, replacing it with unitary change, while proposing that chronological age was not an index of unitary change (E. A. M. Barrett, personal communication, July 30, 1997). In 1986, Rogers explains the correlates in this way:

Originally these were correlates of human development. Well, that didn't fit, because development implies certain kinds of linearity. These are now talked about as correlates of patterning; it's nonlinear change. Nonrepeating rhythmicities are similarities, never the same, but they can give us clues. ... Chronological age is not a useful tool for predicting in this system. Correlates are just manifestations that are integral with the growing diversity of pattern that I refer to as higher frequency. ... Correlates are manifestations of field. ... There are findings that support the postulated direction of change. Rhythms have picked up. As I said, these are manifestations of patterning, of this growing diversity" (pp. 11-12).
In her qualitative descriptive investigation of the human-environmental mutual process as manifested through the healing relationship between nurse and client, Carboni (1992) developed the Mutual Exploration of the Healing Human Field-Environmental Field Relationship instrument. Carboni defines the phenomenon of the human field-environmental field relationship as: "a matrix of non-repeating and rhythmic unpredictable potentialities of energy field patterns in continuous flux reflecting the nature of the person-environment relationship" (pp. 136-137). The mutual exploration of the healing human field-environmental field relationship instrument, "designed to capture the changing configurations of energy field patterns of the healing human field-environmental field relationship in order to provide data useful for identifying and understanding " (p. 137) the phenomenon, searches for "a holistic view of the nurse-client relationship" (p.138), and purports to reflect unitary indices of energy field patterns of this relationship.

Carboni (1992) describes a "particle-wave nature" (p.138) to the human field-environmental field pattern, with the particle being the "individual" energy field of each individual and the wave being the "mutual energy fields of individuals in mutual process" (p. 138). Carboni further posits that "the healing human field-environmental field relationship thus requires a cooperative relationship between nurse and client, both cooperating with each other and with the environment in which they are
immersed" (p. 139). At least two major questions arise from this study. First of all, are the notions of particle-wave nature and the requirement of a cooperative relationship between the persons involved with the environment, congruent with mutual process in the science of unitary human beings? Secondly, is the idea of a nurse-client relationship congruent with mutual process in the science of unitary human beings?

Identifying the empirical manifestations of the process of change in the evolution of the potentials of the human life process was the impetus for Hastings-Tolsma's (1992) Diversity of Human Field Pattern Scale (DHFPS). After a pilot study, \( N = 320 \), alpha reliability coefficient of .83, and reliability and validity testing (Hastings-Tolsma, 1996), a main study, \( N = 173 \), confirmed a unitary factor through factor analysis, with an alpha coefficient of .81 (Watson, Barrett, Hastings-Tolsma, Johnston, & Gueldner, 1997). Additional testing is being done to support construct validity and provide evidence of other variables related to diversity of the human field pattern (Hastings-Tolsma, 1996).

When Gueldner (1986) utilized the HFMT to study elderly persons, problems were encountered centering around the understanding of terminology by persons with low level educational preparation and their need for assistance in recording the written responses. The HFMT (Ference, 1979, 1986) was not designed for use with this type of population. In response to those problems, the Index of Field Energy (IFE)
was created by Gueldner (1993). The IFE is a pictorial tool that can be used for both older adults and adults who read below a high school level (Watson, Barrett, Hastings-Tolsma, Johnston, & Gueldner, 1997). As development of the instrument progressed, it was found to correlate strongly with the HFMT (.67), the HFIMS (.66), and the PKPCT (.78); thus, "this instrument is now available as a general and user-friendly ‘glimpse’ into selected manifestations of human field pattern" (Gueldner, Bramlett, Johnston, & Guille, 1996, p. 6). Psychometric testing on two samples, N = 278 and N = 357, established a reliability coefficient of .95.

Initially, Johnston (1994), wanted to devise an instrument "to measure self-esteem, as a self perception concept, for use with elderly research participants" (Watson et al., 1997, p. 93). However, after realizing that self-esteem was too particulate to measure within the science of unitary human beings, Johnston (1994) created the Human Field Image Metaphor Scale (HFIMS) to measure perceived potential and integrality of human field image. Human field image, considered as one manifestation of the human-environmental energy field mutual process (Phillips, 1990) "was defined as an individual awareness of the infinite wholeness of the human field" (Johnston, 1994, p. 7). The HFIMS was pilot tested, N = 50, and then tested with a convenience sample, N = 358, of healthy adults between the ages of 18 and 85. The final scale, with a Cronbach’s alpha reliability coefficient of .91, had a correlation of .71 with the IFE (Gueldner, 1993),
indicating HFIMS as a reliable and valid instrument that is grounded as well as developed within the science of unitary human beings (Johnston, 1994).

Leddy (1995) developed the Person-Environment Participation Scale (PEPS) as a means of measuring the mutual process through participation, with participation, as a manifestation of field pattern, defined "as the experience of expansiveness and ease of continuous human-environment mutual process" (p. 21). Leddy (1995) used a seven-step semantic differential bipolar scale, with content validity of the pairs established in three rounds by persons knowledgeable in the science of unitary human beings. Reliability was tested, along with construct and concurrent validity, in three samples (Leddy, 1995). Sample one, \( N = 239 \), used for testings one and two, demonstrated Cronbach's alpha reliabilities of .91 and .92, respectively (Leddy, 1995). Sample two, \( N = 125 \) (\( n = 104 \) from the previous sample), tested six months later, had an alpha reliability of .90 (Leddy, 1995). Sample three, \( N = 208 \) (\( n = 136 \) from the two previous samples), tested one year after the initial testing, had an alpha reliability of .94 (Leddy, 1995). Construct validity, attained through the factor analytic approach of principal components analysis, revealed two factors. Factor one, expansiveness, accounted for 46.5% variance, while factor two, ease, accounted for 10% variance. Concurrent validity was measured by concurrent administration of a variety of other tests reflective of manifestations of the Rogerian view of human-environmental process, two
of which were author created: the Fatigue Experience Scale (FES), and the Leddy Healthiness Scale (LHS) (Leddy, 1995).

The PEPS was also used in Leddy and Fawcett’s (1997) investigation of the explanatory theory of healthiness. Leddy (1996) defines healthiness "as having perceived purpose and the power to achieve goals" (p. 431). Four concepts, participation, change, energy, and healthiness, along with four widely accepted indicators of health, that is, mental health, current health status, satisfaction with life, and symptom distress were selected for measurement (Leddy & Fawcett, 1997). Eight tools were used to test the theory, two of which had been previously created to measure unitary manifestations: the PEPS to measure participation, "a manifestation of underlying mutual process" (Leddy & Fawcett, 1997, p. 77); and the LHS (Leddy, 1996) to measure healthiness, a unitary field pattern manifestation emerging out of human field-environmental field mutual process (Leddy & Fawcett, 1997).

Path analysis was utilized to examine the explanatory theory of healthiness. Correlations between the scores for participation, change, energy, and healthiness (.59 to .72) suggested that there is a common conceptual "core" between them (Leddy & Fawcett, 1997): Within the science of unitary human beings, the common conceptual core is the human-environmental mutual process (Leddy & Fawcett, 1997). All possible paths from participation, change, energy, and healthiness to the
four indicator variables of mental health, satisfaction with life, current health status, and symptom distress were tested by path analysis. Paths from participation to the four indicator variables were deleted as were paths between change to current health status and symptom distress, and paths between energy to mental health and satisfaction with life. Correlations between the PKPCT and the LHS (r = .62), and the PKPCT and the PEPS (r = .69), had indicated that the concepts are not exactly the same (Leddy, 1996), thereby supporting Rogers (1986) assumption that although mutual process is indivisible, distinctions in manifestations are perceived by the unitary human being (Leddy & Fawcett, 1997).

Several reader concerns regarding terminology used in this study come to mind. First of all, is the use of the term "core", as noted above, congruent with a study based in the science of unitary human beings? Rogers views the term, core, as reductionistic (E. A. M. Barrett, personal communication, September 12, 1997), therefore, it is inappropriate for use with Rogerian research. The concept being tested, healthiness, also summons questions concerning the appropriateness of selection for testing within the science of unitary human beings; since the term health involves value judgments by the persons themselves, Rogers chose not to use the term (E. A. M. Barrett, personal communication, September 12, 1997).

The authors, themselves, question several aspects of the study. One question is whether the inclusion of participation as a concept in the
explanatory theory of healthiness is appropriate when mutual process and participation are not logically congruent (Leddy & Fawcett, 1997). While the authors question the logical congruence of participation (conceptualized as a quantifiable variable in the explanatory theory of healthiness) and mutual process (which they consider a constant, because of its openness rather than a variable), the authors suggest that the same question could be raised about pattern manifestations of change, energy, and healthiness (Leddy & Fawcett, 1997). This problem is summed up with the following query: "... can the [science of unitary human beings] SUHB advance if relevant phenomena are not quantifiable?" (p. 83).

Leddy and Fawcett (1997) also question the conceptual relevance of the term energy, defined as the experience of dynamic and vigorous potential, since it does not fit conceptually with the Rogerian definition of energy: "Energy signifies the dynamic nature of the field" (Rogers, 1992b, p. 29). Although change was viewed as being within the perspective of the science of unitary human beings when defined as "the experience of the continuous variability associated with human-environmental mutual process" (Leddy & Fawcett, 1997, p. 77), it is described as "experienced on a continuum from facilitative (positive) to stressful and enervating (negative)" (Leddy & Fawcett, 1997, p. 78). This description is not congruent with the science of unitary human beings.

In conclusion, it is evident that much of the research concerning
mutual process is of a quantitative nature, although some qualitative research has been conducted. Expert Rogerian scientists (Barrett, 1990c, 1997; Phillips, 1988a, 1988b) have long urged the pursuit of a unique Rogerian research methodology. While this pursuit has been elaborated by at least three researchers (Butcher, 1994, 1996; Carboni, 1992, 1995a, 1995b; Cowling, 1997a, 1997b), only one utilized it with mutual process manifestations (Carboni, 1992).

**Deliberative Mutual Patterning Literature**

Rogers’ science-based practice methodology evolves from the homeodynamic principles of integrality, helicy, and resonancy, with continuous change as the unifying concept (Barrett, 1988). Barrett (1988) describes science-based nursing practice as "an inductive-deductive mutual process" (p.51) which means the client with the nurse continuously evolves knowledgeable care. The two main phases of the Rogerian practice methodology, which are nonlinear and thus not necessarily sequential, consist of pattern manifestation appraisal and deliberative mutual patterning (Barrett, 1990b, 1990d); the caregiver and the client are in mutual process. As with the mutual process literature search, deliberative mutual patterning surfaced only in literature specific to the science of unitary human beings.

Deliberative mutual patterning is defined as: "the continuous process
whereby the nurse with the client patterns the environmental field to promote harmony related to the health events" (Barrett, 1988, p. 50), thus facilitating "the client's actualization of potentials for health and well-being" (Barrett, 1990d, p. 34). In certain caregiving situations the deliberative mutual patterning process itself may be the healing modality (Barrett, 1990d), with "meaningful presence, usually though not necessarily accompanied by dialogue" (p. 34), being the instrument of expression. When viewed from a strict Rogerian perspective, there is no such thing as nurse-patient relationship, the caregiver does not "interact" with the patient and the patient does not "interact" with the caregiver; both the caregiver's and patient's energy fields are in continuous mutual process with their respective environmental energy fields. The caregiver is in continual mutual process with her or his environmental energy field; the patient, as well as all other human fields, is in the caregiver's environmental energy field.

However, as noted in the mutual process review, Rawnsley (1985) interprets "therapeutic use of self" (a nurse-patient relationship), using the notion of conceptual motion and the acronym, H-E-A-L-T-H, as a process of healing that is logically consistent with the science of unitary human beings. The healing behavior of the professional, although currently viewed as an example of deliberative mutual patterning, is explained, through the homeodynamic principles, as a non-invasive healing approach. Some other
non-invasive healing approaches or modalities representative of deliberative mutual patterning are: therapeutic touch (Kreiger, 1987; Meehan, 1988); authentic dialogue between the nurse and client (Moccia, 1988); "imagery, meditation, humor, relaxation, nutrition, affirmation (expressions of intentionality), ... bibliotherapy (selected readings prescribed as therapeutic treatment), and journal keeping" (Barrett, 1990d, p. 36); caregiver composition of Haiku poetry to communicate unique healing messages to the patient (Rapacz, 1989, as cited in Barrett, 1990d); and centering, an aspect necessary for therapeutic touch as well as a facilitator of imagery (Barrett, 1990d).

Barrett (1988) notes

Science-based practice is the use of substantive nursing knowledge, developed through logical analysis and quantitative and qualitative modes of inquiry, to care for people in their world. This dynamic science-art interface is a mutual process whereby knowledgeable caring continuously evolves (p.50).

Integral with deliberative mutual patterning in Rogerian science-based practice is the caregiver's appraisal of pattern manifestations. This "appraisal may include lifestyle parameters of human health such as nutrition, work and play, exercise, substance use, sleep/wake cycles, safety, decelerated/accelerated field rhythms, space-time shifts, interpersonal networks, and professional healthcare access and use" (Barrett, 1990d, p. 34). Appraisal may be an intuitive process in the health caregiver. Appraisal of field pattern manifestations is vital "since energy
fields are identified by pattern and pattern cannot be perceived directly, manifestations of field pattern are extremely important assessment devices in nursing practice" (Cowling, 1990, p.49).

Knowing participation in change, whether manifested by the caregiver or the patient, is the process of change characterized by the continuous knowing patterning of the human and environmental energy fields (Barrett, 1988). The concept of power as knowing participation in change is essential to the concept of health patterning as manifested through both pattern manifestation appraisal and deliberative mutual patterning (Barrett, 1988). Barrett’s (1986) research on this conceptualization of power, with development of an instrument to measure the unitary nature of change, led to the tendering of a Rogerian science-based practice model in 1988.

"Pattern appreciation is a central aspect of guiding assumptions for unitary practice and research " (Cowling, 1997a, p. 53). In 1990, Cowling proposes a model of pattern appreciation, suggesting "a reconceptualization of deliberative mutual patterning" (p. 52). Cowling’s template for unitary pattern-based nursing practice consists of nine constituents. The first constituent specifies that "the basic referent of nursing practice is human energy field pattern" (Cowling, 1990, p. 52); nursing is pattern-appropriate, not disease-appropriate. Constituent two stipulates that "human field pattern is appraised through manifestations of
the pattern in the form of experience, perception, and expressions" (Cowling, 1990, p. 52). The caregiver experiences pattern manifestations in a broad variety of ways: sensorially, as one's own sensations; perceptually through the capacity to be aware of pattern manifestations; and through comprehension of expressions (Cowling, 1997b). Comprehension of expressions may be: directly, as through verbal responses to feelings, or the responses on a tool designed to gather unitary human field expressions; or very subtly, such as through metaphors, visualizations, or imaging (Cowling, 1990).

Constituent three suggests that "pattern appraisal requires an inclusive perspective of what counts as pattern information" (Cowling, 1990, p. 53). From a unitary perspective, pattern appraisal attends to not only sensory information, but the major recurring themes and issues of the patient's life (Cowling, 1990). Constituent four is "the knowledge derived from pattern information involves multiple modes of awareness by the nurse" (p. 53). Appraisal consists of pattern recognition through awareness, observing, noticing, monitoring, and listening, while viewing the patient as a unitary whole.

Constituent five, "pattern information has meaning for pattern appraisal only when constructed within a unitary context" (Cowling, 1990, p. 56), includes five relevant characteristics. They are (a) "data or information from the client is unitary, and not particular" (p. 56); (b)
"inclusion of information expressed from a temporal dimension is understood as four dimensional" (p. 56); (c) "pattern information does not exist separately in reality" (p. 56); (d) "human and environmental fields are in constant mutual process; thus being inseparable, any use of boundaries is constructed" (p. 56); and (e) "pattern information is specific to the individual client" (p. 56). Constituent six relates that "variant formats for presenting and conveying pattern appraisal are applicative to the unitary perspective" (p. 58). Examples of formats are a single word or short phrase describing the essence of the pattern, or a pattern profile incorporating pattern properties or qualities emerging from the pattern information (Cowling, 1990).

Constituent seven specifies that "the primary source for validating pattern appraisal is the client" (Cowling, 1990, pp. 58-59). "Validating pattern appraisal is consistent with knowing participation in change" (p. 59). This phase provides an opportunity for further reflection between caregiver and patient that allows for the possibility of additional pattern information; it also allows for corrected impressions or inferences from the patient (Cowling, 1990). Constituent eight contends that "the basic foundation for intervention is knowing participation in change" (Cowling, 1990, p. 59). With the focus on the integrality of human field and environmental field patterns, deliberative mutual patterning does express the nature of the mutual process (Cowling, 1990), whereby the caregiver
shares the knowledge perceived in the process of pattern appraisal with the patient. The final, or ninth, constituent states that "evaluation methodologies are focused on continual pattern appraisal and confirmation of alterations with the client" (Cowling, 1990, p. 61). The process of evaluation is ongoing, with continuous pattern appraisal, and it is not essential to use it sequentially as elaborated in the article (Cowling, 1990); continuously emerging health patterning aspirations may be the manifestation of the deliberative mutual patterning process as demonstrated by the nature of the process that centers on the integrality of human field patterns and environmental field patterns.

Explication Of Deliberative Mutual Patterning

Through Practice And Research

Deliberative mutual patterning has been explicated through many areas of nursing practice. Madrid (1994) describes deliberative mutual patterning while participating with a patient in the process of dying. Deliberative mutual patterning, initiated to allow the patient the freedom to act intentionally, emerges through meaningful presence, empathy, and listening to the patient’s expression of experience in the relative present. Madrid and Woods-Smith (1994) utilize case studies from nursing practice to illustrate new ways to promote client health and comfort through the use of Rogerian science-based practice. In each case study, the caregiver’s
pattern appraisal and deliberative mutual patterning with the client promoted comfort and well-being. Sargent (1994) portrays healing groups using guided imagery experiences as methods of deliberative mutual patterning, while Morwessel (1994) uses the participatory process of deliberative mutual patterning to facilitate the patient's definition of health while caring for children with heart variations, and their families, in both inpatient and outpatient settings.

Tuyn (1992, 1994) compares "solution-oriented therapy" with the science of unitary human beings in the clarification of Rogerian science-based counseling. Findings reveal that both solution-oriented therapy and the science of unitary human beings shared "at least four essential concepts: change, field uniqueness, rhythms and patterns, and power" (Tuyn, 1994, p. 208). Through the use of pattern appraisal with deliberative mutual patterning in counseling sessions with clients, Tuyn (1994) helps them focus on the use of their strengths in unique new ways for their well-being.

While investigating values of professional nursing in the context of Rogerian science, Haber and Taddeo (1994) postulated that their proposed model demonstrated the continuous unfolding of professional values believed to be manifested by the human-environmental mutual process. The model was organized integral with the concepts of person, health, environment, and nursing. Manifestations of deliberative mutual patterning
that emerge from the human-environmental mutual process are believed to reflect implementation of organizational values congruent with the science of unitary human beings.

Biley (1993) uses a brief case study to explore and illustrate the concept of energy fields. In the case study, use of Rogerian nursing practice methodology, both pattern manifestation appraisal and deliberative mutual patterning, guided care for a patient who had experienced a bilateral mastectomy. The need for patterning with her new body image is addressed through pattern manifestation appraisal and deliberative mutual patterning between the patient and the nurse. Later, Biley (1996) explored the potentials of Rogerian science, phantom pain, and therapeutic touch (TT), using five very brief case studies. While removal of a body part (limb, breast, digit, nose, penis) results in alteration of the person’s three dimensional form, the pandimensional human field image usually remains unchanged, thus manifesting image incongruency (Biley, 1996). Phillips and Bramlett (1994) suggest that this image incongruency, integrated awareness dissonance, may be observed through pattern appraisal. Pain relief of varying levels after TT was manifested in all five cases.

Andersen and Smereck (1989, 1992, 1994) created the Personalized Nursing LIGHT Model, a Rogerian science-based nursing model, to help caregivers guide clients, such as psychiatric inpatients, mental health clinic patients, and intravenous drug users (IVDU) in community outreach urban
settings, toward an improved sense of well-being. This model, called the Rainbow of Awareness, uses phases of pattern manifestation appraisal and deliberative mutual patterning. The authors "hypothesize that drugs are one means used to jump over barriers of 'being' - pain; slings and arrows - to reach short-term, illusionary well-being. ... Addicts experience maximum well-being in another dimension, while most people do not" (Andersen & Smereck, 1994, p. 271).

In the personalized nursing LIGHT model (Andersen & Smereck, 1989, 1992, 1994), deliberative mutual patterning is facilitated through the acronym, LIGHT, which assists both caregiver and client to understand his or her role in the process. The role of caregiver as illustrated by LIGHT is: Love the client, Intend to help, Give care gently, Help the client improve well-being, Teach the process. The role of the client is: Love yourself, Identify a concern, Give yourself a goal, Have confidence and help yourself, Take positive action. When the client is unable or not willing to care for himself or herself, the personalized care LIGHT nursing process model may be used independent of the personalized action LIGHT process intended for use by clients. It is important to remember that the caregiver facilitates LIGHT actions by the client (Andersen & Smereck, 1994). The homeodynamic principles, resonancy, helicy, and integrality are manifested by the personalized action LIGHT process (Andersen & Smereck, 1994).

Research studies (Andersen, 1986; Andersen & Braunstein, 1991;
Andersen & Smereck, 1994; Andersen, Smereck, & Braunstein, 1993) support the usefulness of the LIGHT model. Current research (Andersen & Smereck, 1994) consists of randomized clinical trials with IVDUs, \( N = 762 + \), funded by the National Institute on Drug Abuse. Andersen and Smereck (1989) postulate that extended use of the LIGHT process will result in long-term improvement in well-being, and progress toward self-actualization or eudaimonia.

In conclusion, the literature demonstrates that the aspect of Rogerian practice methodology termed deliberative mutual patterning is being utilized to further nursing science through research investigation and science-based practice.

**Nursing Literature Related To The Caregiver’s Experience Of Deliberative Mutual Patterning With Pain-Ridden Substance Users**

In order to fully understand the caregiver’s experience of deliberative mutual patterning with pain-ridden substance users, nurses’ perceptions of the field pattern manifestations of substance use and pain were elucidated from relevant literature. Although the literature review that follows is necessary in order to understand the caregiver’s experience of deliberative mutual patterning with pain-ridden substance users, the terminology is in the language in which it was written, appearing incongruent at times, with the language of the science of unitary human beings.
The literature reveals that nursing attitudes (nursing perceptions of field pattern manifestations) may be one of the most important factors influencing patient care (Allen, 1993; Boorer, 1971; Carveth, 1995; Grief & Elliott, 1994; Naegle, 1994; Sullivan, Handley, & Connors, 1994), and a significant factor in the accomplishment of the nursing role (Bradley, 1983). Indeed, Parette, Hourcade, and Parette (1990) note that potentially "dysfunctional" nursing attitudes (field pattern manifestation perceptions by nurses and other healthcare professionals) are likely to impair the provision of high quality care. For example, nurses' attitudes (nurses' perceptions of field pattern manifestations) are considered one of the important factors influencing a nurse's ability to identify and address alcohol use (Sullivan et al., 1994). Furthermore, the nurse's attitudes about substance use pattern manifestations shape the caregiving potential of the nurse-client relationship, sometimes enhancing the care given, but more often closing the door to ways of working together (Naegle, 1994).

Some nurse researchers have studied the issues of substance use in conjunction with nurses' attitudes (perceptions of field pattern manifestations) (Johnson, 1965; Long & Gelfand, 1995; Moody, 1971; Weschler & Rohman, 1982) and the influence of nurses' attitudes on the way pain is managed (Kemp, 1995; Koo, 1995; Lisson, 1989; McCaffery, 1991; Miller, 1994; Nash et al. 1993; Pritchard, 1988; Ryan et al. 1994; Taylor et al. 1984; Von Gunten & Von Roenn, 1994; Wakefield, 1995;
Waldrop & Mandry, 1995). Yet, nurses' attitudes regarding substance users who are experiencing pain (nurses' perceptions of field pattern manifestations reflecting the mutual process and/or deliberative mutual patterning of human and environmental energy fields of substance users reporting pain), have received little attention in the nursing literature (Cross & Urbanski, 1994). Therefore, only two studies are reviewed in this section.

Ryan et al. (1994) investigated nurses' attitudes toward cancer pain and the use of opiate drugs by measuring the "liberalness" of their actions. Liberalness is defined as advocating maximum tolerated analgesia early in the course of the disease and advocating for patient control of analgesia. Nurses were also asked to identify the percent of time they believed that patients accurately reported, under-reported, and over-reported their pain and need for narcotics. The researchers used an author-created 82-item questionnaire to sample N = 718 oncology nurses and N = 72 long term care facility (LTCF) nurses. Results showed that oncology nurses were no more liberal in their attitudes toward cancer pain than were the LTCF nurses; for both groups the mean liberalness score was 17. Given that the highest possible score on liberalness was 24, the data suggested that all the nurses were relatively liberal in their pain management attitudes. Both groups of nurses agreed that patients reported pain reliably over 60 per cent of the time; however, later in the questionnaire, more LTCF nurses than oncology
nurses believed that patients over-reported their pain. Knowledge scores for effective pain management were low, although there appeared to be a readiness on the part of all the nurses to learn more about pain management.

Wakefield (1995) used a technique called reflexive analysis in applying Foucault's (1967) Notion of Madness to study nurses' attitudes about pain. The qualitative design sampled N = 5 general surgical nurses working in three similar surgical units, utilizing unstructured interviews. Foucault's notion of madness includes the four notions of critical consciousness, practical consciousness, enuciative consciousness, and analytical consciousness.

In critical consciousness, nursing mirrors an empirical rote response style. The nurse uses a mechanistic style, organizing time and response to patients into discrete categories. This results in the imposition of analgesic administration on a 4-6 hour schedule with no concern for the quality or uniqueness of the pain (Wakefield, 1995).

Practical consciousness embodies a creative rote style. The nurse utilizes some flexibility regarding the use of prescribed interventions, wielding the power of foreclosure. Methods of treatment for the individual's pain that exists outside the nurse's definition of appropriate characteristics are withheld (Wakefield, 1995).

Enuciative consciousness utilizes an empirical intuitive style. The
nurse employs a greater degree of flexibility regarding pharmacological administration. In this context, staff may engage in judgmental processes concerning the existence of pain. There may be vigilance to eradicate or at least effect recognition of medication abusers. The staff may fear initiating an addictive response. However, in this response style, staff members realize that pain may reemerge ahead of the clock time and may medicate if the patient's overt manifestations of pain matches the staff member's perceptions of overt pain characteristics (Wakefield, 1995).

Analytical consciousness is a creative intuitive style. Pain within this context is seen as the object of knowledge converging with matter (biopsychosocial pain experience) "to allow acknowledgement of the sensation as a diverse, dynamic experience" (Wakefield, 1995, p. 909). Patient and nurse join to form a therapeutic relationship which nurtures "the emergence of a state of harmony between body, mind and spirit" (p. 909). The nurse may refute some of the biomedical principles in favor of a more eclectic whole-person approach (Wakefield, 1995). In this practice method, knowledge of pain is seen as being receptive to the individual patient's needs. This is akin to the notion by McCaffery (1983) that pain is what the patient says it is. The most efficacious pain interventions would be used for pain alleviation.

Although Wakefield's (1995) account of nurses' talk about pain did not describe negative perceptions of pattern manifestations per se, findings
revealed that the nurses in this study adhered to an empirical rote response style which imposed a mechanistic process of analgesic administration. They failed to take the individual pain needs of patients into consideration. This "critical consciousness" response style (Foucault, 1967) reinforces the idea that pain management praxes should strictly adhere to empirically reinforced scientific principles encapsulating biomedical techniques. In this study, an empirical rote response style failed to allow acknowledgement of pain as a diverse, dynamic, individual experience" (Wakefield, 1995), and could be considered as synonymous with negative perceptions of pattern manifestations. Observation of, and discussion with, the nurses revealed that the empirical rote response features were adhered to even when the patients needed individualized pain intervention such as that offered through a creative intuitive response process.

In response to the paucity of research investigations regarding the phenomenon of the caregiver's experience of deliberative mutual patterning with pain-ridden substance users, Rogers' (1992b) declaration seems appropriate. "The science of nursing was arrived at by the creative synthesis of facts and ideas and is an emergent, a new product" (Rogers, 1992b, p. 28). One way to further this synthesis is by using qualitative research to answer the pressing need to investigate humans in ways that enhance their humanness (Rogers, 1992b).
The Rogerian Perspective Of Care and Caring

Since the term "care" is used in the data gathering guide questions, it is important to include a brief overview of Rogers' (1990, 1992a, 1992b, 1994a) comments on caring. While writing a short critique of Nightingale's (1859) work, Rogers (1992a) states: "It is relevant to draw attention to the use of caring as a way of using nursing knowledge: it should not be confused with the science of nursing" (p. 60). While Rogers alludes to caring as being an "in" word in her 1990 writing, she explicated her concerns about the concept of caring, telling the reader that although caring is a practice modality currently receiving much attention in nursing, as such, it does not uniquely identify nurses as the only carers, reiterating that "caring is simply a way of using knowledge" (Rogers, 1992b, p. 33). "Caring is doing, it is practice" (Rogers, 1994a). "Nurses care on the basis of ways they use the science of unitary, irreducible human beings" (Rogers, 1992b, p. 33).

Alligood (1994) succinctly summarizes the "place" of caring in nursing when she writes:

More importantly, the emphasis on caring is vocational nursing: caring focuses on nurses and what nurses do. We cannot put the emphasis back on nurses and what nurses do. The unitary view of practice set forth in Rogerian science clearly places the focus of nursing on the person as a human being within an environment that synthesizes his or her past, dreams for the future, relationships with people and things in the world, and health as he or she experiences it. The meaning of what nursing is emerges from this focus; therefore, the understanding of nursing is dependent on this focus. Nightingale understood this, and when we had drifted away
from her idea, it was Rogers who pointed us back in the right direction (p. 228).

The science of unitary human beings may provide an innovative framework to use as an expression of caring for persons experiencing life-patterning difficulties (Horvath, 1994). Rogers (1992b) notes, with concern, that unconditional love, reported by some researchers to be considered as synonymous with care or caring (Curzer, 1993; Van Hooft, 1987), is also receiving attention in nursing. Rogers (1992b) suggests alternative ways of expressing caring or concern for patients through the use of "attitudes of hope, humor, and upbeat moods" (p. 33).

Summary

A comprehensive review of the literature has not revealed studies specific to the caregiver's experience of deliberative mutual patterning with pain-ridden substance users. Therefore, studies and articles examining the related phenomena of change, mutual process, deliberative mutual patterning, and substance use and pain literature were reviewed and the studies critically appraised. Given the numerous conceptual gaps and methodological shortcomings, the need for research guided by a theoretical base such as the science of unitary human beings is evident. Through the utilization of a qualitative research design, rich detail and fertile data on the caregiver's experience of deliberative mutual patterning with pain-ridden substance users emerged. Chapter III specifies the methodology used in
this study for knowledge development of the caregiver’s experience of deliberative mutual patterning with pain-ridden substance users.
CHAPTER III

METHODOLOGY

Background Of Descriptive Exploratory Research Method

Descriptive research design originated within the social science disciplines. As a process that yields findings based upon conversations and observations, it is deemed a human science method focusing on discovering the meaning of a life event in time (Parse, Coyne, & Smith, 1985). Human beings' definitions of the universe emerge from their life event experiences. The descriptive method embodies a contextual elaboration of the situation as well as retrospective occurrences and prospective intentions surrounding the life event (Parse et al., 1985). "The description, as told through the interrelationship between the researcher and the subjects, reflects the unitary nature of [the human] and the connectedness of [the human] with the environment" (p. 91). Descriptive exploratory is one of the methods of choice when a researcher seeks to study the human-environment energy fields as a unit (Parse et al., 1985).
**Description Of Descriptive Exploratory Research Method**

The descriptive exploratory method intensively investigates a phenomenon to uncover patterns and themes when the researcher has specific questions about an experience (Parse, 1996). This method explores the meaning of a life event for a group of subjects who have experienced a unique happening (Parse et al., 1985). Since this method is not governed by a specific ontology, there is inherent flexibility for guidance by explication through a nursing theoretical perspective (Parse, 1996). Objectives evolving from the conceptual framework are the basis for constructing data gathering questions for the researcher-participant interview (Parse, 1996).

**Rationale For Use Of Descriptive Exploratory Method**

A qualitative exploratory method is suggested when there is minimal prior research, few existing hypotheses, and very little information known about the nature of the phenomenon (Patton, 1990). According to Parse et al. (1985), when a researcher seeks to study the interaction of human-environment as a unit, the descriptive exploratory method is appropriate. Furthermore, the descriptive exploratory method begets hypotheses for future research, thus enhancing theory (Parse et al., 1985). The caregiver’s experience of deliberative mutual patterning with pain-ridden substance users is a phenomenon about which little is known and which
has not been researched. Using Rogers' science of unitary human beings, which is firmly rooted in the simultaneity paradigm, as a nursing theoretical perspective, the descriptive exploratory method (Parse et al., 1985) was an appropriate method to guide this research study.

Research Design

The design used for this study was the descriptive exploratory design (Parse et al., 1985).

Participant Selection

The population was caregivers who had participated with pain-ridden substance users. A sample size of 15 registered nurses, who spoke and understood English, and who had cared for a substance user experiencing pain, was obtained from two agencies: a small community hospital located in a rural area; and a large Veteran's Administration facility located in an urban area (See Appendixes A and B for letters of approval to use these sites). Presentations introducing and explaining the study were made for nursing administration and management at each facility. The participants were recruited through use of posted announcements on bulletin boards in the nursing station areas of each facility. The announcements described the need for volunteers to participate in this study (See Appendix C and
Appendix D). E-mail announcements were also sent to each registered nurse in each facility. Participants responded in one of two ways; they called the researcher's telephone number which was included on the announcement poster, or they left their phone number with a specifically named clerical person at either facility and the researcher called them back. A mutually agreeable interview time was selected by the participant and the researcher.

**Ethical Concerns**

Prior to submission of this proposal, approval to conduct the research was obtained from the Institutional Review Boards (IRB) of each data gathering facility and from the Loyola University IRB (See Appendixes A, B, and E). At the time that prospective participants were invited to take part in this study, information explaining the study and the concerns regarding participation were provided. Confidentiality, anonymity, amount of time required for each interview, purpose of this study, and the right to withdraw from the study at any time were thoroughly reviewed; consent forms were provided for signature and a copy was given to each participant. The interviews were audiotape-recorded for transcription with brief observational notes logged by the researcher as the interview took place. No names were used and code numbers were assigned to identify data. The record of code numbers and names were kept separate from the
data in a locked cabinet; it was destroyed when the transcription of tapes was completed. The tapes were transcribed into a word-processing program in the researcher's computer which is secure (cannot be accessed via modem); the computer was locked when the researcher was not using it. The signed consent forms, the audiotapes, back-up disks of the computer hard drive, and any hard copy generated for data analysis were kept in a locked file cabinet when not being used. The audiotapes were kept until the study was completed, then erased, and the transcripts destroyed. (See Appendix F for Information for Participants, Appendix G for Consent Form, and Appendix H for Demographic Form).

Data Gathering Process

In order to gather data, participants were interviewed by the researcher with questions derived from the objectives. The open-ended questions were directed toward describing the caregiver's experience of deliberative mutual patterning with pain-ridden substance users. The majority of interviews took place in the workplace setting, in a convenient quiet area to provide privacy. Interviews with nurses working outside the hospital setting took place in their homes. The interviews lasted 15 to 40 minutes.
Interview Questions By Objective

1. To describe the caregiver’s experiences of deliberative mutual patterning with pain-ridden substance users as a field patterning process;
   (a) What is it like for you to care for pain-ridden substance users when they request pain medication?
   (b) How do you feel when you care for a person who is a substance user and is requesting pain medication?
   (c) What, if anything, does your feeling have to do with the nurse-person process?

2. To describe the caregiver’s experiences of deliberative mutual patterning with pain-ridden substance users as manifesting innovative, unpredictable, and increasing diversity;
   (d) Looking back upon your nursing experiences with pain-ridden substance users, how would you describe the process?
   (e) What changes have taken place?
   (f) How have these changes manifested themselves in you?
   (g) How do you see these manifestations in the future?

3. To describe the caregivers’ experiences of deliberative mutual patterning with pain-ridden substance users in continuously changing irreversible life processes.
   (h) How did the pain-ridden substance users’ changing life processes change you?
(i) How did the changing life processes of pain-ridden substance users’ change your nursing role?

Data Analysis-Synthesis Process

Data analysis-synthesis of the participants’ responses began with searching for themes describing the phenomenon under study (Parse et al., 1985). The researcher followed the procedure outlined in Parse et al. (1985). Specifically, the researcher:

1. Dwelled with the taped and transcribed descriptions,
2. Identified themes in the language of the participants,
3. Specified the themes in the language of the science of unitary human beings, and
4. Synthesized the themes into hypothetical statements.

The analysis-synthesis yielded themes related to each objective. The themes were stated in the language of the participants describing the phenomenon as lived by the participants (Parse et al., 1985). Major themes were transformed from the participants’ language to the researchers’ language at a higher level of discourse and synthesized into hypothetical statements (Parse et al., 1985).

Ensuring Rigor And Credibility

Since the artistic approach to qualitative inquiry accentuates the
irreplcability of the research process and findings, perceives each and every human experience as unique, and views truth as relative, artistic integrity of the research was achieved rather than scientific objectivity. It was communicated by the richness and diversity of the human experience as described by the participants (Sandelowski, 1986). The five standards or criteria for evaluating qualitative research: descriptive vividness, methodological congruence, analytic preciseness, theoretical connectedness, and heuristic relevance (Burns, 1989), were considered in this study.

**Descriptive Vividness**

A description of the participants in their setting, the data collecting experience, and the researcher’s thinking process is presented so that the reader has a sense of how the situation was experienced. Descriptions by participants are offered in direct quotes to ensure that the vividness of their experiences is communicated. This contextual clarity allows the reader to better understand the caregiver’s experience of deliberative mutual patterning with pain-ridden substance users and to use the information to evaluate the other four standards (Burns, 1989).

**Methodological Congruence**

Methodological congruence requires attainment of four dimensions:
ethical rigor, rigor in documentation, procedural rigor, and auditability (Burns, 1989). The researcher identified the science of unitary human beings (Rogers, 1992b, 1994b) as the theoretical base. The method was adhered to closely. The study was guided by objectives flowing from that framework, by an original follower of the science of unitary human beings, and by the author of the qualitative research text outlining this methodology. Appropriate citations are provided.

**Ethical rigor**

"Ethical rigor requires recognition and discussion by the researcher of the ethical implications of various factors related to the conduct of the study" (Burns, 1989, p. 49). This was ensured by following the process set up in the ethical concerns section of this proposal. Documentation of this action to protect participants’ rights is recorded in this study.

**Documentational rigor**

It is important for a researcher to rigorously apply all of the methodological procedures selected for a study. All elements of the study, consisting of the phenomenon, theoretical perspective, research objectives, purpose, research question, justification of the significance, literature review, and methodological concerns, are presented with clarity and accuracy, thereby avoiding threats to the study’s documentational rigor.
Data are accurately recorded in this dissertation.

**Procedural rigor**

The dimension of procedural rigor was attained by utilizing the process of the descriptive exploratory method (Parse et al., 1985) in the appropriate manner. The steps of the research process were clearly used with accurately recorded representative data. The researcher is aware of and considered the many threats to procedural rigor.

**Auditability**

The fourth dimension of methodological congruence, auditability, was met by reporting all of the decisions involved in data transformation into the theoretical schema while considering potential threats to auditability. Sufficient detail was reported to allow a second researcher, using original data, to follow the decision trail and arrive at comparable conclusions. In fact, another nurse researcher reviewed the tapes, transcriptions, and themes at the various levels of discourse to ensure congruence between the original data and the themes.

**Analytical Preciseness**

Analytical preciseness, the third standard or criterion suggested by Burns (1989), is specified through the transformation of data from the
participants’ level of discourse to a higher level of abstraction and synthesized directly into hypothetical statements which imparted meaning to the caregiver’s experience of deliberative mutual patterning with pain-ridden substance users. Because it is so critical to recheck the fit between the schema and the original data (Burns), vigilance to the threats to analytical preciseness were sustained throughout the study. Themes and interpretive statements correspond with the findings and a unified description of the caregiver’s experience of deliberative mutual patterning with pain-ridden substance users as lived by the participants is presented. While patterns were sought, analytic openness was sustained to avoid premature conclusions and to obtain congruence.

**Theoretical Connectedness**

The fourth standard, theoretical connectedness (Burns, 1989), was reflected in the synthesis of themes into hypothetical statements related to the study objectives which flowed from Rogers’ (1992b, 1994b) science of unitary human beings. The hypothetical statements are clearly expressed and logically consistent with the nursing knowledge base (Burns, 1989). The theoretical nursing perspective assisted in revealing a meaningful portrayal of the caregiver’s experience of deliberative mutual patterning with pain-ridden substance users.
Heuristic Relevance

Heuristic relevance, the fifth standard suggested by Burns (1989), is reflected by the reader's capacity to intuitively recognize the caregiver's experience of deliberative mutual patterning with pain-ridden substance users, its theoretical linkage with Rogers' science of unitary human beings, and the ensuing hypotheses for future study. Nurse researchers are able to immediately recognize this phenomenon. The existing body of knowledge regarding the caregiver's experience of deliberative mutual patterning with pain-ridden substance users and related phenomena, is compared with the findings of this study. The findings are interpreted so as to be applicable to nursing practice situations, taking into consideration both the nursing theoretical framework and the researcher's knowledge base. The findings contribute to theory development within nursing and are useful in guiding future research.

Summary

This research study followed a descriptive exploratory design which focused on discovering the caregiver's experience of deliberative mutual patterning with pain-ridden substance users. The method is congruent with the purpose of the research which was to expand nursing science, providing knowledge enrichment through use of the science of unitary human beings. The descriptive exploratory method was appropriate to
answer the research question since there is scant prior research, few existing hypotheses, and little known extant information. The research process consisted of participant selection, the data gathering process, and data analysis-synthesis with transformation into synthesized hypothetical statements. Rigor and credibility were ensured by adherence to the five standards for qualitative research promulgated by Burns (1989): descriptive vividness, methodological congruence, analytic preciseness, theoretical connectedness, and heuristic relevance. The findings of this study are presented in Chapter IV.
CHAPTER IV

PRESENTATION OF FINDINGS

The following is a presentation of the findings elicited from the 15 participants in the descriptive exploratory research study investigating the caregiver’s experience of deliberative mutual patterning with pain-ridden substance users. First is a compilation of the participants’ background information. Then, each objective, with summary statement in the language of the participant and theme in the language of the science of unitary human beings, is presented, followed by excerpts from each participant’s interview. These excerpts are direct quotations from the participants. Finally, an hypothesis synthesized from the themes in the language of the science of unitary human beings is presented as the answer to the research question.

Background Of Research Participants

Fifteen English speaking registered nurses volunteered for this study. The participants came from a variety of backgrounds with different positions within either a large veterans administration hospital or a small community hospital. Two of the participants were recently retired from
their positions. The participants were 13 women and 2 men. All 15 participants were caucasian, between the ages of 38 to 75 years. Educational preparation varied: three participants were prepared at the associate degree level; nine at the diploma level; three participants entered nursing with a bachelor of science in nursing degree and four completed a bachelor of science in nursing degree later in their career. Two participants held master of science in nursing degrees and one participant was pursuing a doctor of philosophy in nursing. Several participants had continued their educational process in various areas and disciplines, with one receiving a bachelor's degree in psychology. The years worked in nursing varied from 10 to 45 years, while the extent of years worked in the current facility ranged from 8 to 20 years. Ten of the participants acknowledged a family history of substance use. Three participants revealed a self-history of substance use with 6 through 23 years in recovery.

**Objective One**

Objective one derives from the homeodynamic principle of integrality, "the continuous mutual human field and environmental field process" (Rogers, 1992b, p. 31). Objective one is: To describe the caregivers' experiences of deliberative mutual patterning with pain-ridden substance users as a field patterning process.
Summary Statement In The Language Of The Participants

Caregivers’ experiences with pain-ridden substance users are difficult with ambivalent feelings of frustration, empathy, and compassion that often may lead to collaborative advocacy with continuing concern for drug-seeking behavior.

Theme In The Language Of The Science Of Unitary Human Beings

Caregivers’ experiences of deliberative mutual patterning with pain-ridden substance users emerge as uniquely integral field patterns manifesting arduous contradictions with a continuous supportive mutual process.

Participants’ Descriptions

Participant one

I believe that ... you have to look at the whole person. Everybody deserves a chance to be given pain medication if they are generally in pain. ... I look at them [pain-ridden substance users] as a person ... you have to look at the person individually ... and if somebody says they’re in pain, then you have to believe that they are in pain, and if a problem arises later ... in regards to a substance or something, then you can deal with that; but you have to believe that the person is in pain. ... A patient that I am particularly thinking of ... it was real difficult to want to give him anything because of his drug-seeking behavior, prior ... so even if he was generally in pain a lot, you know, I looked at him as not needing it ... because of past experiences with him ... feeling like you had no control over the situation, that even if you know it wasn’t in his best interest to give him something at that point, it’s sort of like your hands were tied. So there was a lot of frustration ... [yet] if they ... said "I want to make a change", ... providing them with what they needed or being an advocate for them.
Participant two

Well, first of all, if this person is not in a substance abuse program presently and I am caring for them, I would probably treat them like I'd treat anyone else; if they needed it ... I would give it to them ... however, if this person were on the substance abuse unit being treated for substance abuse, I might confront them. It would depend what I thought. If I really thought they were trying to con me, I might, probably gently confront them. ... I would just be honest with them, but then I state the bottom line is, I would have to go with what they told me. If they said no, I would give it to them. ... Substance abuse is a debilitating illness. It affects all of your life, so I would have compassion for them ... feel compassion for them ... I would treat them like any other person ... we treat our clients like we treat most people. We respect them. We try to treat the whole person ... nurses are compassionate people and empathetic ... .

Participant three

It can be difficult at times, because treating substance dependent people, there is always that question, overriding, about, "are they simply drug-seeking to mood alter or is this something based in fact?" And so, sometimes validating that, can be problematic because pain is such a subjective situation for individuals. ... It really depends on my history with the individual ... if I have an extensive history with them, there can be a certain comfort level that is reached, where I can trust ... based on, not so much intuition, but a historical perspective. That then gives me something to, to go on. ... If I don’t know them as well, then again there is more of this questioning and trying to validate what, where this is coming from, what’s the motivation ... I guess the feeling is, is being unsure. I need, sometimes more data ... to make myself feel more assured that, whatever intervention I take is going to be appropriate. ... My feeling ... it is more empathy and understanding than anything else ... the complexities of substance dependence ... I believe, and I take that into account! ... if I’m going to error it’s going to be in the interest of the patient.
Participant four

Generally, I feel okay with giving them pain medications and I would want to give it to them as fast as possible ... when they ... look like they are in distress, like other ... people do. ... When ... I suspect it’s more of a withdrawal type of a pain thing that they are requesting, and ... I’m kind of unsure about what to do about that ... it’s kinda anxiety-ridden for me ... I want to take care of them and take care of the pain ... to help them be able to cope with it or pretty much to get rid of it so that they can relax and sleep ... I want them to be comfortable just like any other person ... I don’t have a "bias" ... toward substance users, not, as far as the pain control goes. ... Well, I should tell you after a while when you deal with a substance abuser that sometimes what the doctor orders for pain medication, isn’t enough for them, doesn’t seem to do anything for them at all ... so it makes me more and more anxious ... I’m anxious because I have no control over the situation because they’re in pain ... and it is really difficult then to deal with that patient because they really are in pain. ... I’m kind of unhappy with the situation ... at the system for the way that they are mismanaging the ... way they are treating the people. ... I am trying to do for them and be kind to them and stuff and to relieve their anxiety at least, ... then the more I can feel a little more of an advocate for these people.

Participant five

I don’t feel anything different, I don’t think anything different ... I am looking at someone who has obviously got a complaint and they come to me as a nurse to help them and I feel pretty, pretty comfortable with that and that is just automatic. ... I have ... concern, empathy, those kind of normal things, though I know that I automatically register a "red flag" especially if it seems to me that the kind of pain that they are describing seems to be that of a chronic nature. ... So my feeling is ... that there is even more to say to somebody who is a substance abuser that might be suffering from pain ... You know, around here ... I’m looked upon as somebody with a great deal of caring and understanding and ability to take extra time and go the extra mile for ... patients. ... I would have to say, [though], at times it could be, it could be frustrating.
Participant six

Being in [the work area] I don’t think twice about pain and take it as a genuine, and go from there. ... taking care of plenty of them, I don’t have a problem. Sometimes ... I think they are more afraid that they are not going to get enough ... and sometimes they are manipulative. ... Well, I feel, "hmmm, does he need more medicine?", and you have to go over and talk to him, and you have to use your judgment and go from there ... you always think, "is he being manipulative?" ... that goes hand-in-hand ... because they are on the more abusive side now, if they don’t think they are getting something ... you get a little bothered by it and then I think you probably did cop a little attitude ... although, pain is pain and you have to keep going with that. ... I’m definitely more of an advocate ... but at the same time you want to make sure you’re ... not manipulated by them.

Participant seven

It is not a problem ... this is what we do [pain relief] and if they need it, they’ll get it ... they have a need for it. ... that’s our job. They’re here, they need us. We provide it [pain relief]. ... I feel very sympathetic for them ... I feel very badly for them ... I don’t know what I can do to help people, not even get started.

Participant eight

Anytime a hospice person wants pain medication, I assume that they are in pain and need pain medication. We had three ... really heavy substance abusers ... and I have to admit there were times when I questioned whether they were people who needed pain medication or whether they were having, cravings ... the one in particular ... it was difficult ... very difficult ... Whenever anyone is complaining of pain, my first concern is comfort. ... Aside from the irritation of that one [patient], and sometimes asking questions, for the most part, my feelings are really warm toward these people, regardless of their past history. ... I saw a person yesterday ... I know he felt my warm feelings ... and I could sense his depression, his desperation and his pain ... and I think that pretty much describes my feelings toward substance abusers who are in pain or very very
sick. Ah, they just, my feelings are warm and loving feelings. ... Sometimes I have felt, just kind of, you know, "do you really need this pain medication, are you really in that much pain", and certainly we had one who I was never sure she was in that much pain, oh, it was just kind of a habit with her, and I would be kind of ... you know like, "do I need to deal with this again?" ... [yet] I find myself anymore, somewhat angry in fact, if I have someone else say, "Well, didn’t they use to drink or use drugs, and isn’t that why they’re using more drugs", which is absolutely untrue, especially in the final stages ... a non-substance user on 1800 mg of morphine twice a day and a substance user is only on 300!

Participant nine

I treat them like any other person who requests pain medication. My personal philosophy is that if the person says they have pain, they have pain, and the kind of things that I judge pain by ... my objective judgment, if they’re grimacing or the hairs on their arms are standing up, their pulse is fast, their blood pressure goes up ... you know, not everyone who has a subjective experience of pain has those things. ... My last shift ... an alcoholic ... came in, appearing to be in very great pain, bent over, clutching his middle, and crying out. Blood pressure, diastolic was 128, his heart rate was 120, and yet the doctor and nurse I was working with ... said "this guy is seeking narcotics" ... I said, "I judge him to be in pain." And, and they called me "Pollyanna!" ... Well, I feel a couple of different ways. One, that if he has pain that pain ought to be relieved. But then we have some patients who ... want something non-narcotic because ... [of] problems in the past. So I walk that line with giving them something ... it’s kind of an uncomfortable situation ... the nurse-person process has a lot to do with advocating for the patient ... a collaborative role with the patient ... an advocate for these patients ... a collaborator.

Participant ten

I find it’s more of a challenge ... It’s easier ... if I’ve dealt with this individual over a period of days versus the first time I meet with them. ... if it’s a known substance abuser ... I don’t withhold
medication for them so if they, you know, request medication, as I would for any other patient. I'd go with the data that I see, objective data, some subjective and I try not to ... penalize them for being substance abusers, you know, when I'm dealing with someone who is asking for, for relief. ... I don't feel, any differently than I would for any other client, who's not a known substance abuser. I can honestly say, there is no real difference to me. You know pain is a subjective thing. If the client says he's having pain or she's having pain, I believe they're having pain. So, I feel that there's a, a relief that needs to be there, that needs to be explored. ... working with clients that have been "labeled" as addicts, and what negative reactions that would bring from my peers who would say, "Well, hell, you know he just wants the stuff, he really doesn’t need it at this point", well, it's like, you know, I don't know about that!, I do know now! I do know now! ... we're [clients and participant] working together to do this, so!

Participant eleven

Well, usually when I first take care of them ... I felt they really had to have something for pain even though they were a substance abuser. ... I just feel that, maybe because of being in the hospital ... he was desperate. And also, of course, if he is being detoxed, he's going through total misery. And I could see that misery, and I had no hesitation ... I think my personhood came through, because as a nurse I always had a lot of compassion for people with pain, and this does not differ with a substance abuse person. And I, so would say part of me went into this. I wasn't all "professional" in doing it because my profession told me to do it. I did it also because I, I felt that this person was in total misery, plain and simple! ... People would talk to you and [say] "how do you stand it?", you know, and the world in general, every where, church, everywhere [about working where she was working] ... yes, "how could you possibly do - be doing this?" Well, I just felt, I said once, "you get into it, it gets hold of you", that's what happens. And I, if you feel like what you're doing's something very worthwhile, even though they may not think so ... I'd do it over again.
Participant twelve

I felt okay with giving the medication to relieve pain ... Well, at first, wondering, you know, what kind of pain the patient is having ... if the pain is really as bad as they’re saying that it is. At first you feel - I felt a little bit uneasy about giving it but then, talking to the patient, finding out more about the patient I was okay with giving it. I felt okay about it. ... I think that when you’re caring for a patient, you know, you need to give them as much help as possible, and I think with the nurse-person process that you have to let the patient know that you are willing to do what the patient needs, for them to feel comfortable and to have the care that he deserves. ... I’m a more compassionate person toward addiction disease, the substance abuser and alcoholic.

Participant thirteen

It’s kind of an ambivalent situation to a certain extent ... there’s a concern as to whether they are just drug-seeking or whether they’re truly in pain and in need of medication ... I feel I have to be more alert ... more aware of what’s going on with the person, what their condition is as opposed to someone who doesn’t abuse substances ... it’s important not to project skepticism ... treat ... according to their having real pain and real concerns ... and balance that with ... giving them a professional manner with concerns about what’s really going on with them. ... be even more of a patient advocate ... I’ve always been an advocate for the patient.

Participant fourteen

I’m sympathetic and empathetic to their pain ... I always was very empathetic and sympathetic to patients ... try to take care of whatever the situation ... may be. ... They are substance abusers ... because of their substance abuse they ... may request ... to support their habit. If that is the case, I would try to evaluate that in that light. But I would not, you know, brush it off just because they are substance abusers ... I don’t feel that there should be any problem ... I just wanted to know that it is a genuine request. ... there are genuine requests! ... I don’t want to miss it [the genuine request] ... Yeah, it doesn’t matter, you know, what problem the patient has ...
as a nurse I feel I need to meet their needs and get them well. ... That’s the process you know.

Participant fifteen

I ... have two feelings depending on the patient and the way they present ... sometimes I’m fairly skeptical, as to the degree of pain, depending on the story, depending on circumstances, is the mechanism of the cause of the pain, I guess in my opinion, legitimate, in terms of the degree they are professing to have ... Initially I feel fairly skeptical unless it’s an obvious ... acute injury kind of thing. I feel like ... "How stupid do you think I am?" ... like "I’m not buying that story!" ... if it’s an obvious injury and I think the patient is in real pain, then I feel really sorry for them, I feel really concerned for them because they feel like they are going to have trouble getting their pain relieved ... I’m more compassionate ... more willing to trust and feel sympathy for the patient ... than some of my colleagues ... that’s where the ambiguity comes from. Some of it’s because of my character because I am an empathetic kind of people person. On the other hand I don’t like to be made a fool of either, so I think that’s with skepticism and because I’ve had some experience with patients’ who have done that, then you tend to feel a little skeptical about that. ... having had some experience with it, ... advocating for that patient if they’re truly in pain.

Objective Two

Objective two reflects the homeodynamic principle of helicy. Helicy "is the continuous, innovative, unpredictable, increasing diversity of human and environmental energy fields" (Rogers, 1992b, p. 31). Objective two is: To describe the caregivers’ experiences of deliberative mutual patterning with pain-ridden substance users as manifesting innovative, unpredictable, and increasing diversity.
Summary Statement In The Language Of The Participants

Caregivers’ experiences with pain-ridden substance users are varied processes of awareness of the need for assessment expertise and increased knowledge, and though sometimes disgusted with the pain-ridden substance user, there is anticipation of continuing improvement and concern that the treatment process be understood by all disciplines.

Theme In The Language Of The Science Of Unitary Human Beings

Caregivers’ experiences of deliberative mutual patterning with pain-ridden substance users manifest as innovative, unpredictable, and increasingly diverse field patternings of deeper understanding, clearer evaluation of impediments, and multiple promises.

Participants’ Descriptions

Participant one

So it is really getting to know ... you have to assess that person, to see ... what kinds of problems they have, what other kind of situations may be tying into their uses of the substances ... using your assessment skills and your processing skills and being able to ... actually work with a different patient ... I think that having had that experience with that one particular patient that was so difficult to work with ... that it really made me sit back and look at, you know, that you have to look at each patient individually. ... I can look and say, I know when these people, they are not drug-seeking. You need to assess it and not just say, "oh, it’s the alcohol or it’s the drugs", you know that they are in pain ... I ... assess them even better ... listen to their concerns ... refer them where they needed to be ... someplace that would be better for them ... there are options for them, you know, the pain management clinics ... the red flags go
up a little faster ... as you get better in assessing ... That’s where the changes in the future would be ... referring them to where they needed to be, and really listening to them.

Participant two

[The process is] ... assessment. I guess I would assess the pain and then treat it and analyze it and then possibly change that process according to the outcome ... Thinking back on when I used to work on a substance abuse unit ... I developed ... a negative, experience process in relating to some of the real chronic people. I’m not proud of that, but ... that did happen ... I didn’t have the same understanding, positive understanding ... if someone I knew was trying, I could keep an open mind. But with someone like this, I didn’t have a very open mind .. with this person my mind is made up ... I would get disgusted ... when we had these chronic people that didn’t try ... I’ve never really walked in their shoes and I don’t really know what it was like ... the only thing important is from today forward.

Participant three

It’s been extensive and varied ... a range of experience and background to ... assess some of those things in a way that may be different than, say a surgical nurse or med surg nurse ... I’d like to think that I’ve become more attuned to, being able to tease out the truth or be able to validate ... I’ve become more expert in some areas of assessment ... more open to possibilities, or potentials, when assessing a situation ... I try to error in the, to the benefit of the patient and that doesn’t necessarily mean, automatically seeking to fulfill their request, but to do, an adequate enough assessment so that if they get their, whatever it is they do need, they can get some relief ... One of the things I had a strong experience with was my colleagues in the emergency department when I worked ... their first thought when in fact almost any substance dependent patient was there for any kind of medication titration or whatever, they first assumed that the patient was drug-seeking ... without even looking at what the underlying factors were. ... I’m not too good at projecting into the future ... but I just think ... my acuity will sharpen ... and I will be able to utilize ... my experience ... meeting the needs
of my patients. ... the only thing I can project into the future, although it may not be linear, it will be progressive.

Participant four

Well, it's pretty much the same as for any other person who is in pain ... you assess how much, you know, that they are in pain and you try to relieve it ... and go back and reassess it ... I realized that they actually were in a lot more pain and it made me look deeper into things ... and in my education about it. I wanted to know why they were still doing it, when the other people didn’t do this, and why, what was happening, so I went back and looked into the substance abuse ... a little more ... made me want to know more ... that I seek out more knowledge ... tried to change it ... [in the future] on an immediate level.

Participant five

It’s certainly placed me in a different position of understanding and it has changed my whole process through the years, of where I’m at today ... made me far more ... willing to listen ... I’m a better nurse ... my ability to be able to ... understand and recognize more of that it is not just to care for these physical needs, that there’s a whole person there, the holistic process ... Having started in this path ... [I’ll] continue down the same path ... being better at what I do. ... Hope ... that I can see some major changes in this particular area in my profession ... the area of substance abuse is ... still ... very misunderstood by the medical profession.

Participant six

You have to use ... a little psychological thing, and I mean over the years you learn, you learn ... certain patients respond to that ... I think they need a little bit of a couple different interventions, you know, maybe to swallow a pill they feel that they’re getting something that way ... [I’ve] changed the way I evaluate ... instead of stopping right there ... you have to seek further ... a little education, going to seminars or things like that ...
learning ... I’m always learning or reading or doing something. ... In the future I would only hope that things only get better ... as far as substance abuse pain related, I am going to just keep practicing how I’m practicing, and reevaluating and going, trying all the tricks I can think of from hand holding on to making him feel a shot too, something like that ... I learned that touching, the hand, just the power of touch is a whole lot ... it works a lot.

Participant seven

... patients are more open with their past history ... [they used to] come in and say that they don’t drink ... and go into DTs ... that’s become less of a problem because people are more open ... I can pick up some fine points where I wouldn’t have been able to do that had I not encountered [substance users] ... you’re just very frank with them and say "When was this?" ... "We need to know because it’s your well-being." ... [In the future] as the number ... decreases we are going to find more and more of them have had exposure to substance abuse, and we’re going to have to, assist them, in their treatment plans in addition to whatever else, the problems they are going to have. ... It has heightened my awareness ... more aware.

Participant eight

... a lot of change ... co-change ... constantly ... I have a lot more understanding, I have a lot more desire to ... I’m content just to change, that I know I’m changing and I’m content just to let the changes happen ... I’m very comfortable with that whole process ... [In the future] I think they just, they will, I’m not sure, because I don’t know where that is leading me ... [there are] attainments I would like to reach, rather than [be] trapped in a circle of substance abuse.

Participant nine

So, it’s kind of a tricky tightrope walking process to make sure that we meet their pain needs, and don’t subvert their
substance abuse problem ... I don’t know enough about pain medication ... I think I need more education in that direction. ... As I’ve gotten more experienced and gotten more information on pain over the years, I very thoroughly understand ... I’ve grown in my understanding ... using whatever techniques are most appropriate to relieve the patient’s pain as soon as possible, no matter what their substance abuse history is ... my understanding of the ... processes of pain have evolved, and my understanding of pain medications, while still in its formative stages, it still needs some work, but that certainly evolved over the years. ... I hope I continue to grow and I hope I get more information ... so that when I’m dealing with the patient, I’ll have better tools to measure his pain ... and the knowledge to go beyond that. ... I don’t know how to get beyond ... [those] who tend to label patients as abusers ... as being drug seekers ... but I hope in the future we’ll be able to figure that out.

Participant ten

It’s easier to make ... a more valid assessment if I’ve dealt with this patient over a period of days ... [the process is] painful, painful ... I remember specifically one individual that had major massive abdominal surgeries ... and I remember thinking to myself, you know, looking at his wounds and, seeing the extent of the surgery itself, thinking "that’s got to hurt" ... I also remember the patient saying to me at one point, that he saw the pain in my face, you know, when he was asking for pain medication, and he said, "it was really uncomfortable for you" and I, I told him, "yeah, it was" you know, seeing what I saw when I took the dressings apart ... yes ... it was a painful process for me. ... there is more of a reliance on objective data like use of a pain scale for me to help clarify things ... I’d like to think I’m more enlightened ... [in the future] I see that it’s not going to be as difficult to treat pain ... the stigma of giving an analgesic to an addict ... may be lessened, because there’ll be more objective, less subjective approaches to pain management ... [patients] will take responsibility for themselves ... so that makes it, you know, something to look forward to.

Participant eleven

Well, I actually learned more. I didn’t know that, all about the
disease ... of alcoholism, and there was a learning process for me here ... for one thing, I had more information ... I wanted to use my skills ... [regarding the future] I don’t like the fact that all the units are closing up, everything is outpatient and is it going to be as successful as it was?

Participant twelve

You got close to the patient by talking to them a lot about what’s going on in their life and what is causing all this pain, and what’s behind it ... I think you have a close rapport with the patient by ... digging into what’s going on with the patient and sitting and listening ... when you think about taking care of an alcoholic or a substance abuser, I think there’s a certain amount of disrespect for them that you feel. And then after you get to know them as a person and take care of them, you learn about the person ... aside from the addiction, and then you gain a respect for them ... that would be a change of learning to care for them ... learning to have respect for them ... there is hope for these patients ... Well, I think more people know about alcoholism ... everybody knows a person with an addiction disease and so I think they are changing their attitudes toward it. You know, that it can be a good person that ends up with a disease that happens to be addiction.

Participant thirteen

The process is mainly kind of investigational ... what’s going on with them ... what are they doing ... you have to look at what they used because if they are an opiate abuser then whatever pain medications they need are going to have to be adjusted in that light because of their tolerance levels and things like that. So, their responses to pain are going to be much different than people who are non-abusers ... their needs are going to be a lot different in terms of what will work for them and what won’t and in terms of their own perceptions of what pain is ... I have a greater understanding ... of people who abuse substances ... so, it’s just kind of changed my level of awareness ... Dealing with them hasn’t been so much of a problem as dealing with other health professionals who don’t have that same understanding and don’t give the patients the measure of respect that they need as a human being ... I see myself ...
progressing along the lines I have been moving along.

Participant fourteen

... I ... tried to assess the need of the patients, to make sure that the patient is in the right situation to get ... the help that he needs to have ... that’s what I have done. ... I have gained a lot of experience ... to identify patients ... have been deceived by their request in ... support [of] their habits ... probably in the beginning I was too empathetic with them and I was kind of naive ... but as I have worked with them for a while, I was a little more careful ... prudent in meeting the realistic need of the patient ... I’m a little more confident ... I’m more confident in the sense that my judgments are probably better than before. ... I still will probably learn more skills ... through my experience, but, I’m more confident nowadays. ... I’m a little more sure. ... better able to make ... decisions ... I think that is just experience and self knowledge. ... In the future ... I will learn more in the way ... that different patients differ, behave differently.

Participant fifteen

I try to really understand why that patient is here, if they really and truly are in pain or if they are being manipulative, because I think I have an ability to understand how that works. ... made me be more thorough in history taking and patient assessment and ... trying to elicit from the patient a little more, pain history or pain control history or things like that. Maybe I feel like I’ve had more experience now that I know how to look at it or how to look for it better ... it’s made me more aware of what their needs are and what, how legitimate they are at the time. ... If I felt the patient were here just, drug-seeking and had acting out behavior, then I would be pretty intolerant, ... like I was being taken advantage of ... again, sort of that "how stupid do you think we are" kind of feeling. And to me I think that’s a real fine line, of where you walk across that one, in trying to be objective with patients. ... And I see some people who can cross that line very quickly and assume that all of them are pain seeking. Personally I don’t know that it would change ... in the future, other than ... to continue to look at it fairly carefully both for the patients and for myself ... overall, for emergency medicine, I see
a real reluctance on the part of physicians and nurses to want to treat patients for pain ... I think ... the key is education for docs and nurses in pain control and what it is really like for folks.

**Objective Three**

Objective three flows from the homeodynamic principle of resonancy which is "the continuous change from lower to higher frequency wave patterns in human and environmental energy fields" (Rogers, 1992b, p. 31). Objective three is: To describe the caregivers' experiences of deliberative mutual patterning with pain-ridden substance users in continuously changing irreversible life processes.

**Summary Statement In The Language Of The Participants**

Caregivers' experiences with pain-ridden substance users are broadening with job changes, increasing assertiveness, movement from sadness to anger, attitude modification, and enhancement of personal growth.

**Theme In The Language Of The Science Of Unitary Human Beings**

Caregivers' experiences of deliberative mutual patterning with pain-ridden substance users manifest as changing mood patterning, lifestyles, and worldviews.
Participants’ Descriptions

Participant one

I think that I’ve been able to work through the anger ... move past that and be able to process the fact ... changes in my attitude, changes in my practice ... this particular patient, I mean he was, oh, I think he was unique, because it really impacted on my life. ... His substance abuse ended up getting his mother murdered and he ended up dying in a forest preserve ... it really made me look at ... did I want to ... deal with particular physicians, and it really changed me because I left that particular hospital and went somewhere else ... it was how I had to practice [that] was not what I wanted to do, and so for me the change was positive. ... it really made me look at my own practice and did I want to stay there and could I deal with it. ... Yeah, I changed my position. ... You grow a lot more and you are able to open up a lot more ...

Participant two

It’s just that my attitude was different. ... if I were working the substance abuse unit again I would have to find a new way to relate to this person because I think the way I was relating was definitely not going to have a positive outcome for him, or for me. ... It was a very positive experience, because I realized that people could change. I realized it is never over until you’re dead. ... It made me realize that, a person with a substance abuse problem has had everything to change in their life. ... So it really made me realize how difficult their struggle is. Learning the Twelve Steps myself changed my life in every way. ... so all in all, I mean for me, there were positive changes in my life. ... Change my nursing role? I think I ... developed a more holistic approach. ... That’s probably the biggest change.

Participant three

I probably am able to rely more on my own perceptions more, than obviously when I was a newer nurse. Thinking back on it now, being a floor nurse ... I relied more heavily on input from my colleagues, than I do now, although I have no compunction about
seeking opinions from colleagues ... why - because again, my own experience has been that my perceptions are not 100% accurate in any situation. So, validation again, one of the ways I may seek validation is either through intra-disciplinary consultation or through nurse-to-nurse consultation. ... As I said before, I can see big changes in my practice, but I don’t spend a lot of time looking back at my own ... evolvement. ... It has changed the way I practice in that I don’t try and anticipate or "disasterize", but on the other hand, I ... try not to jump too quickly to conclusions. ... My philosophy of nursing ... is "I try not to take too much credit and I try not to take too much blame" in anything I do in my practice.

Participant four

Anger toward the system, kinda, in the way they mismanage this kind of area, with this group of people, and sometimes a little anger at some of my co-workers. ... just that the whole thing makes me kind of sad for that person as to how they could live their life like that, or end it like that. ... I wouldn’t say I get angry at the person himself, it’s just that I’m kind of like distressed that they ended up like that, ... that they didn’t realize that they had a choice. ... It just leaves me with a lot of questions about why things happen to people ... it just saddens, really saddens me. ... I don’t know that it’s really a change in my nursing role. It’s just more of an expansion or a, more of a depth ... it just changes your whole view, life view ....

Participant five

I am constantly gauging both sides to see where they’re at. ... I am weighing those circumstances all the time. ... It’s evaluative, ... an ongoing process ... certainly made me far more, you know, open minded, ... really feel where the patient is at. ... As a result of my personal experiences, I’m a better nurse. It’s kind of strange that we have to go through some kind of painful experiences in order to become a stronger, better person, but that’s in fact, the truth of it. ... Having started in this path, in this direction ... one of personal growth ... has helped my professional growth. ... I just see and hope that I ... continue down the same path of expanding ... there’s a broader expanse to what I do than just the patient care. There is a whole lot more going on ....
Participant six

Oh, a little angry ... you get a little angry ... It opens you up a little bit more when you realize about pain and the understanding ... you have to, if they say they’re having pain, you have to say they’re having pain, and believe it, and everyone’s pain thresholds are a lot different. ... Oh, they’ve opened me up more because I know they have a problem, and I can appreciate instead of belittle them about it ... not being so judgmental. ... I think I understand them more than in my early years. ... You just broaden.

Participant seven

I feel very, as I told you before, very sad ... just a little more alert. ... We are not judgmental, we just need to know ... so you’re more assertive in that respect.

Participant eight

I started out with attempting to understand and then went to anger, well, yeah, I guess it was anger too in the beginning, and greater anger and pain, lots of pain ... I think some of the anger was partly due to the nursing process itself, dealing with them on the floor, dealing with their attitudes ... I used to feel responsible ... I felt I had to change the patient, that if the patient didn’t change somehow it was partly my fault ... certainly part of my nursing process. The patient didn’t change, then somehow I hadn’t done my job right. ... I didn’t want to be like that. ... And how does that change me? I don’t really know, except that it does. ... Now I no longer concern myself with the patient’s change ... I’ve come to accept people being whatever they are ... I’m more concerned with comfort and peace, and ... quality of life than I am with ... changing people, making them well, things like that. ... I just don’t have the need to judge them. ... Yeah, to be a more, to have more wisdom, to have more freedom inside my soul. ... It’s assisted with my growth.
Participant nine

I’ve gotten more experienced ... my experience over the years has given me some of the ways that I didn’t know when I was a new graduate, for instance ... for me it’s a growth process ... and a personal goal of trying to be kind. ... My nursing role has progressed from a technical ... to the collaborative role with other healthcare providers and ... with the patient ... It’s made my role a little more challenging ... it’s broader than it was before ... but, I still feel I have a very broad sense of my role. ... I have seen my ... substance abuse patients in pain, I’ve gotten to know them and ... become more engaged with them over time. ... So in my nursing role, I often get along better with some of these patients that the other nurses see as difficult.

Participant ten

I am comfortable knowing that I can’t take and nor should I be in a position to take all of the pain away. ... I can relax and know that I’ve helped that person achieve whatever optimal level they can function with. ... So, I’d say that it’s changed my role more from hands off, [to] more of a partner as opposed to a mother role. You know where I was totally responsible for this client, the entire time ... which was something I felt was very much a nursing role ... and I don’t see that now. ... We agree on what the services will be and how that needs to be managed ... and what the goals are. You know for each one of us ... It’s more of a challenge to me ... I’m optimistic. I feel really good and excited about every, all the research. ... [In reference to a specific patient’s care] this man suffered and I mean he suffered for a good week or two before they managed his pain. That has changed me, a lot in terms of how I saw pain management with the alcoholic. ... I think it did affect my choices in where I was working ... I wanted out ...

Participant eleven

... the first patient ... there might have been some caution ... and then when you experienced more patients, you made changes in the way you felt. ... We did feel kinda discouraged sometimes ... Well, I guess I could get a little angry. I think! I’m sure I did! And
maybe that part wouldn’t show, but I did get angry, yes. And I would tell them, not, I mean I wasn’t swearing at them or anything like that, but I would tell them that we were, you know, upset about this because we believed they could get well! ... It’s not going to change! [how it changed her or her nursing role] I mean, I’m not working there, but I feel that it is still, still very important ... and I don’t think I’ll ever change since I worked up there!

Participant twelve

There is help. There are things they can do to help themselves and there are things that we can do to help them and those are the changes in me that have taken place. ... It made me feel good that we could do these things and help the patient to better themselves. ... Well ... I was better able to take care of them ... There was a change [nursing role]. It was not so mechanical. You know, you spent time with them and there was a close nurse-patient relationship as a result of that. ... I just felt hopeful and good about the whole process.

Participant thirteen

Well, I have a greater ... tolerance ... it puts me in the position of having to be more, more strident and supporting in what their needs are and to be more assertive in terms of ... what the patient’s needs are, and to address their specific issues.

Participant fourteen

As a person, I don’t think I have changed any, because my philosophy of nursing has not changed. I personally have not changed .. I ... always provided care as well as possible. ... I still have the same attitude and philosophy.
Participant fifteen

[Regarding personal growth] ... if the patient were truly in pain and truly needed pain relief ... I ... would be fairly tolerant of any behavior ... acting out type behavior ... [role changes] being more thorough ... trying to establish some trust with that patient so that I would feel like they are really telling me everything I needed to know and I could make a good judgment call. Knowing or feeling like when it was appropriate to sort of convince the ER doc that "yes this person really is in pain and here's how we need to deal with this" ... or "this one doesn't sound quite appropriate", that kind of thing. ... that's the toughest part.

Summary Statements

In The Language Of The Participants

Objective One
Caregivers' experiences with pain-ridden substance users are difficult with ambivalent feelings of frustration, empathy, and compassion that often may lead to collaborative advocacy with continuing concern for drug-seeking behavior.

Objective Two
Caregivers' experiences with pain-ridden substance users are varied processes of awareness of the need for assessment expertise and increased knowledge, and though sometimes disgusted with the pain-ridden substance user, there is anticipation of continuing improvement and concern that the treatment process be understood by all disciplines.
Objective Three
Caregivers’ experiences with pain-ridden substance users are broadening with job changes, increasing assertiveness, movement from sadness to anger, attitude modification, and enhancement of personal growth.

Summary Of Themes
In The Language Of The Science Of Unitary Human Beings

Objective One
Caregivers’ experiences of deliberative mutual patterning with pain-ridden substance users emerge as uniquely integral field patterns manifesting arduous contradictions with a continuous supportive mutual process.

Objective Two
Caregivers’ experiences of deliberative mutual patterning with pain-ridden substance users manifest as innovative, unpredictable, and increasingly diverse field patternings of deeper understanding, clearer evaluation of impediments, and multiple promises.
Objective Three

Caregivers' experiences of deliberative mutual patterning with pain-ridden substance users manifest as changing mood patterning, lifestyles, and worldviews.

Hypothesis

The hypothesis for this research study emerges from the synthesis of the themes in the language of the science of unitary human beings for objective one, objective two, and objective three, and answers the research question: What is the caregiver's experience of deliberative mutual patterning with pain-ridden substance users in relation to: mutual field patterning process; innovative, unpredictable diversity; and continuously changing patterning? Therefore, the hypothesis is The caregivers' experiences of deliberative mutual patterning with pain-ridden substance users manifest as innovative, unpredictable, and increasingly diverse field patternings of deeper understanding, clearer evaluation of impediments, and multiple promises, with a uniquely integral continuously supportive mutual process with arduous contradictions in irreversible lifestyle and worldview changes.
CHAPTER V

DISCUSSION OF FINDINGS

This study sought to discover, from 15 participants, experiences of deliberative mutual patterning with pain-ridden substance users. The research question, "What is the caregiver's experience of deliberative mutual patterning with pain-ridden substance users in relation to: mutual field patterning process; innovative, unpredictable diversity; and continuously changing patterning?" is answered by an hypothesis synthesized from the analysis of the participants' interviews. The hypothesis is: The caregivers' experiences of deliberative mutual patterning with pain-ridden substance users manifest as innovative, unpredictable, and increasingly diverse field patternings of deeper understanding, clearer evaluation of impediments, and multiple promises, with a uniquely integral continuously supportive mutual process with arduous contradictions in irreversible lifestyle and worldview changes.

Field patterning manifestations are viewed as significant to the process of change (Rogers, 1992b) with continuous change considered the unifying concept in the mutually exclusive homeodynamic principles (Barrett, 1988). In this chapter the participants' descriptions, which are
the manifestations of the caregivers' processes of deliberative mutual patterning with pain-ridden substance users, are discussed in relation to the three homeodynamic principles of the science of unitary human beings. Serendipitous findings are also discussed.

Findings Relative To Objective One

Objective one derives from the principle of integrality, "the continuous mutual human field and environmental field process" (Rogers, 1992b, p. 31). Integrality disavows causality thus affirming the continuous mutual human field and environmental field process (Rogers, 1992b): It is important to remember that "association does not mean causality" (Rogers, 1992b, p. 30). Participants' descriptions clarify nursing knowledge concerning the continuous mutual process.

Participants describe arduous contradictions as ambivalent feelings in caring for pain-ridden substance users by saying "it's just like caring for any other patient and yet it is very difficult." The difficulty is associated with several circumstances. If the caregiver knows that the patient is a substance user, there is a tendency to question or even disbelieve the patient's complaints of pain or need for medication. Other difficulties arise from a concern about the possibility of a request for pain medication being a drug-seeking behavior and the caregiver's anxiety about how to approach pain relief for the substance user, which may be compounded by a lack of
cooperation from other disciplines. One participant expresses this process as, "... not any different for me than any patient who’s asking for pain medication", while another relates, "... it was real difficult to want to give him anything because of his drug-seeking behavior, prior, you know."

Another participant describes the process in this way:

... sometimes what the doctor orders for the pain medication isn’t enough for them, doesn’t seem to do anything for them at all, they need higher levels of pain control, analgesics, so it makes me more and more anxious actually. I’m anxious because I have no control over the situation because they’re in pain and the doctors won’t give them anything else ... I can’t do anything for them. I mean, I can try ... .

Another participant believes

Everybody deserves a chance to be given pain medication if they are generally in pain. ... I look at them [pain-ridden substance users] as a person ... you have to look at the person individually ... and if somebody says they’re in pain, then you have to believe that they are in pain, and if a problem arises later ... in regards to a substance or something, then you can deal with that; but you have to believe that the person is in pain.

Some participants describe experiences of discord with co-workers from their disciplines and other disciplines regarding pain relief for substance users, depicting situations wherein other healthcare providers show biases that do not facilitate pain relief for the substance user; and since interdisciplinary collaboration is expected, the caregiver can not give care that relieves the pain. This was exemplified by one participant as

... My last shift ... an alcoholic ... came in, appearing to be in very great pain, bent over, clutching his middle, and crying out. Blood pressure, diastolic was 128, his heart rate was 120, and yet the doctor and nurse I was working with ... said “this guy is seeking
narcotics" ... I said, "I judge him to be in pain." And, and they called me "Pollyanna!" ... Well, I feel a couple of different ways. One, that if he has pain that pain ought to be relieved. ... .

The caregivers’ ambivalent feelings emerge as arduous contradictions of uniquely integral field patternings, manifesting as compassion, empathy, and frustration. One participant describes ambivalent feelings when saying "... I ... have compassion for them" and "I would be frustrated and think they are really not trying ... ." Another participant says, "I’m a lot more compassionate ... more willing to trust the patient and to feel empathy for the patient", yet "[I feel] fairly skeptical, as to the degree of pain, depending on the story, depending on circumstances". According to Rawnsley (1985), from a Rogerian perspective, "empathy is knowledge of the integral self, of the emotional patterning common to the species" (p. 27), which facilitates the human and environmental field integrity.

The participants describe feelings of empathy and compassion as closely related to the nurse-person process, a continuous supportive mutual process manifesting as collaborative advocacy for the whole person. One participant offers this description, "Well, in my view, the nurse-person process has a lot to do with advocacy for the patient. ... The collaborative process ... that occurs now was never part of the process in those days. So that’s evolved. Advocacy has evolved." This could also be described as the participant’s facilitation of the pain-ridden substance user’s "actualization of potentials for health and well-being" (Barrett, 1990d, p.
34), a manifestation of the deliberative mutual patterning phase of Rogerian practice. The caregiver’s experience of deliberative mutual patterning manifests as an integral continuously evolving mutual process between caregivers and pain-ridden substance users, the "... mutual process whereby knowledgeable caring for people continuously evolves" (Barrett, 1988, p. 51).

**Findings Relative To Objective Two**

Objective two reflects the homeodynamic principle of helicy. Helicy "is the continuous, innovative, unpredictable, increasing diversity of human and environmental energy fields" (Rogers, 1992b, p. 31). Caregivers of pain-ridden substance users express their experience of deliberative mutual patterning as continuous, innovative, unpredictable, increasingly diverse field patterning manifestations of deeper understanding, clearer evaluation of impediments, and multiple promises.

The deeper understandings are described by participants in a variety of ways. One participant says

As I get older and see, that’s what I sense that patients want. They want someone who is on their side, who will give them straight information, who will be there ... just being with them. ... I’ve evolved over the years, from someone who was very, just skill oriented, you know, give the injection, start the IVs, and head back to my nursing station, to now, where I ... have more presence with the patients ... [to] be there in more than just the technical sense.

Another participant states, "It’s been extensive and varied. ... I ... assess
... in a way that may be different. ... I have become more expert in some areas of assessment" while another relates, "... it made me want to look deeper into things ... I wanted to know why ... it made me want to know more." Another participant describes the patterning manifestations of deeper understanding as

learning how to deal with a substance user ... and just learning or finding what little tactics work best. ... You have to use a little psychological thing, and I mean, over the years, you learn to give them, to start with pain medicine. ... I learned that touching, the hand, just the power of touch is a whole lot. ... It works a lot!

"... There is more of a reliance on objective data, like the use of a pain scale, for me to help clarify things" states another participant, whereas another views these manifestations as

mainly kind of investigational. ... Their needs are going to be a lot different in terms of what will work for them and what won’t and in terms of their own perceptions of what pain is. ... I have a greater understanding ... so it’s just kind of changed my level of awareness.

Another participant says "I would get disgusted ... when we had these chronic people that didn’t try. ... I’ve never really walked in their shoes and I don’t really know what it was like."

The following statements represent participants’ descriptions of a clearer evaluation of impediments as manifested in innovative, unpredictable, and increasingly diverse patternings. One participant relates, "I can pick up some fine points where I wouldn’t have been able to do that had I not encountered [substance users] ... You’re just very frank with them and say, ‘When was this?’ ... ‘We need to know because it’s your
Another participant states, "Well, I actually learned more. I didn’t know ... all about the disease process ... of alcoholism, and there was a learning process for me here." Another participant describes it as

... when you think about taking care of an alcoholic or substance abuser, I think there’s a certain amount of disrespect for them that you feel. And then after you get to know them as a person and take care of them, you learn about the person ... aside from the addiction, and then you gain a respect for them.

Caregivers describe multiple promises as the anticipation of continuing improvement of healthcare for substance users reporting pain and following up on concerns that the treatment process is understood by all disciplines. The concern regarding the importance of the treatment process being understood by other disciplines is touched on by Tuyn (1994):

Rogerian ... thinkers agree that people are resourceful and resilient in solving dilemmas, surviving difficulties, and creating satisfying lives for themselves. Our central challenge in nursing is to support that process. Therefore, a person’s ability to change and participate knowingly in change (Barrett’s (1988) definition of power) must never be underestimated. Indeed, clients can actually be harmed by the use of pathological labels and frameworks that underestimate their abilities (pp. 209-210).

Participants’ descriptions give evidence of these concerns. One participant relates, "My acuity will sharpen ... and I will be able to utilize ... my experience ... meeting the needs of my patients", while another participant vows "[I’ll] continue down the same path ... being better at what I do. ... Hope ... I can see some major changes in this particular area in my profession, ... the area of substance abuse is ... still ... very
misdunderstood by the medical profession." Another participant recounts

I hope I continue to grow and I hope I get more information ... so that when I’m dealing with the patient, I’ll have better tools to measure his pain ... and the knowledge to go beyond that. ... I don’t know how to get beyond ... [those] who tend to label patients as abusers ... as being drug seekers ... but I hope in the future we’ll be able to figure that out.

Another participant says

I see myself ... progressing along the lines I have been moving along. ... Dealing with them hasn’t been so much of a problem as dealing with other health professionals who don’t have that same understanding and don’t give the patients the measure of respect that they need as a human being.

Yet another participant describes the concerns as

In the future, ... [I’Il] continue to look at it fairly carefully both for the patients and for myself ... overall, for emergency medicine, I see a real reluctance on the part of physicians and nurses to want to treat patients for pain ... I think ... the key is education for docs and nurses in pain control and what it is really like for folks.

The participants’ report gaining deeper understanding, learning clearer ways of evaluation of impediments, and recognizing promises for the future through their experiences of deliberative mutual patterning with pain-ridden substance users. These descriptions are expressed as continuous, innovative, unpredictable, and increasingly diverse field patterning manifestations. These findings are consistent with Rogers’ (1988) statement, "The future is one of growing diversity, of accelerating evolution, of non-repeating rhythmicities" (p. 101).
Findings Relative To Objective Three

Objective three flows from the homeodynamic principle of resonancy which is "the continuous change from lower to higher frequency wave patterns in human and environmental energy fields" (Rogers, 1992b, p. 31). Wave patterns of the human field resonate with wave patterns of the environmental field. Caregivers’ descriptions of their experiences of deliberative mutual patterning with pain-ridden substance users manifest as continuously changing from lower to higher frequency in mood patterning, lifestyle, and world views.

One participant describes the experiences as, "It’s just more of an expansion or a, more of a depth ... you just notice life and you process it ... and it becomes part of you." Another participant clarifies it in this way:

... That change carries over into all aspects of my life, you know, my own emotional and spiritual well-being ... there’s a broader expanse to what I do ... there is a whole lot going on ... I would just see and hope that I would ... continue down the same path of expanding ....

Yet another participant explains, "But, I still feel I have a very broad sense of my role."

Awareness facilitates choices, focuses attention on perceptions (Barrett, 1986), and reflects the resonating changes in directional human field patterning. The participants’ experiences reflect the directional human field patterning of the caregiver and pain-ridden substance user’s deliberative mutual patterning process. For example, mood changes are
described in various ways by the participants. One participant portrays it in this way, "I think I've been able to work through the anger ... move past that ... [there are] changes in my attitude", while another participant states, "It's just that my attitude was different." One participant feels, "distressed ... [there is] anger at the system. It just leaves a lot of questions about why things happen to people." Another participant elaborates

I started out with attempting to understand and then went to anger, well, yeah, I guess it was anger too in the beginning, and greater anger ... I think some of the anger was partly due to the nursing process itself, dealing with them on the floor, dealing with their attitudes. ... I used to feel responsible, ... I felt I had to change the patient, that if the patient didn't change somehow it was partly my fault ... certainly part of my nursing process. The patient didn't change, then somehow I hadn't done my job right. ... I didn't want to be like that. ... I've come to accept people being whatever they are ... I just don't have the need to judge them.

Another participant says, "... I'm optimistic. I feel really good and excited about everything, all the research", while another relates

"... I did get angry, yes. And I would tell them, not, I mean I wasn't swearing at them or anything like that, but I would tell them that we were, you know, upset about this because we believed they could get well!"

Yet another participant describes the change as, "Well, I have a greater ... tolerance."

Continuous change is considered the unifying concept in the homeodynamic principles, even though the principles are mutually exclusive (Barrett, 1988), and it is the goal of nurses to participate in this process of
change for the benefit of humankind (Rogers, 1988). In this study change was evident in participants’ descriptions of irreversible lifestyle and worldview changes.

One participant discloses

Yes ... [there were] changes in my practice. ... I was happy with the people I worked with. ... it was that, how I had to practice was not what I wanted to do. ... It really made me look at my own practice and did I want to stay there and could I deal with it. ... I changed my position ... the change was positive ...

Another participant reveals, "... it just changes your whole view, life view", while for another participant, "... sometimes, it has been a hard process. ... [yet] it’s assisted with my growth." One participant relates, "I’ve gotten more experienced ... my experience over the years has given me some of the ways that I didn’t know when I was a new graduate, for instance ... for me it’s a growth process ...." Another participant divulges, "[In reference to a specific patient’s care] that has changed me ... I think it did affect my choices in where I was working ... I wanted out ....", and indeed, that participant did change jobs. In regard to how it changed his or her nursing role, another participant emphatically states, "... It’s not going to change! I mean, I’m not working there, but I feel that it is still, still very important ... I don’t think I’ll ever change since I worked up there!"

Another participant describes, "it puts me in the position of having to be more, more strident and supporting in what their needs are and to be more assertive in terms of ... what the patient’s needs are ...." This reflects the
resonating changes in the caregivers’ human fields when pain-ridden substance users were in the caregivers’ environmental fields.

Serendipitous Findings

There were some interesting serendipitous findings from this study. In many participants’ descriptions, comments were made as to whether the substance users’ pain was alleviated. According to the related literature, the facilitation of pain alleviation for substance users is often less than ideal in most healthcare areas (Coyle, 1989; Cross & Urbanski, 1994; Kemp, 1995; Koo, 1995; Lisson, 1989; McCaffery, 1991; Miller, 1994; Payne, 1989; Portenoy, 1989; Von Gunten & Von Roenn, 1994; Waldrop & Mandry, 1995). Several participants believe that the substance users’ pain is managed fairly well, while others do not feel it is managed well; that seems to be related to their chosen service areas. For instance, in areas where pain is expected, such as the operating room area, recovery area, and surgical intensive care, the substance user’s complaints of pain may be evaluated and responded to with more compassion, than in the emergency area. This diversity of responses to pain-ridden substance users by nurses and other healthcare providers reflects the mutual processes of the human and environmental energy fields in continuously changing patterning.
CHAPTER VI

CONCLUSIONS, RECOMMENDATIONS, REFLECTIONS

This research study examined the caregiver’s experience of deliberative mutual patterning with pain-ridden substance users, a phenomenon which has not been studied previously. Using Martha Rogers’ (1970, 1980, 1987, 1988, 1990, 1992b, 1994b) science of unitary human beings as the theoretical base to guide the qualitative descriptive exploratory study, the researcher explored with 15 participants, their experiences of deliberative mutual patterning with pain-ridden substance users. The purposes of this study were to expand nursing science, provide knowledge enrichment related to the science of unitary human beings, and to answer the research question. In this chapter, conclusions are presented relative to the aforementioned purposes, with recommendations for further research and practice. The last section of this chapter offers reflections on this research.

Conclusions

The research participants, 13 women and 2 men, described their
experiences of deliberative mutual patterning with pain-ridden substance users. Manifestations of the deliberative mutual patterning process, as exemplified by the participants' descriptions, were analyzed and synthesized into the following hypothesis: The caregivers’ experiences of deliberative mutual patterning with pain-ridden substance users manifest as innovative, unpredictable, and increasingly diverse field patternings of deeper understanding, clearer evaluation of impediments, and multiple promises, with a uniquely integral continuously supportive mutual process with arduous contradictions in irreversible lifestyle and worldview changes. This hypothesis answered the research question: What is the caregiver's experience of deliberative mutual patterning with pain-ridden substance users in relation to: mutual field patterning process; innovative, unpredictable diversity; and continuously changing patterning? This fulfilled the main purpose of the study. The findings were discussed in relation to the three study objectives which flowed from the homeodynamic principles of the science of unitary human beings. Serendipitous findings were also presented.

This research study investigated a phenomenon that has previously been unexplored. Much new knowledge about the caregiver's experience of deliberative mutual patterning with pain-ridden substance users has been gleaned from this study. Some examples are that caregivers have ambivalent feelings of frustration, empathy, and compassion that may
often lead to: collaborative advocacy; continuing concern for drug-seeking behavior; an awareness of the need for assessment expertise and increased knowledge; concern that the treatment process is understood by all disciplines; and personal growth and attitude changes along with times of discouraging sadness and anger. This study has contributed to the growing science base of nursing by increasing knowledge of the manifestations of the caregiver's experience of deliberative mutual patterning with pain-ridden substance users that may assist caregivers in providing care that facilitates pain relief.

**Recommendations**

The descriptive exploratory method enhances understanding and begets hypotheses for future research (Parse et al., 1985). Another contribution from qualitative research findings is related to practice. Mitchell (1996) says that from qualitative findings there are "theory expansion and transformational shifts in knowing" (p. 143). In the following two sections of this chapter the author recommends future research to expand the science of unitary human beings and offers ways that transformational shifts in knowing may enhance nursing practice.
Recommendations For Future Research

No other studies were found that explored the caregiver’s experience of deliberative mutual patterning with pain-ridden substance users. Additional research concerning this phenomenon would expand understanding within the science of unitary human beings. While this study’s participants were caregivers who had experienced deliberative mutual patterning with pain-ridden substance users, three of the participants were also recovering substance users. In conversation that evolved after their interviews were completed, two of them said they feel it would be beneficial for other recovering caregivers to reflect on some of the issues that surface when recalling instances of caring for pain-ridden substance users. A future research study could be conducted with recovering caregivers as participants describing their experiences of caring for pain-ridden substance users. A study could also investigate the uniqueness of the recovering caregivers’ mutual process with their environments. Another study connected to substance users might be to explore elderly alcoholics’ descriptions of quality of life as manifestations of the mutual process between human and environmental energy fields since "... quality of life is integral with and a manifestation of life" (Phillips, 1995). Then lastly, since some serendipitous findings suggested possible ethical dilemmas for caregivers’ of pain-ridden substance users, a study, qualitative or quantitative, exploring this could add to nursing knowledge.
Recommendations For Practice

While the findings from this study reflect some of the dehumanizing care that pain-ridden substance users experience from nurses and other healthcare providers, they also reflect the caring of nurses in the promotion of health and well-being. Knowing the findings of this study, nurses may work with nursing administration and other healthcare providers in the development of policies and standards of care for substance users who are reporting pain. Nursing educational programs could center on issues of caring for substance users who are in pain. Some examples are: methods of providing appropriate care; ways of evaluating nurses’ needs for strengthening their appraisal skills and other competencies that are necessary for the provision of appropriate care to pain-ridden substance users; and interdisciplinary forums to assist with collaboration.

Support or guidance groups could also be offered to deal with attitude changes, as well as provide assistance during the times of discouraging sadness and anger; this could facilitate personal growth. Translating, or transforming, knowledge into human service appears to be a "high priority" for the participants of this study. This transforming is evidenced in participants’ descriptions of personal lifestyle and worldview changes which arose after caring for pain-ridden substance users.

Most nurses do tend to be continuous learners. It is with this in
mind that the researcher quotes from Martha Rogers’ 1966 article on nursing’s story:

Nursing’s story is a magnificent epic of service to mankind. It is about people: How they are born, and live and die; in health and in sickness; in joy and in sorrow. Its mission is the translation of knowledge into human service.

Nursing is compassionate concern for human beings. It is the heart that understands and the hand that soothes. It is the intellect that synthesizes many learnings into meaningful ministrations.

For students of nursing the future is a rich repository of far-flung opportunities--around this planet and toward the further reaches of man’s explorations of new worlds and new ideas. Theirs is the promise of deep satisfaction in a field long dedicated to serving the health needs of people (Rogers, 1966, p. 60).

Madrid and Barrett (1994) augment Rogers’ (1966) thoughts by writing the following: "The potential for Rogers’ science to contribute to changes in healthcare is powerful: it is a participatory model whereby consumers and health professionals form knowledge-based alliances to promote health and well-being" (p. xx). Smith (1994) offers support for theory-guided nursing when she says "Nursing theory-based practice offers an alternative to the dehumanizing, fragmenting, and paternalistic approaches that plague current delivery systems" (Smith, 1994, p. 7). While nursing theory-guided practice is the ideal, that is probably not the reality of most practice today.

It is the author’s belief that nurses need to be in touch with their own rhythms as well as the rhythms of their patients. An understanding of the science of unitary human beings and its practice methodology might prompt nurses to be guided by this theory which could strengthen the way caregivers provide care with pain-ridden substance users. This science
guides nurses to focus on the patient’s participating knowingly in health situations differently from the traditional nursing process which focuses on the caregiver’s activities (assessment, planning, interventions, and evaluations) and does not necessarily include the patient as an active participant in the process.

**Reflections**

In 1990, Martha Rogers exhorted the readers of a new book on Rogers’ science-based nursing to: "Read the chapters in this book within the context of a new worldview. Examine them carefully for contradictions. Envision a future not yet here. Enjoy your forays into the unknown. Change is continuous, inevitable, and exciting" (p. 11). This researcher heard and answered that clarion call during doctoral coursework in late 1995, embarking on an arduous journey down "the road less traveled" (Parse, 1996), which entailed a change of worldview, and led to this research study.

The experience of beginning doctoral research guided by two renowned scholars of the simultaneity paradigm brought to life some of the perils along that "road less traveled" (Parse, 1996). The preciseness and rigor necessary for excellence in qualitative research and for research in the study of unitary human beings and their environments has been adhered to
passionately. There is deep satisfaction in conducting research in a field such as nursing, where the mission is the translation of knowledge into human service (Rogers, 1966).
APPENDIX A

LETTER OF PERMISSION FROM
COMMUNITY HOSPITAL OF OTTAWA
December 5, 1996

Gaile L. Nellett, RN, MSN
Box 730 South Wabena Avenue
Minooka IL 60447

Dear Ms. Nellett;

I have reviewed the letter of explanation you sent regarding your request to collect data for your dissertation research project and grant permission for you to collect data at Community Hospital of Ottawa. I will inform Maeanne Stevens, the Director of Nursing, that you will be interviewing five nurses from various areas of the hospital.

If you need any assistance while you are here please feel free to call or stop by.

Sincerely,

Judy A. Christiansen RN, MS
Vice President Patient Care
APPENDIX B

LETTER OF PERMISSION FROM
VA EDWARD HINES JR HOSPITAL
APPENDIX B

LETTER OF PERMISSION FROM
VA EDWARD HINES JR HOSPITAL

DEPARTMENT OF VETERANS AFFAIRS
Edward Hines, Jr. Hospital
Hines, IL 60141

April 1, 1997

In Reply Refer To: 578/002

Ms. Gaile L. Nellett, MSN, RN
108 South Wabena Avenue
Box 730
Minooka, IL 60447

Dear Ms. Nellett:

Thank you for following up on your November, 1996 request to access nurses at Hines for your research. I discussed your request with the Nursing Executive Board (NEB) today. We all agree that it is feasible for you to recruit and interview 10 registered nurses for not more than 30 minutes each at a mutually-convenient time.

Please send me a copy of your final abstract and of your questionnaire, along with a copy of the approval of your study. Since you are not accessing patients I realize that you do not require Institutional Review Board (IRB) approval. Dissertation Advisor approval will suffice.

We invite you to briefly (10" - 15") present your proposal to the NEB any Tuesday morning at 9:00 a.m. in G416. We also invite you to present your research findings when the study is completed. Please contact my secretary, Michele Eskridge, at (708) 343-7200 extension 5003 to arrange a date.

Ms. Judy Beck, Chief, Mental Health Nursing, extension 7840, is your contact person at Hines.

We look forward to meeting you.

Laura J. Nosek, PhD, RN

p.c.: J. Beck
APPENDIX C

ANNOUNCEMENT 1
APPENDIX C

ANNOUNCEMENT 1

Announcement: Community Hospital of Ottawa

Volunteers Needed For Nursing Research Study

The Caregiver’s Experience of Deliberative Mutual Patterning
With Pain-Ridden Substance Users

My name is Gaile Nellett. I am a doctoral candidate in nursing at Loyola University Chicago and I am looking for nurses to participate in a research study on The Caregiver’s Experience of Deliberative Mutual Patterning With Pain-Ridden Substance Users.

If you are a nurse who has taken care of a substance user who was reporting pain, please consider volunteering. Your participation would consist of a confidential and anonymous audiotape recorded interview that would last about 30 minutes or less, and would be scheduled at your convenience.

For more information, please call me at (815) 467-9233, or leave a phone number with the secretary at Nursing Service, ext. 478 and I will call you back.
ANNOUNCEMENT 2

ANNOUNCEMENT
Veterans’ Affairs Edward Hines Jr. Hospital

Volunteers Needed For Nursing Research Study

The Caregiver’s Experience of Deliberative Mutual Patterning
With Pain-Ridden Substance Users

My name is Gaile Nellett. I am a doctoral candidate in nursing at Loyola University Chicago and I am looking for nurses to participate in a research study on The Caregiver’s Experience of Deliberative Mutual Patterning With Pain-Ridden Substance Users.

If you are a nurse who has taken care of a substance user who was reporting pain, please consider volunteering. Your participation would consist of a confidential and anonymous audiotape recorded interview that would last about 30 minutes or less, and would be scheduled at your convenience.

For more information, please call me at (815) 467-9233, or leave a phone number with Emily at Loyola School of Nursing, Maywood, IL, ph. (708) 216-9101, and I will call you back.
APPENDIX E

LETTER OF APPROVAL FROM
LOYOLA UNIVERSITY CHICAGO INSTITUTIONAL REVIEW BOARD
APPENDIX E

LETTER OF APPROVAL FROM
LOYOLA UNIVERSITY CHICAGO INSTITUTIONAL REVIEW BOARD

INSTITUTIONAL REVIEW BOARD
RESEARCH SERVICES OFFICE
LOYOLA UNIVERSITY OF CHICAGO
6525 NORTH SHERIDAN ROAD
CHICAGO IL 60626
Tel: (312) 508-2471 Matthew Creighton, SJ, Chair

August 1, 1997

Investigator: Gaile L. Nellett
Home Address: P. O. Box 730
108 South Wabena Avenue
Minooka, Illinois 60447
Home Telephone: 467-9233 [Area Code: 815]

Please check the above information for accuracy
and call in any corrections to 508-2471

Dear Colleague,

Thank you for submitting the following research project for review by the Institutional Review Board for the Protection of Human Subjects:

Project Title: The Caregiver's Experience of Deliberative Mutual Patterning with Pain-Ridden Substance Users

After careful examination of the materials you submitted, we have approved this project as described for a period of one year from the date of this letter.

Approximately eleven months from today, you will receive from the IRB a letter which will ask whether you wish to apply for renewal of IRB approval of your project. You will be asked whether there have been any changes in the nature of the involvement of human subjects in your project since it was first approved, and whether you foresee any such changes in the near future. If your responses to these questions are timely and sufficiently explicit, the IRB will at that time renew your approval for a further twelve-month period. If you do not return that form by August 1, 1998, however, your approval will automatically lapse.

This review procedure, administered by the IRB itself, in no way absolves you personally from your obligation to inform the IRB in writing immediately if you propose to make any changes in aspects of your work that involve the participation of human subjects. The sole exception to this requirement is in the case of a decision not to pursue the project—that is, not to use the research instruments, procedures or populations originally approved. Researchers are respectfully reminded that the University's willingness to support or to defend its employees in legal cases that may arise from their use of human subjects is dependent upon those employees' conformity with University policies regarding IRB approval for their work.

Should you have any questions regarding this letter or the procedures of the IRB in general, I invite you to contact me at the address or the telephone number shown on the letterhead. If your question has directly to do with the project we have just approved for you, please quote file number 1748.

With best wishes for your work.

Sincerely,

Matthew Creighton, SJ

M. Caproni, Graduate School; GRANDA CENTRE--LSC
inter-office memorandum to R. R. Perse--original notification
(fax sent on Monday-9/29/97)
APPENDIX F

PARTICIPANT INFORMATION
You are being asked to participate in a study conducted by Gaile L. Nellett, a Ph.D. Nursing candidate at Loyola University Chicago. Although this study may not benefit you directly, it will provide information that may in the future assist nurses in improving the delivery of nursing care.

This study has been approved by the appropriate persons at Edward Hines Jr. Veterans Affairs Hospital, Hines, IL; Community Hospital of Ottawa, Ottawa, IL; and the Institutional Review Board (IRB) at Loyola University of Chicago.

Study participation involves no foreseeable risks or harm to you. Participation will consist of one tape-recorded interview between you and Mrs. Nellett. This will last approximately one-half hour or less, and be scheduled at your convenience at your workplace. You will be asked open-ended questions regarding your experience with substance users who are reporting pain. Demographic data will also be collected, consisting of gender, age, years working in nursing, years worked in current facility, nursing education, and any family or self history of substance use.

The information you share will be strictly confidential. No names will be used in the study, either on the tape, in the transcribed papers, or in the written report. You will be assigned a number to be used on the information that will not be linked to your name. The tape will be erased after the study is completed. All study data collected by Mrs. Nellett will be stored in a secure place.

Your participation in this study is voluntary; you are under no obligation to participate. You may withdraw from this study at any time for any reason without penalty. You are free to ask any questions about this study or about being a subject. You may call Mrs. Nellett at home (815) 467-9233, if you have any other questions.
APPENDIX G

CONSENT FORM
APPENDIX G

CONSENT FORM

CONSENT FORM

Research Study Name:
The Caregiver's Experience of Deliberative Mutual Patterning With Pain-
Ridden Substance Users

Investigator: Gaile L. Nellett, RN; MSN, PhDc
Doctoral Candidate
Loyola University Chicago

I hereby consent to participate in this study. The purpose and process of this study has been thoroughly explained to me. I have also read the information sheet and had any questions fully answered. I understand that Mrs. Nellett will tape-record my interview with her that will last approximately one-half hour, and will erase that tape at the end of the study. I also understand that a transcript of this tape-recording will be made. My name will not be used on the tape, any transcribed papers, or any reports that result from this. I understand that I may withdraw from this study at any time for any reason without penalty.

I also understand that Mrs. Nellett will discuss study data for the purpose of data analysis-synthesis with her Dissertation Committee. My name will not be used in this discussion.

I have read this consent form and voluntarily consent to participate in this study.

Participant's Signature __________ Date __________

I have explained this study to the above participant and have sought his/her understanding for informed consent.

Investigator's Signature __________ Date __________
APPENDIX H

DEMOGRAPHIC QUESTIONNAIRE
APPENDIX H
DEMOGRAPHIC QUESTIONNAIRE

Demographic Questionnaire

Participant #_______

Sex:  Female____  Male____  Age: ______

Race: ______________________

Nursing Education: (check all that apply)

  Associate Degree _____
  Diploma _____
  Bachelors _____
  Masters _____
  Doctorate (Nursing) _____ (Other) _____

Years Worked In Nursing? ______

Years Worked In Current Facility? ______

Family History Of Substance Use? Yes_____ No_____

Self History Of Substance Use? Yes_____ No_____
REFERENCES


VITA

Gaile Hausaman Nellett was born and raised in Ottawa, Illinois. In 1974, she graduated cum laude from Illinois Valley Community College, Oglesby, Illinois, with an A.A.S. in nursing. While there, she received the Sandman Scholarship from the American Lung Association and was inducted into Phi Theta Kappa, honors fraternity. In 1983, she was honored as Business Associate of the Year, Charter Chapter, American Business Women of America, for excellence in mentoring her staff nurses.

In 1993, she graduated from Governors State University, University Park, Illinois, with a bachelor of science in nursing. She was awarded a fellowship and research assistantship at Loyola University Chicago and began her doctoral studies in nursing at Loyola University Chicago in August, 1993. In 1994, she received a Veterans Administration Nursing Administration Fellowship at Hines VA, Hines Illinois. She earned her Master’s of Science in Nursing Administration, from Loyola University Chicago in 1995. She was inducted into Sigma Theta Tau, Honor Society of Nursing, Alpha Beta Chapter in May, 1995. She completed her doctoral program at Loyola University Chicago, earning a PhD in nursing in 1998.
The dissertation submitted by Gaile Hausaman Nellett has been read and approved by the following committee:

Rosemarie Rizzo Parse, R.N.; Ph.D.; F.A.A.N.; Director
Professor of Nursing
Marcella Niehoff Chair
Loyola University Chicago

Karen J. Egenes, R.N.; Ed.D.
Associate Professor of Nursing
Loyola University Chicago

Elizabeth Ann Manhart Barrett, R.N.; Ph.D.; F.A.A.N.
Professor and Coordinator
Center for Nursing Research
Hunter-Bellevue School of Nursing
Hunter College of the City University of New York
New York, NY

The final copies have been examined by the director of the dissertation and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the dissertation is now given final approval by the committee with reference to content and form.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

March 30, 1996
Date

Director's Signature