An analysis of the concept of comfort

Katharine Y Kolcaba MSN RN C
Instructor, College of Nursing, The University of Akron, Akron, Ohio

and Raymond J Kolcaba PhD
Associate Professor of Philosophy, Cuyahoga Community College, Cleveland, Ohio, USA

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COMFORT

Comfort is a term that has a significant historical and contemporary association with nursing. Since the time of Nightingale, it has been cited as designating a desirable outcome of nursing care. Comfort is found in nursing science, for example in diagnostic taxonomies, and in references to the art of nursing, as when practice is described. Roy, Orlando, Watson, Paterson and others use comfort in major nursing theories. The term can signify both physical and mental phenomena and it can be used as a verb and a noun. However, because comfort has many different meanings, the reader has had the burden of deciding if the term is meant in one of its ordinary language senses or if its context reveals some special nursing sense. The purpose of this paper is to analyse the semantics and extension of the term ‘comfort’ in order to clarify its use in nursing practice, theory and research. The semantic analysis begins with ordinary language because the common meanings of the term are the primary ones used in nursing practice and are the origin of technical nursing usages. Comfort is discussed as the term is found in nursing, including texts, standards of care, diagnoses and theory. An account of patient needs assessment is used to cull three technical senses of the term from its ordinary language meanings. After contrasting these senses in order to justify their separateness, they are shown to reflect differing aspects of therapeutic contexts. Defining attributes of the three senses are then explicated and presented in table format. The last section of the paper addresses some of the ways that the extensions of the senses can be measured.

In spite of its widespread use, however, meanings of the term are not specified. The reader has the burden of deciding if the term is meant in one of its ordinary language senses or if its context will reveal some special nursing sense.

Purpose of the paper

The purpose of this paper is to analyse the semantics and extension of the term ‘comfort’ in order to clarify its use in
nursing practice, theory and research. The semantic analysis begins with ordinary language because the common meanings of the term are the primary ones used in nursing practice and are the origin of technical nursing usages. A discussion of the historical and contemporary use of the term in nursing theory follows. An account of patient needs assessment is used to cull three technical senses of the term from its ordinary language meanings. After contrasting these senses in order to justify their separateness, they are shown to reflect differing aspects of therapeutic contexts.

The last task is to address some of the ways that the extensions of the senses can be measured. The paper concludes with a summary of some of the comparative attributes of comfort in the three senses and their use in comfort checklists.

MEANINGS OF 'COMFORT' IN ORDINARY LANGUAGE

Four meanings of comfort occur in ordinary language, as reported in dictionary entries. The first two present the term's basic semantics.

First meaning

Comfort — a cause of relief from discomfort and/or of the state of comfort.

Second meaning

Comfort — the state of ease and peaceful contentment.

Comfort as a cause (first meaning) is supposed to produce comfort as an effect (second meaning). The cause consists of agents and things that supply factors such as encouragement or aid. In this way, a cause of comfort is said to be, 'a comfort to me.' The state of comfort implies an absence of conditions that defeat it, such as worry, pain, grief, trouble, suffering, and so on.

Many defeating conditions of the state are called 'discomforts' and can be either a cause or an effect. The resulting state of discomfort is contrary to the state of comfort. Causes of comfort initiated by agents or produced by things are taken as countervailing forces that eliminate, neutralize or counteract the effects of discomforts. Thought about producing comfort, then, involves analyzing the relationships between the causal series of both comfort and discomfort.

Agents, such as nurses, often identify and eliminate a source of discomfort before it affects a patient. Thus, the state of comfort can exist without a prior state of discomfort. When the discomfort cannot be avoided, it is often neutralized or counteracted with additional comforts.

Third meaning

Comfort — relief from discomfort.

The third meaning can be explained through the first two meanings. The cause of relief is specified by the first. While the relief itself is called a comfort, it need not be equivalent to the state of comfort. It may be relief that is incomplete, partial or temporary. Comfort as relief may be incomplete because it may be relief from just one of many severe discomforts. Second, it may be partial because only a degree of relief is attained. Third, it may last only a short time until discomfort arises again.

By contrast, the state of comfort (second meaning) presupposes the absence of severe discomforts, a high degree of relief from discomforts, and lasting rather than temporary relief from severe discomforts.

Fourth meaning

Comfort — whatever makes life easy or pleasurable.

The fourth definition is derived from the first meaning, where each factor contributes to making life easy or pleasurable. Such factors too can be 'comforts' without producing a state of comfort (second meaning) and do not require that someone initially needs relief from discomforts. The fourth meaning is compatible with the hedonistic goal of maximizing pleasure and, in this aspect, its meaning is foreign to nursing. It is thus eliminated from consideration in research about the technical senses of comfort for nursing.

To complicate further this analysis, the comfortable/uncomfortable dichotomy is also used in all of the meanings. A person may say that a comfortable thing may be the cause of the state of comfort (first meaning), or that he or she is comfortable meaning 'in a state of comfort' (second meaning). Uncomfortable things may lead a person into an uncomfortable state. The relief of a person's discomforts (or uncomfortable things) may make him comfortable, but this may be incomplete, partial or temporary (as with the third meaning).

Fifth and sixth meaning

The etymology of comfort reveals two meanings that come from the Latin word confortare meaning 'to strengthen.
Table 1: Uses of comfort in ordinary language

<table>
<thead>
<tr>
<th>Meanings of comfort</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (a) A cause of relief from discomfort</td>
<td>1 (a) Mary was comforted by the removal of the splinter</td>
</tr>
<tr>
<td>(b) A cause of the state of comfort</td>
<td>(b) When I am in my room, I feel comfortable</td>
</tr>
<tr>
<td>2 The state of ease and peaceful contentment</td>
<td>2 I feel comfortable after my bath</td>
</tr>
<tr>
<td>3 Relief from pain, mental anguish, or other discomfort</td>
<td>3 I am comfortable now because I am no longer cold</td>
</tr>
<tr>
<td>4 Whatever gives pleasure and makes life easy</td>
<td>4 I have enough money to live in comfort</td>
</tr>
<tr>
<td>5 Strengthening, encouragement and support</td>
<td>5 Obsolete in ordinary language</td>
</tr>
<tr>
<td>6 Physical refreshment or sustenance</td>
<td>6 Obsolete in ordinary language</td>
</tr>
</tbody>
</table>

greatly. According to the *Oxford English Dictionary*, however, they are obsolete in modern language.

Comfort — strengthening, encouragement, incitement, aid, succour, support, countenance
Comfort — physical refreshment or sustenance, refreshing or invigorating influence

The meanings indicate causes of renewal, amplifications of powers, positive mindsets, and readiness for action. These influences and conditions are usually not the sort that produce or constitute the typically passive state mentioned in the second meaning. If such influences are potent, then one would expect comforts of these kinds to have strengthened, encouraged, supported, and/or physically refreshed or invigorated a person. It will be demonstrated that all except the fourth meaning can be found in the works of nurse authors.

Table 1 contains a summary of these meanings. In the following two sections, the meanings of comfort will be explicated as found in nursing literature, both past and present. The authors of this paper will designate appropriate meanings, if possible, for each example. In some cases, a derivative of comfort, such as comfortable, discomfort and comforting, is cited and the derived meaning is assigned to it.

**THE HISTORY OF 'COMFORT' IN NURSING**

As early as 1869, nursing was called an art and a science, although the latter was yet to be defined or developed. Various forms of comfort were used to describe the art of nursing. For example, Nightingale (1859) exhorted,

> it must never be lost sight of what observation is for. It is not for the sake of piling up miscellaneous information or curious facts, but for the sake of saving life and increasing health and comfort (second meaning)

In 1926, Harmer discussed the importance of the nurse providing environmental comfort (first meaning) and she observed that the relief of pain and discomfort (third meaning) were central to good practice.

Goodnow (1935) devoted a chapter in her book *The Technic of Nursing* to 'The Patient's Comfort'. She wrote,

> A nurse is judged always by her ability to make her patient comfortable. Comfort is both physical and mental, and a nurse's responsibility does not end with physical care.

(Here, one cannot be sure if the second or third meaning or both are intended because a specific prior discomfort is neither mentioned nor implied.)

In all of these examples, the reader glean a vague understanding that the concept is positive, it entails feeling good and, in some cases, indicates an improvement from a previous state or condition. The reader may associate comfort intuitively with nurturing and/or nursing. However, its meaning is implicit, hidden in context, and is often ambiguous.

**COMFORT AS A NURSING TERM TODAY**

The development of classification schemes for nursing activities marks one of the major advancements in nursing.
Comfort is an important part of these schemes called 'nursing diagnoses.' Until 1990, it was found both in illness and wellness classifications. In her book about nursing diagnoses, Campbell (1984) states, "Comfort evolves from an awareness that comfort needs will be met and that previously experienced comforts will be repeated."

Thus, the dimension of the patient's anticipation that comfort needs will be met provides mental comfort (first meaning).

The term 'comfort measures' is often used to mean a contributing or sufficient cause of a state of comfort. Comfort measures can also cause relief from discomforts (physical comfort) and provide solace or encouragement (mental comfort). In many cases, comfort measures are called nursing interventions if the aim is to promote a state of physical or mental ease. (Of course, other forms of nursing interventions may have nothing to do with causing comfort.) So, 'comfort measures' replaces the noun form of the first meaning in the nursing vocabulary.

A goal of nursing practice, as contained in statements of standards for care, has been generally to help the patient be comfortable or in a state of comfort. The Department of Health, Education and Welfare (DHEW) published a methodology for monitoring quality of care. The methodology contained standards stating that the need for comfort must be met by the nurse if the delivered care is to be deemed 'quality' (1974).

In 1987, the American Nurses' Association (ANA) described the scope of gerontological nursing. The ANA stated, 'Emphasis is placed on maintaining life in dignity and comfort until death' (meanings 2, 3, and/or 5, 6). An assessment tool published by the American Association of Homes for the Aging (Lind 1983), consisted of a questionnaire to be completed by nursing home residents. The residents were asked if their place was comfortable, referring to the environment. If so, this would be a cause of the state of comfort, denoted by the first meaning.

Hamilton (1989) explored the meaning of comfort from the patient's perspective. She used interviews to ascertain how each patient defined comfort. The theme that most frequently emerged was 'relief from pain' (third meaning). But patients also identified good positions in well-fitting furniture (second meaning), and a feeling of being independent, encouraged, worthwhile, and useful (fifth meaning). At the end of the study, Hamilton stated, 'The clear message is that comfort is multi-dimensional, meaning different things to different people.'

**Nursing theories**

Comfort has been an important concept in some nursing theories. For example, Roy built her theory of adaptation around the nurse who helps the patient adapt to four categories of needs—physiological, self-concept, role-function, and interdependence (Roy & Roberts 1981). The nurse was to employ traditional comfort measures to achieve comfort in the physiological mode (first meaning). If one of the six basic physiological needs was compromised, the nurse assessed the problem and provided comfort, thereby relieving the discomforts of physiological compromise.

Orlando (1961) also focused on the needs of patients and the nurse's ability to assess and meet those needs. The nurse accomplished this through an effective nurse–patient relationship. This process consisted of careful observation and utilization of the principles of nursing that Orlando developed in her theory. The nurse was to assess the patient's physical and mental comfort (second meaning), before and after a comfort measure was delivered.

In 1979, Watson published her theory of nursing called the science of caring in which comfort is a significant part. Here, comfort was named as a 'variable that affects external and internal environments.' She stated:

"Comfort activities can be supportive, protective, or even corrective for a person's internal and external environments [first meaning]."

Supporting Orlando's (1961) claim that comfort was physical and mental, Watson (1979) stated that a patient's environment was critical for his or her mental and physical well-being. Therefore, whenever appropriate, the nurse provided comfort through environmental interventions (Watson called environmental interventions 'environmental factor number 8'). Watson also listed seven specific comfort measures that the nurse utilized in this regard. She used the term 'comfort measures' synonymously with 'interventions' as does Roy (Roy & Roberts 1981) (first meaning).

In *Humanistic Nursing* (Paterson & Zderad 1988), Paterson called comfort a construct that communicated 'the nature or experience of nursing.' She believed that comfort was an 'umbrella under which all the other terms — growth, health, freedom, and openness — could be sheltered.' Because Paterson was a psychiatric nurse, she defined comfort from a mental perspective rather than from a physical one. (She believed, however, that mental discomforts could often lead to physical discomforts.) Thus, her definition of comfort was:

'a state valued by a nurse as an aim in which a person is free to be and become, controlling and planning his own destiny, in
accordance with his potential at a particular time in a particular situation

(Paterson & Zderad 1988)

Paterson was using comfort as a stable state (second meaning) but with existential properties of transcendence into freedom (fifth meaning)

CLASSIFICATION OF PATIENT NEEDS

Many instances of comfort in the nursing literature are based on needs being met, as was demonstrated in the theories of Roy and Orlando Peplau (1952) stated.

Physical as well as psychological needs of people — for the satisfaction of their wants for food, rest, sleep, comfort, companionship, understanding — determine to considerable extent the tasks that arise in nursing situations

A patient with unmet comfort needs has a deficit, and when the needs are satisfied, the deficit is removed. In order to provide comfort, then, the nurse must first understand what the need is.

Comfort needs can be divided into three classes. In the first, the need is for being in a comfortable state. An example of this class of needs is the DHESW statement about standards for care cited above. This outcome is appropriate when it is the most desirable condition of which the patient is capable or if comfort provides a respite from the stress and anguish of disease, debilitation or injury. Given the need for rest, the limited powers of the patient, and the usual restricting environments of hospitals, the state of comfort as one of ease and peaceful contentment is a desirable goal (second meaning).

In the second class, the need is for relief from discomfort. Carpenito (1987) defines discomfort (or altered comfort) as a state in which the individual experiences an uncomfortable sensation in response to a noxious stimulus. This is a partially circular definition, but Carpenito further describes the discomforts as acute pain, chronic pain, pain in children, pruritus (a desire to itch) and nausea/vomiting. Here, comfort needs are discussed as in the third meaning where relief is given from discomfort.

In the third class, the comfort need is for education, motivation and/or inspiration. These needs are typically found in patients who are preparing to resume their normal lives. Nurses do not envision normal living for most patients as being just the state of comfort, that is, ‘ease’ or ‘peaceful contentment’. When possible and ethical, nurses aim to empower people to resume their occupations and/or major activities. In her early work, Peplau (1952) raised the question, ‘Can nursing meet needs that arise in ways that promote growth?’ She concluded that this hypothesis was probably true in nursing situations.

The empowerment that this sense of comfort entails conforms to Paterson’s construct of comfort, in which persons’ conditions are being ‘moved through relationship with others by internalizing freedom from painful controlling effects of the past’ (Paterson & Zderad 1988). According to Paterson, this type of comfort frees patients to be ‘all that they could be’ at that time. Here, comfort, as a therapeutic goal, conforms well to a patient being strengthened, encouraged, supported, physically refreshed and/or invigorated. So, while the fifth and sixth meanings are not part of current usage, they assume new life as technical meanings in nursing.

THE THREE TECHNICAL SENSES OF COMFORT

From the six original meanings of comfort, three classes of comfort needs emerge that are relevant for nursing and each is associated with a specific sense of comfort. Each sense is also a prospective technical sense for nursing. These associations are presented in Table 2 and the technical senses of comfort are defined and labelled as (a) the state sense, (b) the relief sense, and (c) the renewal sense. In nursing practice, comfort measures are causes of the referents of these senses. Since each technical sense denotes different realities, the distinctions and functional relationships between them are important for practice, theory, and research. Their contrasting attributes also establish that the senses and their extensions are separate. A discussion of their differentiating attributes follows.

The passive nature of a state of ease has led some psychologists to suggest that the state of comfort is no more than a verbal invention that signals an absence of discomfort. People do not experience comfort at all, they experience only discomfort, and comfort is simply a verbal invention (Parsons 1977). The state is not supposed to have positive attributes. Only because discomforts are relieved is a person said to be in a state of comfort. Contrary to this point of view, the authors argue that the state of comfort often exhibits detectable features.

First, the state of comfort does not presuppose complete absence of discomfort. A person may be in some discomfort yet be at ease. This is possible because sensitivity to discomfort is relative to the individual. A stoic person may be able to withstand discomfort and be at ease while a squeamish one cannot withstand any discomfort and is ill at ease. Also, persons may be highly sensitive to certain kinds of discomforts, e.g. ringing in the ears, but quickly learn to
disregard others, e.g., aching muscles. The state of comfort, then, may be associated with personality characteristics that can be present with or without the absence of discomforts.

A second important difference between the state of comfort and relief from discomforts is that the state is of the whole person. The full range of factors both mental and physical can be described as being involved in the state, that is, the concept of ease can be considered 'in mind' and 'in body' and so on into the more detailed categories of each. Discomforts include adverse stimuli and thoughts that can affect only aspects of persons. A sore ankle is not a sore person. How the person chooses to live with the sore ankle may, but need not, imply a full range of whole-person effects. Thus, the experience of relief from an irritating discomfort may not be a whole-person response, but it usually is of short duration as with the immediate lifting of a burden. Also, the cessation of the experience of relief does not necessarily cause additional states. The usual scenario is that after it serves as a punctuation mark, ordinary conditions and states resume normalcy.

Third, the absence of discomforts is not a sufficient condition for the state of ease. In ordinary living, our activities may be free from discomforts but we may be in an involved, committed and rather tense state. In health care situations, patients may be tense about an impending procedure, a diagnosis, or a family problem. Thus, the state of comfort requires more than the absence of discomforts, it also requires peace of mind and cessation of intense activities.

**Renewal**

Relationships between the third sense (renewal) and the other two (state and relief) reveal that the renewal sense is independent from but has a functional relationship with discomforts. Comfort measures can strengthen a person even though he remains uncomfortable. Programmes of physical therapy often are attended by pain while the therapist helps strengthen the patient through aid and encouragement. Conversely, a person can have no discomfort but fail to be strengthened and invigorated, she may be depressed so that the nurse's comfort measures do not have the desired effect. With these qualifications in mind, it is usually observed that a reduction in discomfort promotes or at least prepares the way for entering a renewed condition.

While being maintained in a state of comfort, a person can begin the process of renewal. This process implies enhanced powers, strengthened motivation, and positive attitudes and outlooks for meeting the life challenges normal for that person. Unlike the state of comfort, which requires the cessation of stressful activities, renewal is sometimes associated with them.

## COMFORT IN NURSING PRACTICE

### The therapeutic context

The difference among the three senses and their denotations indicate that nurses working in therapeutic settings consider all three senses when designing and organizing environments, establishing nursing objectives, and selecting interventions to meet them. This process is somewhat simplified by the standardization of therapeutic contexts and the nursing roles within them. Therapeutic contexts have become specialized into broad divisions according to the condition of patients. In the first division, very ill patients are in environments that are designed not to over-stimulate and tax them emotionally and physically. The state of comfort is appropriate for these patients. Of course, they are also observed for signs of discomfort, and comfort measures are aimed toward relief.

The second division of therapeutic contexts is for patients who are recovering with the aim of gradually increasing their levels of activity to what is normal for them. In this setting, nurses attempt to relieve relevant discomforts and contribute to renewing patients through strengthening and helping to invigorate them. Thus, the three senses of comfort have been operationalized implicitly in established nursing practice with the relief sense being applied in all therapeutic contexts. The relief
Figure 1 The comfort needs of patients

Patients with comfort needs

1. Patients that need to be in a state of comfort
2. Patients that need to be in a state of comfort and need relief from discomforts
3. Patients that need relief from discomforts
4. Patients that need relief from discomforts and renewal
5. Patients that need renewal

Patients with comfort needs met:

A
B
C
D
E
F

sense is augmented by the state sense in the first division and the renewal sense in the second.

Figure 1 illustrates these divisions based on the comfort needs of patients. For example, section A contains patients who have no unmet comfort needs, as when a patient consults a nurse about a minor health problem or a lifestyle change. Should the patient develop a condition requiring care in a first division context, he or she would be within section B, with a need for the state of comfort, or subsection C in the case where the condition is accompanied by discomfort. Should the patient require care in a second division context, he or she would be within section F or subsection E in the case where the condition is accompanied by discomforts. As is indicated, sub-sections C and E are formed by the intersection of section D, the class of patients needing relief from discomforts, with sections B and F.

Figure 1 does not develop all of the mathematically possible combinations of the three classes of comfort needs. The condition of patients determines their needs and the therapeutic contexts in which they can be satisfied. The additional combinations of classes of comfort needs can be used in a further study about nursing practice that is more detailed and less abstract than the present study. The figure, however, does illustrate that the broad divisions of therapeutic context parallel the differing classes of comfort needs according to the three senses.

The measurement of comfort

Because aspects of the therapeutic context are related to the sense of comfort appropriate to them, accounts of how comfort is operationalized can now be specified. The theory of comfort assessment, and therefore the usefulness of nursing interventions, is based on the assessment of the behaviour and physical condition of the patient, the patient's environment both physical and social, and the testimony of the patient or others. Thus, the nurse is seeking evidence of comfort needs and applying that evidence to the desired outcomes, as designated by one of the three technical senses of comfort.

Table 3 presents distinguishing attributes of each technical sense of comfort drawn from the above discussion. The three sets of contrasts speak to nursing practice, theory and research. The measurement contrasts, however, speak directly to nursing research. Some discussion of the connections between Table 3 and nursing research are in order.

A characterization of each sense can be gained by taking 1a–5a, 1b–5b and 1c–5c. A profile of referents of each sense can be gained by considering 6a–10a, 6b–10b and 6c–10c. Aspects of the measurement of each form of comfort can be examined through reading 11a–15a, 11b–15b and 11c–15c. If this approach is taken, comprehension of the point-by-point contrasts, that is, 1abc, 2abc, etc., is enhanced.

The implications in the semantic contrasts are drawn from each sense by itself. When conjointed with other factors, however, the conjunction may imply much else. For example, the state sense does not imply relief from discomforts (3a), because a person can be in the state without experiencing prior discomfort. Descriptions of both the
### Table 3 Differentiating attributes

<table>
<thead>
<tr>
<th>State sense</th>
<th>Relief sense</th>
<th>Renewal sense</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Semantic contrasts</strong></td>
<td></td>
</tr>
<tr>
<td>1a Holistic</td>
<td>1b Non-holistic</td>
<td>1c Holistic</td>
</tr>
<tr>
<td>2a Implies ease as a state</td>
<td>2b Does not imply ease as a state</td>
<td>2c Does not imply ease as a state</td>
</tr>
<tr>
<td>3a Does not imply relief</td>
<td>3b Implies relief</td>
<td>3c Does not imply relief</td>
</tr>
<tr>
<td>4a Does not imply renewal</td>
<td>4b Implies only partial and temporary renewal</td>
<td>4c Implies whole and enduring renewal</td>
</tr>
<tr>
<td>5a Requires cessation of stressful activities</td>
<td>5b Has no activity requirement</td>
<td>5c Demonstrated through activities, even if stressful</td>
</tr>
<tr>
<td></td>
<td><strong>Referential contrasts</strong></td>
<td></td>
</tr>
<tr>
<td>6a Refers to a stable state</td>
<td>6b Refers to a passing condition</td>
<td>6c Refers to an enduring condition</td>
</tr>
<tr>
<td>7a The state is passive</td>
<td>7b The condition is passive</td>
<td>7c The condition is active</td>
</tr>
<tr>
<td>8a Must be the state as a whole</td>
<td>8b Can be whole or partial relief</td>
<td>8c Can be whole or partial renewal</td>
</tr>
<tr>
<td>9a General lack of motivation, not ready to perform</td>
<td>9b Relief indicates neither motivational status nor readiness to perform</td>
<td>9c Positive motivation, readiness to perform</td>
</tr>
<tr>
<td>10a Movement from discomfort to comfort is not sufficient as its sign</td>
<td>10b Movement from discomfort to comfort is sufficient as its sign</td>
<td>10c Movement from discomfort to comfort is not sufficient as its sign</td>
</tr>
<tr>
<td>11a Measured by a factor analysis of the state</td>
<td>11b Measured by a factor analysis of relief</td>
<td>11c Measured by a factor analysis of renewal</td>
</tr>
<tr>
<td>12a Absence of severe discomfort</td>
<td>12b Cessation of discomfort, sometimes severe</td>
<td>12c Can be compatible with discomfort, sometimes severe</td>
</tr>
<tr>
<td>13a All environmental influences are important</td>
<td>13b Only environmental influences causing relief are important</td>
<td>13c Environmental influences enhancing motivation and performance are important</td>
</tr>
<tr>
<td>14a Behavioural evidence criteria for ease, contentment, and peace are satisfied</td>
<td>14b Behavioural evidence criterion for change in behaviour from discomfort to its absence is satisfied</td>
<td>14c Behavioural evidence performance criteria are satisfied</td>
</tr>
<tr>
<td>15a Testing for a present state is applicable (unless comfort measures are being applied)</td>
<td>15b Pre- and post-testing are applicable</td>
<td>15c Pre- and post-testing are applicable</td>
</tr>
</tbody>
</table>

State and its context of use may imply that a factor leading the way to the state may include relief from some discomfort. The same observation can be made for factors 2b, 2c, 3c, and 4a.

The referential contrasts remove us from the semantic realm to comfort as a non-linguistic psycho-physical reality. The measurement contrasts are of the differing realities. The distinction, for example, is between the state sense meaning the whole person (1a), a person being in the state as a whole (8a), and the measurement of that reality (11a). The three sets of contrasts speak to nursing practice, theory, and research. The measurement contrasts, however, speak directly to nursing research. Some discussion of the connections between Table 3 and nursing research is in order.

### COMMENTS ABOUT COMFORT CHECKLISTS

While evidence for the state of comfort, discomfort or enhanced powers is highly complex, nurse practitioners have ascertained and used enough of it in their interventions to assure high probability of success. The study of the efficacy of comfort measures should, accordingly, be drawn from the wealth of nursing experience. The authors anticipate that this would usually indicate a programme of studies rather than generalization from a single study. A programme of studies would take account of multiple variables such as patient types, levels of nursing skill, disease variations, and differing social and physical environments. Since results of programmes of study will, in all likelihood,
Table 4 Three steps for comfort research

1. Select the appropriate sense of comfort from the list in Table 2 (second column).
2. Select desired outcomes for the specific nursing practice in accordance with Table 3, and design checklist items for pre- and post-tests accordingly.
3. Tailor the tool for the specific patient type.

reflect the diversity and complexity of nursing practice, the way is prepared for knowledge gained to be applied in perfecting practice.

On the elementary level, research designs for testing comfort measures include a description of the patient's condition before and after measures are administered. For a given population, increased comfort indicates a degree of effectiveness while no change or a decrease in comfort indicates a degree of ineffectiveness. The nurse researcher can take three steps in designing a tool to measure comfort in a particular setting. These are listed in Table 4.

Nursing science has yet to devise a method for measuring the positive attributes of the state of comfort, such as signs of contentment and well-being. However, this state is often implicitly used as a baseline to which signs of discomfort are compared. An example of this usage is a comfort checklist for patients with Alzheimer's disease (Fabiszewski et al. 1988). The list contains only signs of the lack of the state of ease, such as wailing and aggression. So, the tool is misnamed a comfort checklist because its criteria are exclusively for discomforts.

The sense of 'relief' presupposes passivity with its attendant behavioural signs. The discomfort items on a list of signs of relief should fit into the generic categories of pain, troubled states, physical irritation, and so on. For research purposes, the nurse should limit the items on a checklist to those targeted by the comfort measure being tested. The post-test will indicate if the targeted discomforts have been relieved.

The cessation of pain is the condition that most commonly depicts the relief sense of comfort. Questionnaires can be used to measure the location, character, pattern and magnitude of pain. An example of an instrument which measures referents of the relief sense is the McGill pain tool (McGuire 1988). Some of the response categories in this tool refer to pain that comes and goes, such as 'brief', 'momentary', 'transient', 'periodic' and 'intermittent'. After a nursing intervention, relief from the pain at that location, character, pattern and magnitude can be ascertained.

Measuring renewal

When a checklist measuring renewal is being tested, it is legitimate to use a mixture of subjective and performance criteria. A subjective criterion may measure the difference between a sullen and an energized mindset. Suppose that an unspirited patient does not perform a task, will not perform it, or thinks that for medical reasons he should not perform it. A low score on a checklist, of course, indicates a lack of performance, but items measuring subjective factors may reveal the aetiology of that lack. Determining why the patient was unmotivated would enable the researcher to ascertain the sort of comfort measures that could renew the performance mindset.

An example of a tool for measuring renewal is provided by Young in an unpublished thesis (1982). It measures women's performance during labour with and without the comfort measure of therapeutic touch. The researcher demonstrates that touch strengthens and invigorates women in labour, thereby improving their performance. The evidence for this result is reported through a scoring system. Young's study proves the point that some patients, even in severe discomfort, can nonetheless be comforted so that they have a positive attitude, remain somewhat composed, and are ready to perform.

Comfort measures can bring out and amplify dispositions of character such as courage, inner strength, fortitude, persistence, and so on. The patient without such a character structure, however, may have few resources to rely upon. In this way, the discomforts and the effects of comfort measures vary from patient type to patient type. This also indicates that a broad repertoire of comfort measures may be required in order to promote renewal in the full spectrum of patients.

CONCLUSION

Comfort is a concept venerable in nursing history, and while it is informally integrated into nursing practice, it still represents a frontier in nursing research. As preparation for embarking onto that frontier, the authors presented an analysis of the concept and the theory of some of its relationships to nursing practice and research. The emerging objective for nursing science is to establish a research loop with practice. The results of comfort research should inform, direct and improve practice. Modified practice then can be the object of further research which improves practice further, and so on.

The initial task in operationalizing the term resulted in the delineation of comfort into the three senses of state.
relief and renewal. The senses facilitate precise communication as well as provide the conceptual resources for assessing comfort needs, designing measurement tools, and determining comfort outcomes. It is now feasible to develop comprehensive instruments that measure aspects of the referents of the three senses which are then organized into three subscales. Or, a researcher can measure total patient comfort by incorporating aspects of the three subscales into one tool.

A conceptual richness

The details of this analysis revealed a conceptual richness which makes plain the unexpected complexity of comfort as a reality in human experience. Nursing research can begin to tap this vein of conceptual and experiential wealth in advancing theoretical and experimental knowledge for human practice. As research progresses, nurse scientists can begin to assemble emerging discoveries into a total gestalt of this historic nursing concern.

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