Kolcaba's Comfort Theory: An Overview and Discussion of Potential Nursing Applications

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"The technical term for comfort for health care is the immediate state of being strengthened by having the needs for relief, ease, and transcendence addressed in the four contexts of holistic human experience: physical, psychospiritual, sociocultural, and environmental." (Kolcaba, 1992b). Guided by this overarching definition, Kathy Kolcaba developed a middle-range theory for nursing called "Comfort Theory (CT)". This paper will provide (1) an overview of CT; (2) an analysis of how the theory might be utilized for advanced nursing practice; (3) a specific example of proposed use, and; (4) a brief summary of the theory's strengths and limitations as well as its future direction.

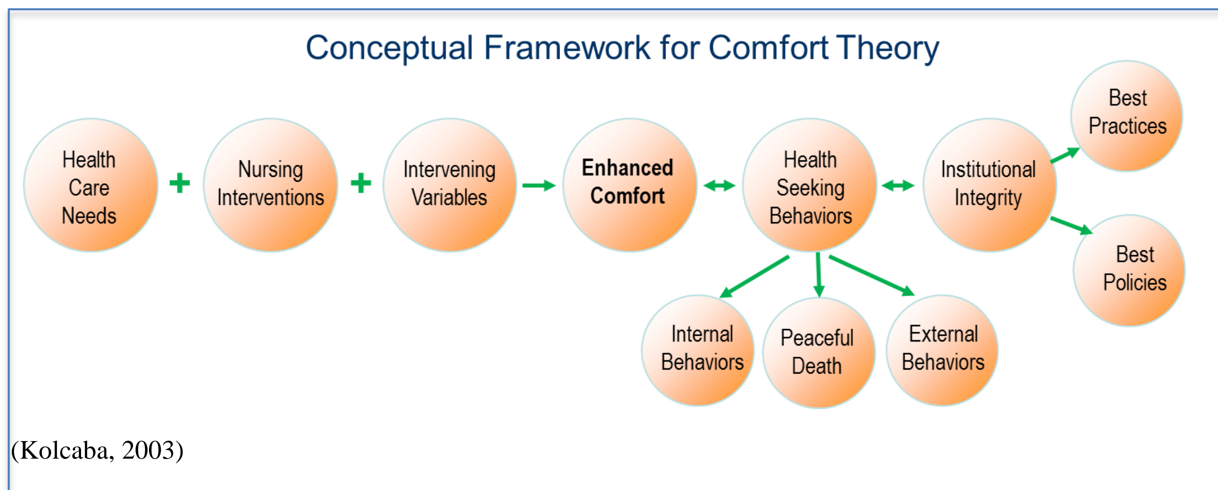
Overview of Comfort Theory

CT was developed by Kathy Kolcaba, and her personal background provides a context for some of the overall aspects of the theory. Dr. Kolcaba spent many years in clinical practice, including a role as head nurse in a dementia unit (Parker & Smith, 2010). Her experiences in these roles, including her brother's death from cancer at age 41, inspired her work on CT and help explain her emphasis on ease of suffering and end of life treatment (Kolcaba, 1997). However, one of the main drivers for her work was the trend of nursing towards a technology focus (Kolcaba, 2003). Dr. Kolcaba stated, "The overall purpose of CT was to highlight the importance of comforting our patients in this high tech world" (Kolcaba, 2003).

With these factors defining her overall goals, Dr. Kolcaba began her research and theory development. To assist her efforts, she used relevant work from other theorists. The ideas in her model about Relief, Ease, and Transcendence came from Orlando, Henderson, and Paterson / Zderad, respectively (Kolcaba, 1997). Dr. Kolcaba also borrowed the framework for parts of CT from Henry Murray and then added nursing concepts (Kolcaba, 1997).

Utilizing these sources in combination with her clinical experiences and educational pursuits, Dr. Kolcaba's first related publication was in 1991 and concerned the concept of comfort (Kolcaba & Kolcaba, 1991). In 1992, her work was extended through the publication of an initial framework (Kolcaba, 1992a). Over the next 10 years, Dr. Kolcaba published numerous papers further defining CT (Kolcaba, 1997). In 2003, she published a compilation, "Comfort Theory and Practice: A Vision for Holistic Health Care and Research" (Kolcaba, 2003).

From this timeline of work, Dr. Kolcaba's model can be summarized into three parts and theoretical assertions, based upon figure 1. The first part states that effective comforting interventions will result in increased comfort for patients and families (Kolcaba, 2003). The second part suggests that this increased comfort of recipients will positively affect the recipients' health-seeking behaviors (HSBs), which are subsequent recipient goals that are negotiated between nurses and the recipients (Kolcaba, 2003). Finally, the third part proposes that increased engagement in HSBs will result in increased Institutional Integrity (Kolcaba, 2003).



(Kolcaba, 2003)

Figure 1 – Conceptual Framework for Comfort Theory (Kolcaba, 2003)

In the model, three types of comfort are defined: (1) Relief - the state of a patient who has had a specific need met; (2) Ease: a state of contentment, and; (3) Transcendence - the state in which one rises above one's problems or pain (Kolcaba, 2003). For these three types of comfort,

the model defines four contexts in which the comforts occur: (1) Physical – related to biological and homeostatic mechanisms; (2) Psychospiritual – associated with the internal awareness of self; (3) Environmental – related to external surroundings and influences, and; (4) Sociocultural - pertaining to family, societal, and religious practices issues (Kolcaba, 2003).

These types and contexts of comfort can be aligned in a matrix format (an example of which is shown later in table 1) and can be used to determine nursing comforting interventions. Based on the CT model, these interventions can be technical, coaching or "comfort food for the soul" (Kolcaba, 2003). Technical interventions include medications, treatments, and procedures and represent the minimum expected performance from nursing (Kolcaba, 2003). Coaching includes efforts such as listening, advocacy, and referrals. Finally, "comfort food for the soul" are extra efforts and include things such as massage, music, family support, etc (Kolcaba, 2003).

These comfort measures in the CT model are based on certain assumptions in the context of the nursing metaparadigm. Kolcaba defines nursing as "the intentional assessment of comfort needs, design of comfort measures to address those needs, and re-assessment of patients, families, or community comfort after implementation of comfort measures" (Kolcaba, 1997). She describes patient as "an individual, family, or community in need of health care", while she identifies environment as "exterior influences which can be manipulated to enhance comfort" (Kolcaba, 1997). Finally, Kolcaba defines health as "optimum function of a patient / family / community facilitated by attention to comfort needs" (Kolcaba, 1997).

Utilization of CT in Advanced Nursing Practice

Based upon the context of the nursing metaparadigm and the CT overview, it is easy to see how the theory may be used in practice. In fact, CT has been applied to many different types of nursing practice including breast cancer, urinary incontinence, pediatric nursing, peri-

anesthesia environments, nursing administration and management, and others (Kolcaba, 1997). It has also been applied to geriatric environments, but primarily in terms of end of life planning and long term care (Kolcaba, 1997). For this analysis, that previous work will be extended to examine the use of CT for advanced practice nursing for rural geriatric primary care.

In this environment, the context of the issues of the population can be used to refine the primary areas of the general CT conceptual framework, as depicted in figure 2.

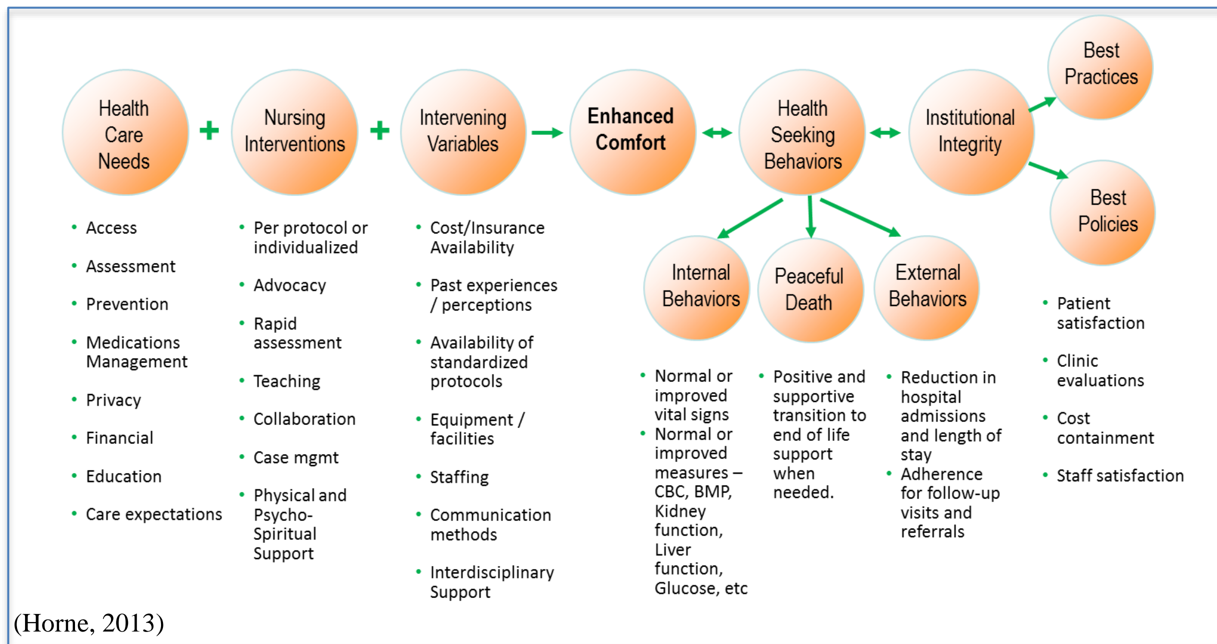


Figure 2. Conceptual Framework for Rural Geriatric Primary Care

For rural geriatric primary care, the health care needs are broader than for an acute setting or an application of CT in a more narrow population. As such, the needs include everything from normal assessment, prevention, and medical management to more comprehensive topics involving access, education, and financial concerns. Comfort interventions for this population are also expansive and must address advocacy, collaboration with other healthcare / non-healthcare groups, and extended case management. These broader interventions are critical for a rural geriatric group since there are many intervening variables that negatively affect this population such as availability of specialists, costs, facilities, and a primary care resource shortages.

In terms of the desired enhanced comfort results, the internal behaviors include typical biological measurement improvements, but there is also an additional focus on preventative and chronic care. In fact, a positive measurable outcome should be a reduction in hospital admissions and duration. Given the geriatric population, supportive end of life assistance is also important. These outcomes should result in an improved situation in the rural clinic, in terms of patient and nursing satisfactions, healthcare outcomes, and overall management.

Specific Potential Example of Proposed CT Use

Based upon the overall CT conceptual framework for rural geriatric primary care, the next step to outline CT use involves the development of an overall comfort taxonomy.

Taxonomy Structure for Rural Geriatric Primary Care

Comfort / Context	Relief	Ease	Transcendence
Physical	Cardiac issues Hyper/Hypoglycemia Diminished vision, hearing Hypothyroid issues Memory loss, Depression Incontinence / Constipation Pain Falls	Normal Blood Sugar Vision and hearing aids Pain managed Secure balance Alzheimer's support Stable, managed medications Cancer remission	Positive preventative and regulatory health seeking behaviors to manage health conditions
Psychospiritual	Anxiety, Anger Loss of control Loss of faith Sexuality	Confidence Faith Positive body image	Mental and spiritual growth
Sociocultural	Financial distress Loss of spouse / family Family / Spouse stress / changes Friends - death / changes	Financial planning and other assistance Regular social interactions Positive family involvement	Growth of social network; volunteer activities (if able / applicable)
Environmental	Transportation difficulties Home / Facilities Government policy changes	Available , accessible, and adequate transportation Stable and appropriate living conditions	Proactive actions to improve living situations

(Horne, 2013)

Table 1. Taxonomy Structure for Rural Geriatric Primary Care

Utilizing this matrix as a guideline for needed comfort measures, the CT model can be effectively used on a day to day basis through these three steps: (1) performance of a holistic

assessment of the patient's comfort needs; (2) design of appropriate comfort interventions based upon the assessment results, and; (3) measurement of the success of the interventions based on follow-up assessment, surveys, and observations of health seeking behaviors. These steps are reflected in table 2, the comfort measures for rural geriatric primary care.

Comfort Measures for Rural Geriatric Primary Care

Comfort Intervention	Examples
Technical	Assessments: • Thorough history; Check vitals, CBC, BMP, Cholesterol, TSH, etc • Test hearing, vision, balance; Perform mini-mental status exam • Assess any pain, skin, and musculoskeletal issues • Assess and update / manage medications Interventions: • Diagnose and treat physical issues based on results from listed assessments; manage polypharmacy
Coaching	Assessments: • Cultural needs, spiritual desires; Family situation; social situation • Financial status; Living status Interventions: • Provide resources, referrals, advocacy, encouragement, and support for psychosocial, sociocultural and environmental needs.
Comfort food for the soul	Assessments: • Actions needed to move to transcendence comfort level Interventions: • As applicable: home visits, development of geriatric social groups, government and private advocacy , family interventions, etc

(Horne, 2013)

Table 2. Comfort Measures for Rural Geriatric Primary Care

It is important to note that the rural geriatric primary care conceptual model, taxonomy, and comfort measures are presented as a draft set of ideas for using CT in this population. Additional work, verification, testing, and analysis of the concepts and tools in actual clinical situations will be needed to refine this approach.

Strengths, Limitations, and Future Direction for CT

Through the discussion of the potential use of CT in a rural geriatric primary care setting, some of the strengths of the model are evident. CT is clearly translatable across different types of

practice settings, it is fairly easy to define, and it lends itself well to verification. Comfort questioners can be used to access the relative success of the comfort measures on the populations and the institutions. In fact, there have been multiple verifications of part one of the model, thus proving that effective comforting interventions will result in increased comfort for patients and families (Alligood & Toomey, 2010). However, Dr. Kolcaba and others agree that additional empirical tests of the theoretical assertions for the second and third parts of CT are needed (Kolcaba, 1997). It is also clear that use of the model in any practice setting may be gated by the level of support from nursing administration. As Dr. Kolcaba has indicated, nurses do need to be given the appropriate time to assess and implement the comfort measures, and this is not easily obtained in today's time constrained and task oriented nursing structure (Kolcaba, 2003).

In terms of the model's future, additional research will explore verification of the theoretical assertions in parts two and three. Additionally, Dr. Kolcaba has shown great interest and has several projects underway to utilize CT for nursing comfort and related nursing administration, including magnet certification assistance (Kolcaba, 2003).

Conclusion

Through a discussion of the key features of Dr. Kolcaba's CT, the overall approach of the model and its applicability for nursing practice have been examined. An additional more detailed analysis has been presented describing how CT might be used in a specific clinical setting – rural geriatric primary care. Using the tools from the CT model, specific approaches were developed for use of CT in the rural geriatric primary care population. Finally, a brief discussion of the limitations of that approach, as well as the model overall were examined, followed by the proposition for the future activity and development of CT. Dr. Kolcaba's work is clearly a valuable and ongoing asset for the nursing profession.

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