

Two middle range theory evaluation paper



**ASSIGN
BUSTER**

The purpose of this paper is to evaluate two middle range theories abilities to test the concept of comfort for the practice question “ Do neonatal nurses who care for dying infants who attend an end of life care educational training program compared to neonatal nurses who do not attend the program experience a difference in comfort levels (Comfort Level for Caring for Dying Infants (CLCDI)) when caring for a dying infant? ” A summary of two middle range theories the Comfort Theory (Kolcaba, 1994) and the Theory of Self-Efficacy (Resnick, xxxx) will be summarized and then critiqued using Smith and Liehr’s (xxxx) Framework for Evaluating Middle Range Theory. The discussion will conclude with a summary of strengths and weakness’ of the theories and a research hypothesis to reflect that reflects the most appropriate theories conceptual definitions and propositions.

Introduction

Background

Despite nurses as frontline caregivers for dying patients and their families many nurses have identified that they struggle with the responding adequately to the emotional devastation to parents and siblings when caring for a neonate with an unresolved terminal condition (Frommet, 1991). With the advances in neonatal care and life sustaining treatments, sick and very preterm infants do not often die in utero, at birth, or shortly after birth, but instead they often live much longer in a healthcare paradigm of comfort care and dignified death. This relatively new emersion of the end of life model integrates a more holistic approach which considers a more comprehensive view of the patient’s needs (emotional, spiritual, and medical) (Mallory, 2002; Mallory, 2003; WHO, 2002). With this paradigm shift, health care

professionals are obligated to assess the adequacy of their own knowledge, attitudes, and beliefs about death and dying. Multiple studies regarding nurses preparation for dealing with death and dying have consistently found that nurses that nurses do not feel educationally prepared to care for dying patients and insist that healthcare professionals should receive additional education on end of life care to bridge the deficit gap (Frommet, 1991; Robinson, 2004; White, Coyne, Patel, 2001; Beckstrand, Callister, Kirchhoff, 2006). These findings have led to a further observation that nurses caring for these complex patients regularly experience moral distress from competing principles of their personal, collegial, organizational, and religious/spiritual ethics (Frommet, 1991).

Practice Problem

To help ease this moral distress an evidence based end-of -life educational training program for NICU nurses has been successfully implemented in several neonatal intensive care units (NICU's) to increase the nurses comfort level of caring for neonates and their families at the end of life (Bagbi, Rogers, Gomez, & McMahon, 2008). To determine if an evidence based end of life educational program impacts nurses comfort levels in caring for dying infants and their families a question was developed using the population (P) intervention (I) compared to (C) outcome (O) format (Newhouse, Dearhold, 1997). The following discussion will focus on this PICO question “ Do neonatal nurses who care for dying infants who attend an end of life care educational training program compared to neonatal nurses who do not attend the program experience a difference in comfort levels (Comfort Level for Caring for Dying Infants (CLCDI)) when caring for a dying infant? ” During

the intervention a monthly 1 hour, neonatal end of life education program will be conducted over a 6 month period of time based on research about what nurses would like to know about caring for a dying infant (Robinson, 2004).

For the purpose of this problem, comfort is defined as the ability of the NICU nurse(s) to show adequate knowledge and skills in providing neonatal end of life care for dying babies and their families. For this problem comfort will be measured as a score on the ordinal scale of Comfort Level Caring for Dying Infants (CLCDI). The instrument consisting of 15 items, measured on a 5 point Likert type scale equates scores of 1= never; 2= rarely; 3= sometimes; 4= often, 5= always measures the level of comfort a NICU nurse has caring for dying infants as opposed to their perception toward pediatric or neonatal end of life care (Bagbi, Rogers, Gomez, and McMahon, 2008). In evaluating the score, the higher the reported score the greater level of comfort NICU nurses have in caring for dying babies.

Testing the Concept of Comfort

A portion of Kolbaca's (1991) Theory of Comfort and Resnick's (2008) Theory of Self-Efficacy, two middle range theories, will be used to test the concept of comfort for providing an organizing structure. Based on previous studies about nurse's comfort when caring for patients', propositions five and six of Kolbaca's Theory of Comfort seem to be a promising fit for this problem (Kolbaca, 1991, Kolbaca, XXX). These propositions collectively propose that patients, nurses, and other members of the healthcare team agree upon desirable and realistic health seeking behaviors (HSB's) and if enhanced comfort is achieved, patients, family members, and/or nurses are

strengthened to engage in HSB's, comfort is further enhanced (Kolbaca, 1991). However, comfort as defined conceptually in this case as "knowledge and skill" can alternatively be equated with a sense of competence or self-efficacy of the NICU nurse to care for a dying infant and their family. There are many examples in the nursing literature linking self-efficacy to knowledge and skill (xxxx, xxxxx).) Self-efficacy, knowledge, and skills are also central to Bandura's theory, which is the basis for Resnick's (xxxx) Self-Efficacy theory. Self-efficacy as described in Resnick's (xxxx) Theory of Self-Efficacy for this context is described as the judgment about the nurses' ability to organize and execute a course of action required to attain designated types of performances. The theory states that perceived self-efficacy, defined as the individual's judgment of his or her capabilities to organize and execute courses of action, is a determinant of performance (Resnick, xxxx). Self-efficacy beliefs provide the foundation for human motivation, well-being, and personal accomplishment (Resnick, xxxx). According to Resnick (XXXX) theory individuals with higher levels of self-efficacy for a specific behavior (caring for a dying infant) are more likely to attempt that behavior. There are many examples in the literature using the Theory of Self-Efficacy to support nursing education interventions (xxxxx, xxxxx). For these reasons, Resnick's Theory of Self-Efficacy (xxx) will be used to test the concept of nurses comfort or knowledge and skill (self-efficacy) in caring for dying infants and their families. The purpose of the following discussion is to summarize, describe, analyze, and evaluate these theories using the Framework for the Evaluation of Middle Range Theories (Smith, 2008) and conclude with a synthesis and research hypothesis to reflect conceptual definitions and propositions of the theory with the best fit.

Theory Summaries: Comfort and Self-Efficacy

Kolcaba's Comfort Theory

The Comfort Theory is a humanistic, holistic, patient need based nursing derived middle range theory (Kolcaba, xxxx). The concept of comfort has had a historic and consistent presence in nursing. In the early 1900's , comfort was considered to be a goal for both nursing and medicine, as it was believed that comfort led to recovery (McIlveen & Morse, 1995). Over time comfort has become an increasingly minor focus, at times reserved only for those patients for whom no further medical treatment options are available (McIlveen & Morse, 1995).

The term comfort is used as a noun (comforter), adjective (comforting), verb (to comfort), or adverb (comfort the patient) (xxx). It is also used as a negative (absence of discomfort), neutral (ease), or positive (hope inspiring). Webster (1990) defines comfort as relief from distress; to soothe in sorrow or distress; a person or thing that comforts; a state of ease and quiet enjoyment free from worry; anything that makes life easy; and the lessening of misery or grief by calming or inspiring with hope. The origin of comfort is confortrare which means “ to strengthen greatly”(Kolcaba, 1992). Based on the diversity of these terms comfort is a complex term. Kolcaba's (1991) concept analysis of comfort helped to clarify the role of comfort as a holistic concept for nursing. This review confirmed that comfort is a positive concept and is associated with activities that nurture and strengthen patients (David, 2002). Over a period of years and revisions Kolcaba (1994) developed the comfort theory which continues to evolve and change with changes as recent as 2007 (Figure 2).

Kolcaba (1994, 2001, 2003) has defined comfort as “ the immediate state of being strengthened through having the human needs for relief, ease, and transcendence addressed in four contexts of experience (physical, psychospiritual, sociocultural, and environmental)”. The terms relief, ease, and transcendence are types of comfort that occur physically and mentally (Figure 2). The terms are defined based on definitions from medicine, theology, ergonomics, psychology, and nursing (Kolcaba & Kolcaba, 1991). Relief is the state of having a discomfort mitigated or alleviated. Ease is the absence of specific discomforts. Transcendence is the ability to “ rise above” discomforts when they cannot be eradicated or avoided (e. g., the child feels confident about ambulation although (s)he knows it will exacerbate pain). Transcendence, as a type of comfort, accounts for its strengthening property and reminds nurses to “ never give up” helping their children and family members feel comforted. Interventions for increasing transcendence can be targeted to improving the environment, increasing social support, or providing reassurance.

The three types of comfort occur in four contexts of experience: physical, psychospiritual, sociocultural, and environmental. These contexts were derived from an extensive review of the nursing literature on holism (Kolcaba, 1992). When the three types of comfort are juxtaposed with the four contexts of experience, a 12-cell grid is created, which is called a taxonomic structure (TS) (Figure 1) . Taken together, these cells represent all relevant aspects (defining attributes) of comfort for nursing and demonstrate the holistic nature of comfort as an important goal of care. All comfort needs can be placed somewhere on the taxonomic structure, and the cells are not

mutually exclusive. A sample pediatric case study using the TS as a guide for a holistic comfort assessment is demonstrated below (see Figure 1).

The concepts for the middle range for Comfort Theory include comfort needs, comfort interventions, intervening variables, enhanced comfort, health-seeking behaviors, and institutional integrity (Kolcaba, 1994). All of these concepts are relative to patients, families, and nurses (Kolcaba, 2003; Kolcaba, Tilton, & Drouin, 2006). There are eight propositions which link the above concepts together. All or parts of the Comfort Theory can be tested for research (Peterson & Bredow, 2010).

In the comfort theory, Kolcaba asserts that when healthcare needs of a patient are appropriately assessed and proper nursing interventions carried out to address those needs, taking into account variables intervening in the situation, the outcome is enhanced patient comfort over time (Kolcaba, 2007). Once comfort is enhanced, the patient is likely to increase health-seeking behaviors. These behaviors may be internal to the patient (eg, wound healing or improved oxygenation), external to the patient (eg, active participation in rehabilitation exercises), or a peaceful death. Furthermore, Kolcaba asserted that when a patient experiences health-seeking behaviors, the integrity of the institution is subsequently increased because the increase in health-seeking behaviors will result in improved outcomes. Increased institutional integrity lends itself to the development and implementation of best practices and best policies secondary to the positive outcomes experienced by patients (Kolcaba, 2007).

To translate the concepts to practice the effectiveness of a holistic intervention can be targeted to the taxonomic structure for enhancing comfort in a specific patient, family, or nurse population over time. Holistic comfort is defined as the immediate experience of being strengthened through having the needs for relief, ease, and transcendence met in four contexts of experience (physical, psychospiritual, social, and environmental). The comfort theory has been operationalized in many research settings with a variety of patient and target populations ranging from end of life care to the comfort of nurses (xxxx).

Resnick Theory of Self-Efficacy

Self efficacy is described as a way to organize an individual's judgment of his or her capability to execute a course of action. The Theory of Self-efficacy states that self-efficacy expectations and outcome expectations are not only influenced by behavior, but also verbal encouragement, reflective thinking, physiological sensations and role or self-modeling (Bandura, 1995).. Through self evaluation an individual judges their capability to perform and established self expectations which is visually depicted in the conceptual model (Appendix 2) (Resnick, 2008).

Resnick's Theory of Self Efficacy is based on Bandura's social cognitive theory and conceptualizes person-behavior-environment as triadic reciprocity the foundation for reciprocal determinism (Bandura, 1977, 1986).

Most of the research into self-efficacy beliefs among older adults has been quantitative and has consistently supported the influence of those beliefs on behavior. However, it has not been established how efficacy beliefs actually

influence motivation in older adults, or what sources of efficacy-enhancing information help strengthen those beliefs.

Kolcaba's Comfort Theory: Description, Analysis, and Evaluation

Theory Description

Historical context. The Comfort Theory is a humanistic, holistic, patient need based nursing derived middle range theory (Kolbaca, xxxx). The concept of comfort has had a historic and consistent presence in nursing. In the early 1900's , comfort was considered to be a goal for both nursing and medicine, as it was believed that comfort led to recovery (McIlveen & Morse, 1995). Over time comfort has become an increasingly minor focus, at times reserved only for those patients for whom no further medical treatment options are available (McIlveen & Morse, 1995).

The term comfort is used as a noun (comforter), adjective (comforting), verb (to comfort), or adverb (comfort the patient) (xxx). It is also used as a negative (absence of discomfort), neutral (ease), or positive (hope inspiring). Webster (1990) defines comfort as relief from distress; to soothe in sorrow or distress; a person or thing that comforts; a state of ease and quiet enjoyment free from worry; anything that makes life easy; and the lessening of misery or grief by calming or inspiring with hope. The origin of comfort is confortrare which means “ to strengthen greatly”(Kolcaba, 1992). Based on the diversity of these terms comfort is a complex term. Kolcaba's (1991) concept analysis of comfort helped to clarify the role of comfort as a holistic concept for nursing. This review confirmed that comfort is a positive concept and is associated with activities that nurture and strengthen patients (David, <https://assignbuster.com/two-middle-range-theory-evaluation-paper/>

2002). Over a period of years and revisions Kolcaba (1994) developed the comfort theory which continues to evolve and change with changes as recent as 2007 (Figure 2).

Structural Components.

Assumptions. Kolcaba's Theory of Comfort (1994) makes four basic assumptions about reality. She assumes that humans beings have holistic responses to complex stimuli; comfort is a desirable holistic state that is germane to the discipline of nursing; human beings actively strive to meet, or to have met, their basic comfort needs, and that comfort is more than the absence of pain, anxiety, and other physical discomforts (Kolcaba , 2009).

Concepts. Kolcaba defines six concepts of comfort which are relative to patients, families, and nurses (Table 1) . The term family, as defined by Kolcaba (2003) encompasses significant others as determined by the patient (Kolcaba, 2003; Kolcaba, Tilton &Drouin, 2006). The first concept is of comfort needs which is the relief/ease/transcendence in physical, psychospiritual, sociocultural and environmental contexts of human experience. Comfort interventions in the model are defined as interventions of the health care team specifically targeting comfort of the patient, family and nurses. Intervening variables are positive or negative factors over which the health care team has little control, including physical limitations of the hospital or patient's home, cultural influences, socioeconomic factors, prognosis, concurrent medical or psychological conditions. Health-seeking behaviors are those behaviors of patient, family or nurses (conscious or unconscious) which promote well-being; may be internal, external or towards promoting a peaceful death. The final concept, institutional integrity, added

<https://assignbuster.com/two-middle-range-theory-evaluation-paper/>

in most recently, are values, financial stability and wholeness of health care facilities at the local state or national levels.

Propositions. To help test the concept of nurses' comfort caring for dying infants, propositions five and six of Kolcaba's comfort theory are examined. These propositions state that patients, nurses, and other members of the healthcare team agree upon desirable and realistic health seeking behaviors (HSB's) (five) and if enhanced comfort is achieved, patients, family members, and/or nurses are strengthened to engage in HSB's, which further enhances comfort (six). These propositions provide rationale for why nurses and other health care professionals should focus on the patient, family, or in this case the nurses comfort beyond altruistic reasons. Because health seeking behaviors include internal and external behaviors almost any health-related outcome important in a healthcare setting can be classified as a health seeking behavior (Peterson & Bredow, 2010). The desirable and realistic health seeking behavior (HSB) for this study is nurses' comfort (knowledge and skills) to relieve moral distress in caring for a dying infant and their family. Several studies support that moral and other types of distress are frequently observed in nurses who care for dying infants (Frommet, 1991) and most importantly indicate that nurses are seeking education regarding patient end of life issues (XXXXX). It is believed that reducing this distress and frustration can be affected through an effective end of life educational programs and is likely to improve the knowledge and skills nurses need to help increase their comfort level in caring for dying infants (xxxxx).

Functional Components. Visualizing the concepts in the conceptual model, the

Theory Analysis and Evaluation

To analyze and evaluate Kolcaba's Comfort Theory (1994) the substantive foundation, structural integrity, and functional adequacy of the theory using Smith and Liehr's (2008) Framework for the Evaluation of Middle Range Theories is discussed below (Appendix 1).

Substantive foundations. Assessing the substantive foundation of a middle range theory is based on four criteria (Smith, 2003). The first criterion evaluates whether the theory is within the focus of the discipline of nursing. Kolcaba's comfort theory successfully addresses four concepts comprising the metaparadigm of nursing, defining the concepts as they correspond to the theory (Dowd, 2002; Kolbaca, 2007) as well as presents a diagram of how the Comfort Theory relates theoretically to other nursing concepts (Figure 2) (Kolcaba, 1994) . Nursing is described as the process of assessing the patient's comfort needs, developing and implementing appropriate nursing interventions, and evaluating patient comfort following nursing interventions. Person is described as the recipient of nursing care; the patient may be an individual, family, institution, or community. Environment is considered to be the external surroundings of the patient and can be manipulated to increase patient comfort. Finally, health is viewed as the optimum functioning of the patient as they define it. The ability of the framework to suggest interventions that help guide nursing interventions to increase comfort supports the discipline of nursing, and in doing so meeting the first criteria.

The second criterion evaluates whether the assumptions are specified and congruent with the focus. The four assumptions in the Comfort Theory are explicitly stated and so meet the second criteria. Comfort theory (xxxx) assumes that humans beings have holistic responses to complex stimuli; comfort is a desirable holistic state that is germane to the discipline of nursing; human beings actively strive to meet, or to have met, their basic comfort needs, and that comfort is more than the absence of pain, anxiety, and other physical discomforts (Kolcaba , 2009).

Because the Comfort Theory (XXXX) substantially describes the concept of comfort at the middle range level of discourse, the third criterion of the substantive foundation is met. Kolcaba's (1991) concept analysis of comfort helped to clarify the role of comfort as a holistic concept for nursing. This review confirmed that comfort is a positive concept and is associated with activities that nurture and strengthen patients (David, 2002). The Comfort Theory provides an excellent description, explanation, and interpretation of the comfort concept in multiple domains and practice settings. Comfort theory is at the middle range level in that is defined in a measurable way and can be operationalized in both research and practice settings.

The final criterion for this category evaluates if the origins are rooted in practice and research experience. The Comfort Theory has been used in numerous practice and research settings to provide a framework where patients have comfort needs and enhancing their comfort is valued. It has also been used to enhance working environments, especially for nurses, and most recently as a framework for working toward national institutional recognitions. More specifically parts are all of the theory have been used to

test the effectiveness of holistic interventions for increasing comfort (xxxxxxx), to demonstrate the correlation between comfort and subsequent HSB's (xxxxx) and to relate HSB's to desirable institutional outcomes. It has also been used as a framework for helping families make difficult decisions about end of life (xxxxx). International and national healthcare institutions have also used Comfort Theory to enhance the work environment for nurses (xxxx). In these cases, nurses comfort is of interest and is theoretically related to the integrity of the institution. Summarize specific studies and tools used here.

Structural integrity. There are four criterion for evaluating structural integrity. The first criterion is that the concepts are well defined. The concepts (defined above) of comfort needs, comfort interventions, intervening variables, enhanced comfort, health-seeking behaviors, and institutional integrity are clearly defined and easy to understand. There are numerous examples of applying the concepts in the literature for further clarification (xxxxx).

The second criterion of structural integrity is that concepts within the theory are at the middle range level of abstraction. The concepts of the Comfort Theory-comfort needs, comfort interventions, intervening variables, enhanced comfort, health seeking behaviors, and institutional integrity are near the same level on the ladder of abstraction at the middle range level. They are more concrete because they can and have been operationalized and measured (xxxxx).

The third criterion of structural integrity is that there are no more concepts than needed to explain the phenomena. Overall, the concepts adequately explain the phenomena of comfort. The theory is synthesized and organized in a simple manner. Lastly, the fourth criterion evaluates whether the concepts and relationships among the concepts are logically presented with a model. In the Comfort Theory (1994) model the ideas are integrated to create an understanding of the whole phenomenon of comfort in a model. The Comfort Theory (1994) model is a great example of presenting the concepts and statements in a linear logical order so the appreciation of the theory can be recognized (Smith, 2003).

Functional adequacy. Because the criterion for functional adequacy overlap somewhat the five criterion will be discussed collectively. The five criterion include: theory can be applied to a variety of practice environments and clients; empirical indicators have been identified; published examples exist of research and theory in practice; and that the theory has evolved through scholarly inquiry. The Comfort Theory easily meets all of these criteria. For example, the Comfort Theory has been used widely in a variety of research in practice settings and patient and family populations. Even though the Comfort Theory has been used most widely with patients and families at the end of life and surrounding holistic palliative care nursing interventions, there has been a broad application of the theory in other populations as well including mothers in labor (xxxx), Alzheimer patients (xxxx), pediatric intensive care unit patients and families (xxxx), patients on bedrest (xxxx), those undergoing radiation therapy (xxxx) and for infants comfort and pain (xxxx). Most recently research of using the theory in practice has expanded

to support institutional nursing recognition and comfort in the nursing working environment. In each of the populations mentioned above a psychometric comfort instrument has been developed as empirical indicators of concepts in the theory. However, the empirical indicators extend beyond empiricism and some include perceptions, self reports, observable behaviors and biological indicators (Ford-Gibloe, Campbell, & Berman, 1995; Reed, 1995). The Comfort Theory (1994) has also been revised with the latest revision in 2007. The empirical adequacy of the Comfort Theory is evidence of the maturity of this theory (Smith, 2003).

Summary

The Comfort Theory (1994) is a well defined and well tested theory. Its strength lies in the versatility, adaptability, and testability of the concepts. The comfort theory clearly defines the concepts in the theory and the relationship between them. Because the comfort theory meets most of the substantive foundations, structural integrity, and functional adequacy criteria the Comfort Theory (1994) is a strong middle range theory. An area that could increase the generalizability especially for nursing institutions is a change in the term in the model of “ nursing interventions” to “ comfort interventions” (xxxxx).

Resnick’s Self-Efficacy Theory: Description, Analysis, and Evaluation

Theory Description

Historical context. Resnick’s Theory of Self Efficacy is based on Bandura’s social cognitive theory and conceptualizes person-behavior-environment as

triadic reciprocity the foundation for reciprocal determinism (Bandura, 1977, 1986).

The cognitive appraisal of these factors results in a perception of a level of confidence in the individual's ability to perform a certain behavior. The positive performance of this behavior reinforces self-efficacy expectations (Bandura, 1995).

Structural Components. Although it is not explicitly stated, the core of this theory assumes that people can consciously change and develop or control their behavior. This is important to the proposition that self-efficacy also can be changed or enhanced through reflective thought, general knowledge, skills to perform a specific behavior, and self influence. This perspective is rooted in the model of triadic reciprocity (foundation for reciprocal determinism) in which personal determinants (self-efficacy), environmental conditions (treatment conditions) and action (practice) are mutually interactive influences. Therefore, improving performance depends on changing some of these influences (Bandura, 1977). In order to determine self-efficacy an individual must have the opportunity for self evaluation to evaluate how likely it is he or she can achieve a given level of performance.

Concepts. The two major components of self efficacy include self-efficacy expectations and outcome expectations (Table 2). Self-efficacy expectations are judgments about the personal ability to accomplish a given task.

Outcome expectations are judgments about what will happen if a given task is accomplished. These two components are differentiated because individuals can believe a certain behavior will result in a specific outcome,

however, they may not believe they are capable of performing the behavior required for the outcome to occur (Bandura 1977, 1986). For example, a NICU nurse may believe attending an end of life education series will increase his/her knowledge and skill and ease moral distress, but may not believe that they could provide sensitive care for some ethical, religious, or moral reason. It is generally anticipated, but not always realistic that self-efficacy will have a positive impact on behavior. There are times when self-efficacy will have no or a negative impact on performance (Vancouver, Thompspon, & Williams, 2001). Bandura (1977, 1986, 1997) suggests that outcome expectations are based largely on the individual's self-efficacy expectations, which generally depend on their judgment about how well they can perform the behavior; can be disassociated with self-efficacy expectations; and are partially separable from self-efficacy judgments when extrinsic outcomes are fixed. Because the outcomes an individual expects are the results of the judgments about what he or she can accomplish, they are unlikely to contribute to predictions of behavior (Bandura, 1977).

Judgments about one's self-efficacy is based on four informational sources including enactive attainment, vicarious experience, verbal persuasion and physiological state. The first source, enactive attainment, or the actual performance of a behavior has been described as the most influential source of self-efficacy information (Bandura, 1986,; Bandura & Adams, 1977). There has been repeated empirical evidence that actually performing an activity strengthens self-efficacy beliefs due to informational sources (Bandura, 1995). The second source, vicarious experience or visualizing other similar people perform a behavior, also influence self-efficacy (Bandura, Adams,

Hardy, & Howells, 1980). Conditions that impact vicarious experience include amount of exposure or experience to the behavior (least experience causes greater impact) and amount of instruction given (influence of others is greater with unclear guidelines) (Resnick & Galik, 2006). Another source verbal persuasion or exhortation involves telling an individual he or she has the capabilities to master the given behavior. Verbal encouragement from a trusted, credible source in counseling or education form has been used alone to strengthen efficacy expectations (Castro, King, & Brassington, 2001; Hitunen et al. 2005; Moore et al., 2006; Resnick, Simpson, et al., 2006). The final information source physiological feedback or state during a behavior can be important in relation to coping with stressors, health functioning, and physical accomplishments. Interventions can be used to alter the interpretation of physiological feedback and help individuals cope with physical sensations, enhancing self efficacy and resulting in improved performance (Bandura & Adams, 1977).

Propositions. To help test the concept of nurses' comfort caring for dying infa