

Giving Voice to Vulnerable Populations: Rogerian Theory

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Objectives

At the end of this chapter, the reader will be able to

1. Explain Rogers' perspective on vulnerability.
2. Describe the characteristics of vulnerability.
3. Define “well-being” from the perspective of the research on Rogers' theory described by the authors.

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The human condition of vulnerability is a concept of vital concern to nurses, in that a large portion of nursing practice is spent either helping individuals who find themselves in a vulnerable position or helping them avoid vulnerability. Nursing, however, has been slow in developing theoretical constructs of vulnerability within a nursing perspective (Spiers, 2000). Traditional definitions of vulnerability are framed within an epidemiological approach to identify individuals and groups at risk for harm. Groups most often labeled as vulnerable include the elderly, children, the poor, people with disability or chronic illness, people from minority cultures, and captive populations such as prisoners and refugees (Saunders & Valente, 1992). Labels of vulnerability are customarily applied in relation to socioeconomic, minority, or other stigmatizing status (Demi & Warren, 1995) and reflect a tendency to blame the victim for his or her status rather than the prevailing social structures. The generally accepted marker for vulnerability has been the inability to function independently in accord with the values of a particular society. Fortunately, there is growing dialogue about vulnerability from the perspective of the person experiencing it—a view that is more congruent with the philosophical stance of nursing (Morse, 1997; Spiers, 2000).

The Rogerian conceptual system (Rogers, 1992), which focuses on the person as integral with and inseparable from his or her environment, holds considerable relevance as an innovative nursing framework to use in addressing the problem of vulnerability. Accordingly, the remainder of this chapter is directed toward application of the theoretical base of Rogerian nursing science to the human condition of vulnerability. Because persons who are vulnerable are at greater risk for not being heard, the last section of the chapter describes the Wellbeing Picture Scale (WPS), a 10-item innovative picture-based tool that offers a menu of paired pictures rather than words, giving people who may not be able to read English text an alternative, more user-friendly way of expressing their sense of well-being.

A ROGERIAN PERSPECTIVE OF VULNERABILITY

According to Martha Rogers, energy fields are the fundamental unit of everything, both living and nonliving. These fields are without boundary and dynamic, changing continuously. Two energy fields are identified: the human field and the environmental field. Rogers emphasized that humans and environments do not *have* energy fields; rather, they *are* energy fields. Likewise, she insisted that the human field is unitary and cannot be reduced to a biological field, a physical field, or a psychosocial field. As postulated by Rogers, human and environmental fields flow together in a constant mutual process that is unitary rather than separate. Within this worldview, humans are energy fields that exist in constant mutual process with their immediate and extended environmental energy field, which includes, and cannot be separated from, other living and nonliving fields. She also postulated that both human and environmental energy patterns change continually during this process. The inseparability of the human energy field from its immediate and extended environmental energy field is perhaps the most central feature of the Rogerian conceptual system.

Phillips and Bramlett (1994) assert that the mutual human–environmental field process can be harmonious or dissonant. Resonant with Rogers’ science, these researchers posit vulnerability as an emergent condition that arises when there is dissonance within the mutual human–environmental field process. This view is consistent with Rogerian scholar Barrett’s (1990) theory of power, which associates power with individuals’ knowing participation in change within their mutual human–environmental process for the betterment of the whole, including themselves. These authors perceive vulnerability as the opposite condition of power—as a condition that may occur when an individual is unable or does not choose to participate in an informed and purposeful way in change. Persons in this situation essentially have no voice and may be intentionally or unintentionally left behind in a compromised position. Within this line of thinking, an individual’s sense of dissonance or disharmony within the mutual human–environmental field process would be viewed as a manifestation of vulnerability, placing individuals or groups at risk. Barrett developed a text-based tool, Power as Knowing Participation in Change (PKPC), to measure this concept; a subscale of the tool addresses awareness as an essential feature of knowing participation.

Lack of knowing participation may be associated with a number of scenarios. Individuals may be uninformed or misinformed about situations involving their unique

human–environmental field process, or they may be unable to participate due to one or more specific circumstances such as illness (e.g., stroke or dementia) or injury (e.g., hip fracture). Common situations that may limit or prevent knowing participation include compromised vision or hearing, aphasia, difficulty with mobility, and confusion or dementia. Other circumstances that may limit knowing participation include any situation that hinders a person from engaging in sufficient communication within the community; examples might include lack of transportation or limited language facility. Insufficient means or the inability to move about freely may diminish presence, making it more difficult, if not impossible, to be “at the table” to achieve representation. Stigmatized individuals or groups such as single mothers, persons who are homeless, and persons perceived as unattractive or different are also at risk for a lack of information or misinformation that may lead to inappropriate participation based on misjudgment. Indeed, information may even be withheld intentionally if participation is not welcome.

Parse’s (2003) theory of community becoming, which is also an extension of Rogers’ nursing science, is particularly applicable to the theoretical tenet of vulnerability. Parse defines community in terms of the relational experience of being “in community,” describing it as a resource that is dynamic and continuously changing to represent the good of the individual to achieve the best for all. According to her definition, community is not a location or a group of people who have similar interests; rather, community is the human connectedness with the universe, including connectedness with what she terms “yet-to-be possibles.” This view represents a paradigm shift, wherein vulnerability is an emergent characteristic of the community in the process that occurs when an individual or group becomes disconnected from the group and, therefore, from needed resources. Parse describes a nontraditional model of health service for individuals and families who have become disconnected from resources in this way. This process involves developing a vision of possibilities and inviting others to capture this vision, thereby energizing the community to build partnerships to overcome the disconnect.

Within this conceptualization, vulnerability arises as an emergent characteristic when connectedness is compromised by a lack of communication or flawed communication that leads to exclusion from resources. Vulnerability might be seen as an unfortunate estrangement from the process of community. Within this view, persons who are at particular risk for vulnerability are those who for some reason are unable to call enough attention to their needs to garner the support of their community.

Based on Parse’s (1997) “human becoming” perspective, this author’s view of nursing practice also differs from traditional nursing practice in that the nurse does not offer standardized professional advice or opinions stemming from the nurse’s own value system. Rather, according to Parse, nursing involves a “true presence with and respect for the other,” wherein the nurse dwells with the person or family to enhance their perceived “possibles.” Parse points out that it is essential to go with vulnerable persons to where they are rather than to attempt to judge, change, or control these individuals. It is in dwelling with the individual in discussion that meanings emerge, and it is in this process of illuminating meaning that possibilities for transcendence are seen.

In Parse's words:

The nurse in true presence with person or family is not a guide or a beacon, but rather an inspiring attentive presence that calls the other to shed light on the meaning moments of his or her life. It is the person or family in the presence of the nurse that illuminates the meaning and mobilizes the capacity to transcend and move beyond. The person is coauthor of his or her own health . . . choosing rhythmical patterns of relating while reaching for personal hopes and dreams. (Parse, 1997, p. 40)

She continues:

True presence is a special way of *being with* in which the nurse bears witness to the person's or family's own living of value priorities. True presence is an interpersonal art grounded in a strong knowledge base "reflecting the belief that each person knows *the way* somewhere within self." (Parse, 1997, p. 40)

Certainly, nowhere is it more important to respect the person as he or she is than when working with vulnerable individuals.

Parse describes a humanitarian model of nursing practice based on true presence and profound respect. Use of this model enables people to find actions that increase their ability to knowingly participate in change to improve their position, thereby becoming less vulnerable. Parse refers to this process as the search for the possible beyond the now.

Unfortunately, even in this overall positive system, some persons are likely to find themselves in vulnerable circumstances. Some individuals and groups (such as young children) are placed at risk because they cannot speak for themselves and depend on others to advocate for them. Likewise, sick or frail members of the community may be too weak or impaired to participate knowingly (or sufficiently) in the change process to advance their betterment. They may not be mobile enough, think clearly enough, or be articulate enough to capture community attention and garner the resources they need.

Individuals or families at special risk for vulnerability include those with the following characteristics:

- Have energy-draining illnesses or conditions such as stroke, heart attack, cancer, or depression
- Are not included in the dominant culture
- Have compromised language facility, making them at greater risk for being unheard
- Are out of their familiar turf (i.e., new in the community and do not know the "rules" or avenues for help)
- Are unable to comprehend information (i.e., never learned to read, have diminished vision or hearing, are unconscious or have dementia, or are unable to comprehend English)
- Have illness or injury that limits independence (i.e., broken hips that make it more difficult to stay physically connected with the community)

- Lack the ability to access services needed for everyday life (i.e., means for obtaining food, place to live, health services)
- Are in a position of diminished visibility (e.g., live in a remote area or are homebound, becoming disconnected from community notice)

Viewed from Parse's theory of community becoming, the approach to overcoming vulnerability is a matter of reconnecting the person or group to the community. This bonding sometimes happens naturally through family and friends or through social institutions and/or programs such as churches and civic organizations. In other cases, it may take the focused attention and time of individuals, such as nurses, to help the person or family as they gain insight about the possibilities that are available to them.

GIVING VOICE: AN APPLICATION OF ROGERIAN NURSING SCIENCE

To address the lack of voice that is so intricately associated with the experience of vulnerability, this section describes a simple picture tool, the WPS, developed within the Rogerian conceptual system to amplify the voice of persons who otherwise might not be heard (Gueldner et al., 2005).

The WPS is a 10-item non-language-based pictorial scale that measures general sense of well-being as a reflection of the mutual human–environmental field process. It was originally designed as an easy-to-administer tool for use with the broadest possible range of adult populations, including persons who have limited formal education, do not speak English as their first language, may not be able to see well, or may be too sick or frail to respond to lengthier or more complex measures. Ten pairs of 1-inch drawings depicting a sense of high or low well-being are arranged at opposite ends of a seven-choice, unnumbered, semantic differential scale. The 10 items included are eyes open and closed, shoes sitting still and running, a butterfly opposite a turtle, a candle lit and not lit, a faucet running full and dripping, puzzle pieces together and separated, a pencil sharp and dull, the sun full and partially cloud covered, balloons inflated and partially deflated, and a lion and a mouse. Individuals are asked to view each of the 10 picture pairs and mark the point along the scale between the pictures to indicate which they feel most like—for example, a lighted candle or an unlit candle. The brief instructions for the WPS are translated and administered in Taiwanese, Japanese, Korean, Egyptian, and Spanish.

Psychometric properties for the WPS tool were established in a sample of 1027 individuals in the United States, Taiwan, and Japan; the sample was 56% Asian, 34% white, and 10% African American or Hispanic. The overall Cronbach's alpha was found to be 0.8795 across the three countries. Five of the 10 items were completely consistent across countries (puzzle, balloon, sun, eyes, and lion), and all others were consistent across two of the three countries.

CONCEPTUAL FORMULATION OF WELL-BEING

Rogers maintained that “the purpose of nursing is to promote health and well-being for all persons wherever they are” (1992, p. 258). According to Hills (1998), well-being is

generally defined as a relative sense of harmony and satisfaction in one's life. Smith (1981) and Todaro-Franceschi (1999) have defined health as movement toward self-fulfillment or realization of one's potential, a view that is congruent with Parse's (1997) theory of human becoming. Newman (1994) does not distinguish health from well-being, but singularly defines it as a manifestation of expanding consciousness that may occur during, but is not separate from, the experience of illness. This view is supported by the work of Hills (1998), who demonstrated a relationship between well-being and awareness.

Conceptually, the WPS assesses the energy field in regard to four characteristics judged to be associated with well-being: frequency of movement (i.e., intensity) within the energy field, awareness of oneself as energy, action emanating from the energy field, and power as knowing participation in change within the mutual human–environmental energy field process.

Frequency

The term *frequency* denotes the intensity of motion within the energy field(s). It is postulated that higher frequency is associated with a greater sense of well-being and that it is experienced as a sense of vitality.

Awareness

Awareness refers to the sense an individual has of his or her potential for change within the mutual human–environmental field. It signals readiness for moving toward one's potential and is postulated to be positively associated with a sense of well-being. The concept of awareness is congruent with Newman's (1994) theory of health as expanding consciousness and Parse's (1997) theory of human becoming (unfolding). Barrett (1990) included a subscale of awareness in her PKPC tool, and Hills (1998) discussed enlightenment as a manifestation of expanded awareness, higher level field motion, and well-being. Awareness is postulated to be a positive manifestation of the dynamics of the mutual human–environmental field process.

Action

Action is conceptualized as an emergent of the “continuous mutual human–environmental field process” (Rogers, 1992), reflecting the frequency of the human energy field. It is viewed as an expression of field energy associated with well-being. Examples of action include activities associated with daily living, such as preparing food, eating, personal grooming, participating in social events, exercising, or doing chores, as well as actively engaging in innovative thinking or the creation of art forms.

Power

As described by Barrett (1990), *power* is the capacity of an individual to engage knowingly in change. Barrett defined it as the degree to which an individual is able to express energy as power to create desired change within his or her human–environmental energy field process. When power is prominent, a person is expected to possess a sense of confidence; conversely powerlessness is associated with a sense of vulnerability. Power might also be conceptualized as the capacity of an individual to commute the three aforementioned conditions (energy expressed as frequency, awareness, and action) into an emergent sense of well-being.

WPS DEVELOPMENT

The more than 10 years of developmental work and field testing of early versions of the WPS revealed a correlation with several other tools designed to measure aspects of well-being within the Rogerian framework (Gueldner, Bramlett, Johnston, & Guillory, 1996). Johnston (1994), in a sample of nursing home residents and community-dwelling elders, reported a highly significant correlation ($r = 0.6647$) between the WPS tool and her Human Field Image Metaphor Scale, which uses two- or three-word metaphors to measure image. Gueldner et al. (1996) found an even greater correlation ($r = 0.7841$) between the WPS and Barrett's (1990) PKPC tool, which measures an individual's capacity for awareness, choices, freedom to act intentionally, and involvement to bring about harmony in the human–environmental field process.

Davis (1989), in a matched sample of 30 men 19–51 years of age who had been hospitalized for traumatic injuries and 30 non-injured men, demonstrated positive significant correlations between the score on the WPS and scores on the PKPC tool ($p = 0.002$) and Rosenberg's self-esteem scale ($p = 0.02$).

Hindman (1993), in a sample of 40 nursing home residents and 40 community-dwelling older adults, demonstrated a significant correlation ($p = 0.001$) between the mean score on the WPS and humor as measured by the Situational Humor Response Questionnaire. She also found that the mean score was higher for the community-dwelling group of older adults ($p = 0.001$) than for their counterparts who lived in nursing homes, and that individuals who perceived their income as adequate scored higher ($p = 0.05$) than those who perceived their income to be less than adequate. Older participants scored lower ($p = 0.05$) on the WPS.

Hills (1998), in a study of 874 mothers of 6-month-old infants, found that mothers who scored higher on the picture tool also reported higher levels of awareness ($p = 0.001$) as measured by the awareness subscale of Barrett's (1990) PKPC tool and well-being ($p < 0.001$) as measured by Cantril's Ladder for Well-Being.

Gueldner et al. (2005) administered the WPS and the Geriatric Depression Scale (GDS) to 215 community-dwelling older adults (64% female and 36% male; 55 to 97 years old) who were attending lunch events at six senior centers in upstate New York. These researchers reported a significant negative correlation ($p < -0.01$) between the WPS and the GDS. One-fifth of the study participants (20%) scored above the cut-off point of 5 (indicating concern for depression) on the GDS; 10% scored above 8 on the GDS, and three individuals scored an alarming 13–14 on the GDS. These findings support the ability of the more user-friendly WPS to screen for depression in community-dwelling elders.

USE OF THE WPS WITH CHILDREN

Because of their dependent status, children are at particular risk for vulnerability. Their voices may not be heard, but others tend to speak for them. Thus the developers of the WPS believe that this tool holds promise for giving voice to children as well as to adults. The WPS has been used by two researchers to measure well-being in children.

Abbate (1990) used the early 18-item version of the tool as a pre- and post-test measure of well-being in eight school-aged children (aged 5 to 16 years) with cerebral palsy who

participated in a 10-week therapeutic horsemanship program. The mean of the pre-test scores was 82.75; the mean of the post-test scores was 86.38. The scores of four children increased over the 10-week period, the score of one child did not change, and the scores of three children decreased. All of the children in the study had already been riding horses for several years, leading Abbate to suggest that some of the children may have already achieved the most significant gains from their participation in the riding program before the study began. Abbate noted that even the most impaired children seemed comfortable and confident in placing their mark along the seven-point scoring line between the picture pairs (the younger ones used crayons), supporting this tool's utility with children. This investigation was the first study to use the WPS tool with children, and the sample was small. Nevertheless, its findings provided impetus and direction for developing a children's version of the instrument.

Terwilliger (2008; Terwilliger, Gueldner, & Bronstein, in press) modified the format of the 10-item WPS for use with a sample of 19 fourth- and fifth-grade elementary school children (13 girls and 6 boys; 53% white, 37% black, and 10% Hispanic) who were judged by the school nurse as being overweight or at risk for depression. The primary purpose of this study was to test the capacity of a 4-month-long after-school physical activity program to decrease childhood overweight and depression. Overweight was determined based on waist circumference and actual weight by height, and depression was identified via the Childhood Depression Inventory, Long Version (CDI-LV).

The scoring mechanism for the WPS was simplified for use with these children. The original seven-point Likert scale between each pair of pictures was reconfigured and abbreviated to four boxes; two boxes were placed closer to the picture on the left of the page and the other two boxes were placed closer to the picture pair on the right side of the page. For each item, the investigator asked the children to point to the picture they "felt most like." The children were then asked to place a mark in one of the two boxes to indicate whether they felt "a little bit" like the picture they had chosen or "a lot" like it. The investigator repeated each item and pointed out the designated boxes as many times as necessary if the child seemed to have difficulty understanding the scoring instructions. The scoring mechanism was adjusted so that the children's scores retained the range from 7 to 70, with higher scores indicating a higher sense of well-being.

The scores for the WPS-CV in this sample of children ranged from 22 to 70, with a mean score of 58. No statistically significant difference was found between the WPS-CV pre-intervention and post-intervention scores, which is not surprising given the small sample size. Nevertheless, a score of 50 or less on the WPS-CV pinpointed the two students whose CDI-LV responses indicated suicidal intent, and use of a score of 60 or less as a cut-off point would have identified all but one of the students found to be at risk for depression. These findings lend support for the further testing of the WPS-CV in at-risk children.

In summary, work by Gueldner et al. (1996), Hills (1998), and Johnston (1994) confirmed a high correlation between scores on the WPS and other measures of well-being developed within the Rogerian conceptual system. Additionally, the work of Davis (1989), Hills (1998), and Hindman (1993) demonstrated a high correlation between the WPS tool and a number of established

measures of well-being developed by other disciplines. Although both were limited in sample size, the studies of Abbate (1990) and Terwilliger (2008) demonstrated the potential utility of this tool in children.

CONCLUSION

Based on these findings, the WPS is offered as a general measure of well-being mediated through frequency, awareness, action, and power emanating within an individual's mutual human–environmental field process. This instrument is seen as having the potential to give voice to those who are too sick or weak to participate in studies that require lengthy or complex measures of well-being. A secondary purpose of the tool rests in its potential for use as an easy-to-administer clinical indicator of well-being across a wide sector of clinical settings. Based on the work of Abbate (1990) and Terwilliger (2008; Terwilliger et al., in press), a children's version of the tool has been developed and tested, and is offered as a measure of well-being in children. A growing number of studies have also demonstrated its ability to give voice to persons within international populations who may have difficulty reading English text.

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