10 Nurse-Patient Interaction: A Vital Salutogenic Resource in Nursing Home Care

Gørill Haugan

Abstract

We are now witnessing a major change in the world's population. Many people globally grow very old: 80, 90, and 100 years. Increased age is followed by an increased incidence of functional and chronic comorbidities and diverse disabilities, which for many leads to the need for long-term care in a nursing home. Quality of life and health promotive initiatives for older persons living in nursing homes will become ever more important in the years to come. Therefore, this chapter focuses on health promotion among older adults living in nursing homes. First, this chapter clarifies the concepts of health, salutogenesis, and pathogenesis, followed by knowledge about health promotion. Then insight and knowledge about the nursing home population is provided; what promotes health and well-being in nursing home residents?

Health promotion in the health services should be based on integrated knowledge of salutogenesis and pathogenesis. The salutogenic understanding of health is holistic and considers man as a wholeness including physical, mental, social, and spiritual/existential dimensions. Research indicates that various health-promoting interventions, specifically the nurse–patient interaction, influence on older adults in nursing homes as a wholeness of body–soul–spirit, affecting the whole being. Hence, dimensions such as pain, fatigue, dyspnea, nausea, loneliness, anxiety, and depressive symptoms will be influenced through health-promoting approaches. Therefore, two separate studies on the health-promoting influences of nurse–patient interaction in nursing home residents were conducted. In total, nine hypotheses of directional influence of the nurse–patient interaction were tested, all of which finding support.

Along with competence in pain and symptom management, health-promoting nurse–patient interaction based on awareness and attentional skills is essential in nursing home care. Thus, health care workers should be given the opportunity to further develop their knowledge and relational skills, in order to "refine" their way of being present together with residents in nursing homes. Health professionals' competence involves the "*being in the doing*"; that is, both the *doing* and the way of *being* are essential in health and nursing care.

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G. Haugan, M. Eriksson (eds.), *Health Promotion in Health Care – Vital Theories and Research*,
https://doi.org/10.1007/978-3-030-63135-2_10

Keywords

Health promotion · Holistic health concept · Nursing home · Nurse–patient interaction · Salutogenesis and pathogenesis · Salutogenic nursing home care · Spiritual care · The "Being in the Doing"

10.1 Background

Currently, the world faces a shift to an older population; 125 million people are now aged 80 years or older [1].While this shift started in high-income countries (e.g., in Japan 30% of the population is already over 60 years old), it is now low- and middle-income countries that are experiencing the greatest change. Today, most people can expect to live into their 60s and beyond [1]. Between 2015 and 2050, the proportion of the world's population over 60 years will nearly double from 12% to 22%; by 2050, the world's population aged 60 years and older is expected to total two billion, up from 900 million in 2015 [1, 2]. Soon 30% of the world's population is 60 years and older. All countries in the world face major challenges to ensure that their health and social systems are ready to make the most of this demographic shift [1].

There is, however, little evidence to suggest that older people today are experiencing their later years in better health than their parents. Age is no disease. Yet, most chronically ill people today are older adults. Increased age is followed by an increased incidence of functional and chronic comorbidities and diverse disabilities [3], which for many leads to the need for long-term care in a nursing home (NH). Accordingly, the WHO's Global Strategy and Action Plan on Aging and Health [1] includes the development of systems for providing long-term care as one among five priority areas for action. Systems of long-term care are needed in all countries to meet the needs of older people.

As people live longer, it is important to ensure that the extra years of life are worth living, despite chronic illnesses. This is important not only to the individual elderly, but also to the families, the local community as well as the society. Quality-of-life (QoL) and health promotive initiatives for older persons living in NHs will become ever more important in the years to come. Therefore, this chapter focuses on health promotion among older adults living in NHs. First, this chapter clarifies the concept of health, followed by knowledge about health promotion. Then insight and knowledge about the NH population is provided; what is health and health promotion in the NH context?

10.2 The Salutogenic Concept of Health

To promote health, we need knowledge of what health is and what creates health and thus well-being. Instead of focusing only on disease and risk of disease (framed as pathogenesis), Aron Antonovsky [4] focused on "What creates health?" This question was the starting point of the salutogenic understanding of health, which represents a turning point in the understanding of health research. An increasing number of researchers have now realized that a unilateral focus on disease and risks of getting sick (pathogenesis) does not necessarily increase or strengthen an individual's health [5]. The human life is multifaceted; people's health is exposed to many different types of stress, to which the individual responds differently. Not everyone gets sick from major stresses, risk factors, losses, crises, and illness. Who are the salutogenic ones, those who maintain health despite stressing life circumstances? What makes them go through these negative life events without getting sick? Do they just have luck? And others bad luck? Or are there any salutogenic resources that preserve health during difficult circumstances?

Antonovsky [4, 6] is considered the "father of salutogenesis." The concept of salutogenesis originates from the Greek notion of "*salus*" which means health and the Latin term "*genesis*" which means origin. Bottom line, salutogenesis—the salutogenic understanding of health and the gradually evolving salutogenic concepts—signifies knowledge about the origin of health, that is, knowledge of what gives, facilitates, and

supports health. From a salutogenic perspective, health is a positive concept involving social and personal resources, as well as physical capacities. The concept of salutogenesis has matured since 1986 and has become a core theory of health promotion [5].

The salutogenic concept of health is holistic [4], considering man as a wholeness including a physical, mental, social, and spiritual/existential dimension. Nursing and other health professions are grounded in the holistic understanding of health, implying that human beings consist of these above-mentioned four dimensions [7]. However, by theoretically splitting the human into four, man is no longer one unit, but four "divorced" parts, which is contradictory. Health care is largely based on this fragmentation of man which causes unnecessarily suffering; often patients feel treated like a diagnosis, a case, or an object the doctor is treating and health professionals are controlling, and not as a whole living person. Figure 10.1 illustrates the entity of the human being involving a physical, emotional, social, and spiritual/existential dimension. However, this picture of a human being divided into four parts, dimensions or levels, is merely theoretical. Figure 10.1 has a red dotted line which circulates; even though we theoretically claim that there are different dimensions in the whole, it is still a whole because these four dimensions are integrated into each other and act like an entirely integrated wholeness, a human being. A constantly ongoing interaction integrates the dimensions or levels in the whole [8], all controlled via the brain [10]. Nothing is "just emotional" or "just physical," everything is integrated into everything. In human being, everything is interrelated and influences on everything.

Fig. 10.1 The wholeness of man involving a physical, emotional, social, and spiritual/existential dimension, interrelated by a steady interaction between the dimensions. ©Gørill Haugan

Hence, man is a unique and indivisible physical-psycho-social-spiritual entity in which body, mind, and spirit are integrated and constantly interact with each other, right down to the microcellular level [9, 10]. That is, the human experiences, expectations, thoughts, and feelings are physiological states or biochemical conditions in the body, with subsequent bodily consequences impacting the whole being [11]. Research has shown and shows ever more clearly that there are connections (interaction) between the mind (our thoughts, feelings, and experiences) and the body in the development of most diseases and ailments [12]. Negative emotions and prolonged stress expose the organ systems to stress that can result in illness. Our emotions are biochemical realities in our bodies. Since they have nowhere else to be, we feel and recognize our emotions in the body [11]. Candace Pert is an internationally recognized stress researcher showing that the brain "talks" to the immune cell system by means of "messenger cells" called neuropeptides or transmitters. When the brain interprets emotions such as fear, anger, or sadness, all the immune cells are told about this interpretation. Pert [11] describes this process as "bits of the brain floating around the body." Simply put, our emotions and thoughts "float around the body," materialized as peptides (protein molecules) and a myriad of complex chemical and physiological processes. Studies on stress have claimed that feeling fear triggers more than 1400 known physical and chemical stress reactions, activating more than 30 different hormones and neurotransmitters [13]. Furthermore, the stress literature highlights that positive attitudes and expectations are not just changing moods, but biological realities in the body. Seligman [14] and Keyes [15–18] have shown that optimism and "flourishing" have a great positive impact on human health. Several studies

have shown that a specific kind of white blood cells called "natural killer cells," increase during cognitive therapy, as well as by various relaxation and visualization techniques [19, 20]. Recent research implies that for example perceived meaning-in-life is important for maintaining not only mental/emotional well-being, but physical and functional well-being as well [21–23]. A novel study demonstrated humans' holistic existence showing that perceived meaning-in-life as well as loneliness affected older adults' brain function [23]. These findings advance our understanding of phenomenon such as meaning and loneliness which operate not only by emotions or experiences but represent physical states in human's brains [23]. Loneliness and meaning-in-life are reflected in the intrinsic network architecture of the brain. Thus, various health-promoting interventions, tailored to the individual and specific context, influence on the patient as body–mind–spirit impacting on the whole being. Accordingly, dimensions such as pain, fatigue, dyspnea, nausea, anxiety, and depressive symptoms will be affected through health-promoting approaches.

10.3 Health Promotion

The first international conference on health promotion was held by the World Health Organization in Ottawa, Canada, in 1986. Here, the Ottawa Charter [24] was drafted and approved, describing health promotion as "*… the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health*" [24]. Transferred to the health services, health promotion entails to develop the individual's health promotion skills by providing information, knowledge, support, guidance, care, and coping techniques. Furthermore, the goal is to reorient the health service in a health-promoting direction; the Norwegian Directorate of Health highlighted this as early as 1987 [25]. However, according to the Shanghai declaration of promoting health [26], it seems important to re-emphasize this primarily positive orientation of health promotion, as indicated in the 1986 Ottawa Charter [5, 27]. The Shanghai declaration from 2016 recognizes that health and well-being are essential to achieving sustainable development. Consequently, not only hospitals but also NHs should be developed in a health-promoting direction.

It is important to emphasize that health promotion approaches do not mean a disregard of pathogenesis. Knowledge of pathogenesis, i.e., knowledge of disease, risk, and prevention, is important in all health disciplines and of course in the health services. When people get injured or ill, whether it be heart disease, lung disease, cancer disease, mental illness, or the need for a surgical intervention, knowledge of illnesses, injuries, and trauma, as well as the treatment of them, is crucial to peoples' lives. However, the health services now need a clear and explicit synthesis of pathogenesis and salutogenesis; both paradigms are important. Instead of juxtaposing pathogenesis and salutogenesis, they should be integrated into a holistic way of understanding and working with health. Humans' health should not only be treated, but also promoted and facilitated. Health is always present, while illness and injury occur from time to time. Thus, health is the basic and the origin and should therefore be the basis, on which the health services are founded. What might health promotion look like in the NH population?

10.4 Older Adults in Nursing Homes

The NH population is characterized by high age, frailty, mortality, disability, powerlessness, dependency, vulnerability, poor general health, and a high symptom burden [3, 22, 28]. Accordingly, moving to a NH results from numerous losses, illnesses, disabilities, loss of functions and social relations, and facing the end-of-life, all of which increases an individual's vulnerability and distress. Residents in NHs have few opportunities to make personal decisions or exercise control over their lives. Many residents perceive their institutionalization as the beginning of their loss of independence and autonomy

[29–31]. Idleness and time spent in passive activities, such as doing nothing, sleeping, and waiting is commonplace among NH residents [32, 33], which leads to feelings of boredom, loneliness, and indignity [34–37]. Residents have used terms like trapped, stuck, confined, isolated, and discouraged to describe how they feel about the institutional life [29].

Consequently, the NH population is at a high risk of declined well-being and quality-of-life (QoL) [38–40]. Finding approaches to increase well-being among older adults in NHs is highly warranted. Responding to this need, the approach framed "Joy-of-Life-Nursing-Homes" (JoLNH) was developed in Norway. The JoLNH is a national strategy for promoting well-being, meaning and QoL among NH patients [41]. In accordance with recent research [37, 42–45], the JoLNH national strategy implies implementation of the "Joy-of-Life" philosophy and working approach emphasizing that spiritual and emotional needs such as perceived meaning and joy-of-life, culture, meaningful activity, connectedness, relationships, and enjoyment shall be integrated essentials of NH care. Based on the theoretical framework of salutogenesis [4, 6], well-being theory [17, 46, 47] and qualitative in-depth interviews with 29 NH residents, a conceptual structure depicting the essence of the joy-of-life phenomenon in NHs, were derived [48], and a quantitative measurement model for joy-of-life was developed and framed the Joy-of-Life Scale (JoLS) [49]. These qualitative findings revealed that positive relationships, belongingness, meaning, moments of feeling well, and acceptance conceptualized the essence of the joy-of-life phenomenon among NH residents [48].

10.4.1 Vital Salutogenic Resources in Nursing Home Care

Studies of social support in the NH population [50, 51] show significant correlations with well-being. A systematic review on well-being among older adults staying in care facilities identified four themes: (1) acceptance and adaptation, (2) attachment to others, (3) home environment, and (4) qualities in the relationship with their caregivers [52]. Moreover, a recent study among elderly in NHs showed that spiritual well-being was strongly associated with the experience of support, trust, meaning-in-life, and a perspective beyond death [53]. Experience of meaning, which is a central aspect of spiritual and emotional well-being, has also shown a clear connection with belonging/affiliation [54, 55], as well as with satisfaction [56] and dignity [37] among NH residents. Self-transcendence [57] and meaning [21, 22] are shown to explain variation in well-being, physically, emotionally, socially, functionally, and spiritually, among older adults in NHs. This means that if self-transcendence, joy-of-life, and perceived meaning-in-life increase, also the resident's well-being—physically, emotionally, socially, functionally, and spiritually—will increase. Connectedness is seen to be essential in self-transcendence, meaning, and joy-of-life.

Older people experience changes in roles, relationships, and living environments that increase their risk for experiencing social isolation and loneliness, particularly when moving to a NH. With advancing age, it is inevitable that people lose connection with their friendship networks and find it more difficult to initiate new friendships and to belong to new networks. Older adults living in NHs often experience limited opportunities for social connection despite proximity to peers [58], which has implications for mental health and QoL [59].

10.5 The Nurse–Patient Relationship: Connectedness and Well-Being

A link between well-being and connectedness is emerging in the literature [60]. Despite old age, chronical diseases, or frailty, the desire for affiliation and social bonding is an intrinsic human need, also when living in a NH. Deprivation of intimate relationships and social engagement adversely affects the physical and emotional well-being of older people. Loneliness and depression are detrimental to elderly individuals' emotional well-being [51, 61–64]. Older adults

describe loneliness as "an aversive emotional state" which is associated with negative and painful feelings, "isolated from intimate relationships," "being deprived from social and external support systems," and "being abused and neglected" [65]. A lack or loss of companionship and an inability to integrate into the social environment are critical correlates of loneliness [66, 67], which is seen to associate with mortality among older adults [68–70].

A systematic review of living well in elderly care homes identified four key themes: (1) connectedness with others, (2) caring practices, (3) acceptance and adaptation, and (4) a homelike environment [52]. Moreover, studies have identified a sense of belonging (connectedness) as a core issue for well-being among NH residents [43, 48, 71–74] pointing at "feelings of support and trust," "searching for meaning and finding answers," and "a perspective beyond death" as essential to their spiritual well-being [53]. A sense of belonging and connectedness contribute to meaning-in-life [54, 55] as well as NH resident satisfaction [56] and dignity [37]. Resident's dignity was recently described related to "slow care" [75]; that is, care without rushing anything, which is seen to be particular important in care of people having dementia [76]. Accordingly, studies have shown that positive experiences in NHs can occur and are important for residents' QoL and well-being [43, 48, 52, 53, 77]. To facilitate such positive experiences, relationship-centered approaches seem required [52, 53, 78, 79].

Through the last decades, the importance of establishing the nurse–patient relationship as an integral component of nursing practice has been well documented [80–83]. International well-accepted nursing theorists describe nursing as a participatory process that transcends the boundaries between patient and nurse and can be learned and knowingly deployed to facilitate well-being [84–91]. The perspective of promoting health and well-being is fundamental in nursing and a major nursing concern in long-term care [92–94].

Communication is an important aspect of nursing; typically, a nurse's duties cannot be performed without communication with her patients. The quality of care and the care ethics are embedded in the nurse–patient relationship. Some attributes of this relationships have been identified by older adults: in a milieu of openness and trust, the qualities of intimacy, sense of belonging, caring, empathy, respect, and reciprocity [71] appear to be health promoting, supporting resident's joy-of-life, healing, strength, and/or growth [45, 71, 95–97].

Caring nurses engage in person-to-person relationships with the NH resident as a unique person. Excellent nursing care is defined by the nurses' way of "being present" together with the older adult while performing the different nursing activities, in which attitudes and competence are inseparably connected. The competent nurse is present and respectful, sincere, friendly, sensitive, and responsive to the NH resident's feelings of vulnerability; she understands his needs, is compassionate to different sufferings, and provides emotional support and confirmation [56, 80, 81, 98, 99]. Thus, nursing care as a moral relational practice increases patients' well-being; qualitatively good nurse–patient interaction helps patients gain a sense of trust, safety, comfort, confirmation, value, dignity, and enhanced well-being (ibid). The experience of being listened to is crucial to long-term care patients, since this is how they experience feeling good, satisfied, valued, and cared about [100, 101], as a part of slow care [75]. Frustration and suffering result from the experience of not being attended to or treated with indifference [96, 102–104]. The nurse–patient interaction performs to be a fundamental health-promoting resource for older adults in NHs. Therefore, we conducted two studies investigating possible impacts of the nurse–patient interaction on well-being in the Norwegian NH population.

10.6 Nurse–Patient Interaction Is a Salutary Factor: Two Norwegian Examples

These two studies were conducted to investigate the possible influences of NH residents' perceived nurse–patient interaction on multidimen-

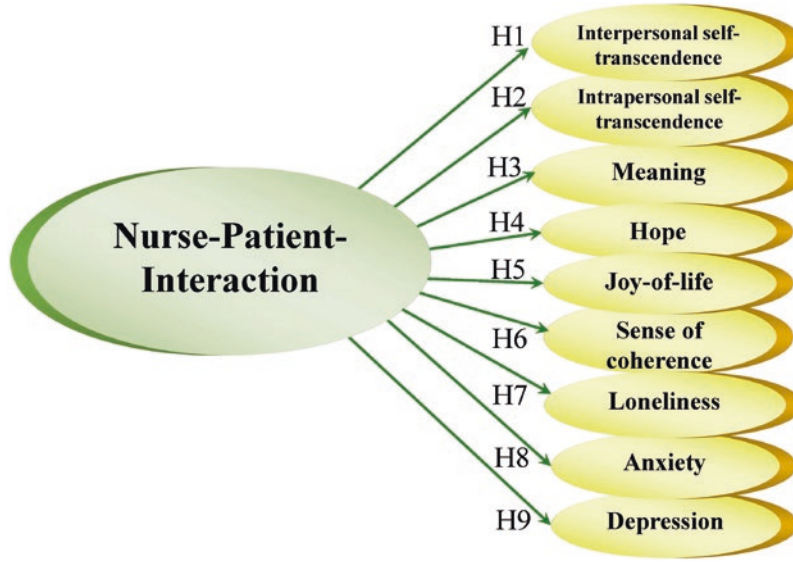

Fig. 10.2 Hypothesized relationships between nurse–patient interaction and variables found to be highly and significantly correlated with well-being

sional well-being. In order to do so, a total of nine hypotheses of direct relationships between nurse–patient interaction and interpersonal (H1) and intrapersonal (H2) self-transcendence, perceived meaning-in-life (H3), hope (H4), joy-of-life (H5), sense of coherence (H6), loneliness (H7), anxiety (H8), and depression (H9) were tested using advanced statistics such as SEM and regression analysis. Since evidence has shown that self-transcendence, meaning, hope, joy-of-life, and sense of coherence are highly positively correlated with well-being in vulnerable populations such as NH residents, these variables were included. Likewise, loneliness, anxiety and depression were selected since they are detrimental to NH residents' well-being. Figure 10.2 portrays the hypothesized directional influence of the nurse–patient interaction (H1–H9).

10.7 Methods

10.7.1 Data Collection

Study 1 collected cross-sectional data in 2008–2009 from 202 residents in 44 different Norwegian NHs; a total of nine different scales were included which totaled 130 items [94]. Study 2 was conducted in 2017–2018 and collected cross-sectional data from 188 residents in 27 different NHs, including seven scales corresponding to 120 items [105]. In total, nine hypotheses of direct relationships between nurse–patient interaction and interpersonal (ST1) and intrapersonal (ST2) self-transcendence, perceived meaning-in-life, hope, joy-of-life, sense of coherence, loneliness, anxiety, and depression were tested.

Inclusion criteria were the same in both studies except residential time, which was 6 months for study 1 and 3 months for study 2: (1) local authority's decision of long-term NH care; (2) residential time 3/6 months or longer; (3) informed consent competency recognized by responsible doctor and nurse; and (4) capable of being interviewed. A nurse who knew the residents well presented them with oral and written information about their rights as participants to withdraw at any time. Each participant provided written informed consent.

Due to impaired vision, problems holding a pen, etc., this population has difficulties completing a questionnaire on their own; therefore, both studies conducted one-on-one interviews by three (study 1) and six (study 2) trained researchers in the informant's private room in the NH. Researchers with identical professional background (RN, MA, trained, and experienced

in communication with elderly, as well as teaching gerontology at an advanced level) were trained to conduct the interviews as identically as possible. The questionnaires relevant for these two studies were part of a battery of nine (study 1) and seven (study 2) scales comprising 130 and 120 items, respectively. To avoid misunderstandings, the interviewers held a large-print copy of questions and possible responses in front of the participants. Approval by the Regional Committee for Medical and Health Research Ethics in Central Norway (Study1: Ref.no.4.2007.645, Study 2: Ref.nr 2014/2000/REK Central) was obtained as well as from the Management Units at the 44 (Study 1) and 27 (Study 2) NHs.

10.7.2 Participants Study 1

The sample consisted of 202 (80.8% response rate) of 250 residents who met the inclusion criteria. These 202 participants represented 44 different NHs in central Norway. Ages ranged from 65 to 104 years, with an average of 86 years (SD = 7.65). A total of 146 women (72.3%) and 56 men (27.7%) participated; the mean age was 87.3 and 82 years, for women and men, respectively. In this sample, 38 (19%) were married or cohabiting, 135 (67%) widowed, 11 (5.5%) divorced, and 18 (19%) single. The average residence time in the NH at the time of the interview was 2.6 years (range 0.5–13 years); 117 participants stayed in rural municipalities while 85 stayed in urban municipalities. Long-term NH care was defined as a 24 hours day care for 6 months or longer; short-term and rehabilitation stays along with patients diagnosed with dementia were not included. The data were collected in 2008–2009.

10.7.3 Participants Study 2

This sample consisted of 188 (92% response rate) out of 204 long-term residents who met the inclusion criteria. These 188 represented 27 different NHs in two large and two smaller urban municipalities in Norway. A total of 88 participants lived in certified joy-of-life NHs, while 100 lived in ordinary NHs. Age ranged from 63 to 104 years, with an average of 87.4 years (SD = 8.57). A total of 132 women (73.33%) and 48 men (26.67%) participated; the mean age was 88.3 years (SD = 1.80) for women and 86 years (SD = 1.16) for men. In this sample, 23 (12.2%) were married, 22 (11.7%) cohabitants, 1 (0.5%) single, 106 (56.4%) widowed, and 37 (19.7%) divorced. Long-term care in NHs was defined as 24 hours day care for 3 months or longer; short-term stays, rehabilitation stays, and residents diagnosed with dementia were not included. The data were collected during 2017–2018.

10.7.4 Measurements

The variables involved in Fig. 10.2 were measured using different scales translated into Norwegian and validated in the Norwegian NH population. Both studies involved the nurse–patient interaction scale, self-transcendence scale, the purpose-in-life test, and the hospital anxiety and depression scale. Additionally, study 1 included the Herth Hope Index, and study 2 included the joy-of-life scale, the orientation to life questionnaire and a global question assessing loneliness.

The Nurse–Patient Interaction Scale (NPIS) assessed nurse–patient interaction. The NPIS was developed in Norway to measure the NH patients' sense of well-being derived from the nurse–patient interaction [80, 96, 100, 106]. The NPIS comprises 14 items identifying essential relational qualities stressed in the nursing literature; a validation study in an NH population demonstrated good psychometric properties [97]. The NPIS is a 10-point scale from 1 (not at all) to 10 (very much); higher numbers indicate better perceived nurse–patient interaction.

The Self-Transcendence Scale (STS) developed by Reed [107, 108] was used to measure self-transcendence. The STS comprises 15 items reflecting expanded boundaries of self, identified by intrapersonal, interpersonal, transpersonal, and temporal experiences [109], all of which are characteristics of a matured view of life. Each item is rated on a 4-point Likert-type scale from 1 (not at all) to 4 (very much); higher scores indi-

cate higher self-transcendence. The STS has been translated into Norwegian and validated in NH patients [110] showing a two-factor construct (STS1 and STS2) to be most valid and reliable among NH patients [110]. In the present studies, we applied this two-factor construct.

The Purpose-in-Life (PIL) test: Based on Viktor Frankl's [111] logotherapy, Crumbaugh and Maholick developed the PIL test [112] to assess perceived purpose and meaning-in-life. The PIL comprises 20 items worded as statements. Each statement is scored from 1 to 7; 4 represents a neutral value, whereas the numbers from 1 to 7 stretch along a continuum from one extreme feeling to the opposite kind of feeling. Higher numbers indicate stronger meaning-in-life. As part of study 1, the Norwegian version of the PIL was validated among NH residents [113], showing good psychometric properties.

The Herth Hope Index [114] assessed hope in study 1. The Herth Hope Index (HHI) comprises 12 items assessed on a 4-point Likert scale; the HHI was validated among older adults in Norwegian NHs and found to have good psychometric properties [115].

The Joy-of-life Scale (JoLS) was developed and validated for use in study 2. The JoLS includes 13 items on a 7-point scale ranging from 1 (not at all) to 7 (very much); higher number indicating stronger JOL. The JoLS demonstrated good psychometric properties in the NH population [49].

The Orientation to Life Questionnaire (OLQ) measured sense of coherence (SOC) [116]. Based in the salutogenic health theory, Antonovsky (1987) developed the original 29-item OLQ, measuring SOC. Later the 13-item short version of the OLQ was developed; the Norwegian version of the short OLQ-13 was used in the present study, rating the items on a 7-point scale providing two anchoring verbal responses, e.g., "very seldom or never" and "very often." Total score ranges from 13 to 91; higher scores indicate a stronger SOC [4, 6]. The OLQ was recently validated among nursing home residents and demonstrated satisfactory psychometric properties.

The Hospital Anxiety and Depression Scale (HADS) [117] comprising 14 items includes subscales for anxiety (HADS-A 7 items) and depression (HADS-D 7 items). Each item is rated from 0 to 3, where higher scores indicate more anxiety and depression. The maximum score is 21 on each subscale. The HADS has shown good to acceptable reliability and validity in the NH population [118]. The global question "Do you feel lonely?" assessed loneliness on a scale of 1–4 (1 = frequent, 2 = occasional, 3 = rare, 4 = never).

10.7.5 Analyses

Due to sample size, all paths were not tested in one complex SEM model. Thus, different SEM models of the hypothesized relations between the latent constructs of nurse–patient interaction and (1) self-transcendence (interpersonal and intrapersonal) [97], (2) meaning-in-life [55, 119], (3) hope [120], (4) anxiety and depression [45], and (5) joy-of-life [105], were tested by means of LISREL 8.8 [121] and Stata 15.1 [122], while the assoications with sense of coherenec and loneliness were tested by regression analyses using IBM SPSS Statistics [123].

Using SEM, random measurement error is accounted for and psychometric properties of the scales in the model are more accurately derived. At the same time, the direct, indirect, and total effects throughout the model are estimated. SEM models combine measurement models (e.g., factor models) with structural models (e.g., regression); a major issue is evaluation of model fit. The conventional overall test of fit is the chi-square (χ^2); a small χ^2 and a nonsignificant p-value correspond to good fit [121]. In line with the rule of thumb given as conventional cut-off criteria [124], the following fit indices were used: The Root Mean Square Error of Approximation (RMSEA) and the Standardized Root Mean Square (SRMS) with acceptable/good fit, respectively, set to 0.08/0.05 [124, 125], the Comparative Fit Index (CFI) and the Non-Normed Fit Index (NNFI) with acceptable/good fit, respectively, 0.95/0.97, the Normed Fit Index (NFI), Tucker Lewis Index (TLI) and the Goodness-of-Fit Index (GFI) at 0.90/0.95, and the Adjusted GFI (AGFI) 0.85/0.90 (ibid.). The frequency distribution of

the data was examined to assess deviation from normality; both skewness and kurtosis were statistically significant. As normality is a premise in SEM, we corrected for the non-normality by applying the Robust Maximum Likelihood (RML) estimate procedure and stated the Satorra–Bentler corrected χ^2 [126].

10.8 Findings

Study 1 (N = 202) demonstrated significant effects of residents' perceived nurse–patient interaction on anxiety and depression [45], meaning-in-life [55], interpersonal and intrapersonal self-transcendence [97], and hope [120]. Furthermore, the findings showed that the nurse–patient interaction is a resource not only for self-transcendence, hope, and meaning [79], but also for QoL [44], mental health [89], as well as physical, emotional, social, functional, and spiritual well-being [127] in the NH population. A total of 17 scientific articles have been published based on study 1, as well as a chapter in an international scientific anthology [127]. Study 2 has so far resulted in 8 scientific publications including this chapter, showing among others a significant influence of nurse-patient interaction on sense of coherence and loneliness. Figure 10.3 summarizes the findings in study 1 and study 2: the green arrows illustrate significant direct relations, while the red tiny dotted arrows demonstrate significant mediated relations. Accordingly, Fig. 10.3 illustrates that nurse–patient interaction significantly influences on hope, joy-of-life, meaning-in-life, interpersonal and intrapersonal self-transcendence, sense of coherence, all aspects of well-being, loneliness and physical/mental symptom severity.

Furthermore, intrapersonal and interpersonal self-transcendence and meaning have shown direct and/or indirect impact on all the various dimensions of well-being, that is, physical, emotional, social, functional, and spiritual well-being. In addition, meaning revealed significant associations with symptom severity, physical, and psychological functions in the NH population [22]. Therefore, the different SEM models based on study 1 indicated significant mediated influences as illustrated by the red dotted lines in Fig. 10.3. In short, find-

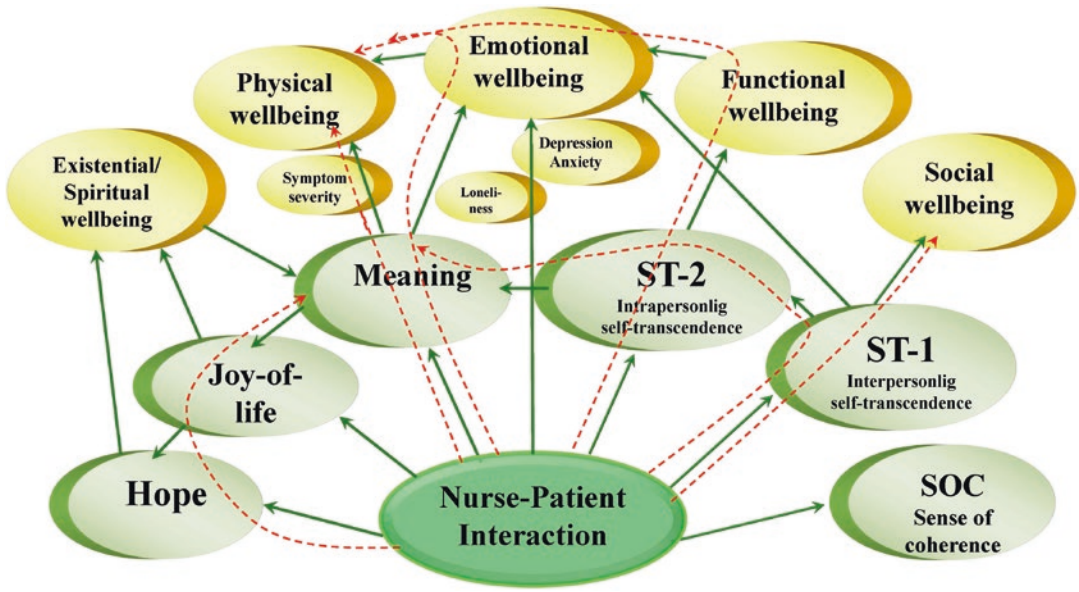

Fig. 10.3 Summary of the findings from study 1 and study 2. Relationships between nurse–patient interaction and hope, joy-of-life, meaning, intrapersonal and interpersonal self-transcendence, sense of coherence, well-being, loneliness and symptom severity. *Note*: ——→ = direct relations (effects); - - - - → = indirect relationships (mediated effects) © Gørill Haugan

ings from study 1 indicate that the nurse–patient interaction has significant impact on all dimensions of well-being, mediated through hope, meaning, and self-transcendence (inter and intra).

Structural equation and regression models based on data from study 2 (N = 188) indicated that the nurse–patient interaction has significant impact on joy-of-life [105], sense of coherence [128] and loneliness [...] [129]. In addition, study 2 supported the findings of study 1 showing that the nurse–patient interaction is of great importance revealing highly significant associations with both interpersonal and intrapersonal self-transcendence as well as perceived meaning-in-life [49]. Figure 10.3 illustrates the significant associations in study 1 and study 2.

10.9 Discussion

In these two studies, nine hypotheses of directional relationships of nurse–patient interaction with inter- and intrapersonal self-transcendence, meaning-in-life, hope, joy-of-life, sense of coherence, loneliness, anxiety and depression were tested, and all of which found support. What does this mean for clinical practice? To elaborate on this, we should look at how the nurse–patient interaction was assessed. The NPIS includes 14 items, measured on a scale from 1 (not at all) to 10 (very much). The higher the score, the better is the perceived interaction with the nurses. Figure 10.4 shows in detail which aspects are included in the measurement model of nurse–patient interaction; the NPIS includes NH residents' experiences of trust, respect, feeling listened to, taken seriously and understood, acknowledged, and recognized as a unique person, as well as included in decisions regarding one's life and the experience of meaningful contact. In total, these aspects constitute the older adults' NPIS scores.

Statistical analyzes showed that residents' experience of these qualities in the nurse–patient interaction contributed to the experience of self-transcendence, meaning, hope, joy-of-life, and

Nurse-Patient Interaction Scale (NPIS)

On a scale from 1-10, to which degree du you experience .....

1	2	3	4	5	6	7	8	9	10
Not at all									Very much

1. I have confidence and trust in the nurses
2. The nurses take me seriously
3. Interaction with the nurses makes me feel good
4. The nurses understand me
5. The nurses make all possible effort to relieve my plagues
6. The nurses involve me in decisions regarding my dayli life
7. The nurses treat me with respect
8. The nurses ask me how I am
9. The nurses are listening to me with interest
10. I often get hurt or sad from how the nurses interact with me
11. Interaction with the nurses contributes to meaning in my life
12. The nurses pay attention to me as a person
13. I am satisfied with the communiction with the nurses
14. Interaction wth the nurses is the most important to my thriving

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Fig. 10.4 Nurse–Patient Interaction Scale (NPIS) assesses perceived nurse–patient interaction. © Gørill Haugan

sense of coherence, and alleviation of loneliness, anxiety and depression. What is more, positively perceived nurse–patient interaction strengthens residents' joy-of-life [105], meaning-in-life, and self-transcendence [55, 97]; the latter two have shown significant impact on physical, emotional, social, functional, and spiritual well-being [21, 57, 119, 130–134]. Thus, the interaction between the nurse and the older adult can be used to promote health and well-being. By facilitating specific qualities in the interaction with their residents, nurses influence on NH residents' health and well-being. The nurse–patient interaction is a vital health-promoting resource in NH care. How can this be explained?

10.9.1 Nurse–Patient Interaction - a Salutogenic Resource

Initially, this chapter established the salutogenic understanding of health based on man being a unit of body–mind–spirit, where the physical, emotional, social, and spiritual/existential dimensions together constitute an integrated entity, in which everything interacts and thus influences everything. Accordingly, experiences of meaning as well as joy-of-life, etc. not only affect the emotional dimension. Since human being is an integrated wholeness, all experiences affect the human unity of body–mind–spirit. That is, also the body—physical well-being and symptom severity—will be affected by perceived meaning and joy-of-life. In fact, meaning and joy are biochemical states in the body [11].

Generally, NH residents have many diseases, ailments, fatigue, pain, and dyspnea [135, 136] and depend on care and help of nurses to stay well. Many are waiting for death. Missing opportunities for meaningful activities, several spend a lot of time doing nothing, sleeping, and waiting [33–37], and social contact with others outside the NH is scarce. Hence, nurses represent the most essential source of social contact as part of the nursing care. Furthermore, in this life situation, the individual might feel vulnerable in interaction and communication with others; especially in relationship with those in power, such as the nurses and other health care professionals, who have power for both good and bad. The Danish philosopher Løgstrup [137] highlighted vulnerability related to being handed over to others, as the case is in NH care. Løgstrup [137] underlined the ethical demands arising from relationships of power, such as the nurse–patient relationship; the nurses hold some of the residents' life in their hands. Considering this, relational competence together with competent pain and symptom management is crucial for health promotion in NH care. Relational competence includes knowledge and professional skills to use the nurse–patient interaction in health-promoting ways, that is, to carefully observe and competently influence the older adults, so that health and well-being increase.

10.9.1.1 Practical Implications: Professionals' Attention and Influencing Skills

Relational competence involves both attentional and influencing skills [138]. Nurse's attention is the leading "tool." Therefore, health-promoting interaction is based on attention-related skills. The health care professional consciously uses and regulates one's attention; that is, what one sees, hears, feels, smells, senses, and thinks during the interaction with the residents. What are you paying attention to? Or where do you direct your attention? Health-promoting interaction requires awareness skills that are based on an active and openly receiving presence. By a sensitive presence [88], the professional nurse uses her senses and presence to perceive and receive what is important to the resident, in order to welcome and attend to what the older adults expresses, verbally and non-verbally. In this way, nurses create trust; a sense of being taken seriously, being acknowledged and attended to as a real person. This promotes health and well-being in vulnerable older individuals in NHs. However, nurse–patient interaction is also about fostering a common understanding of what is at stake right here-and-now; what does the resident think, feel, and experience? The resident's emotions and experiences should be given attention and under-

stood by the health care professional. This is how nurses let the older NH resident become a person, which is highly health promoting.

Attention skills include being sensitive to the NH resident's choice of words, volume, tone, and power in the voice, as well as rhythm of expression (staccato), tempo (fast-slow, pauses), nonverbal expressions such as a sigh, breath, gaze, facial expressions, skin color, posture, congruence, authenticity. There is a wealth of information in such cues [138, 139], which are vital in achieving health-promoting nurse–patient interaction. The instrument of your attention is yourself and what you see, hear, feel, and sense. Therefore, health care professionals need to stay well connected with one's inner self. Still, any focus of attention will always include something and consequently exclude something else. Therefore, it is important to notice whether undue attention is paid or if there is any lack of attention to something that should be attended to. An example illustrating this point is a resident who dares to open up and tell about her loneliness. She is crying. What are you as a health care professional paying attention to? The fact told about her loneliness? Or the emotional expression of crying? What are you doing? Are you listening? Do you explore what this is about? Or do you start to comfort? There is no facet. But, taking time to listen and explore, allowing the resident room and space to become clear to herself, would be health promoting and even more soothing than any well-intentioned comfort. In some cases, health professionals' attempts to comfort become more of a strategy that maintains the problem, rather than helping to solve it. For example, focusing on what this old lady is saying about being lonely instead of focusing on her crying can, paradoxically, cause this lady to feel overlooked, rejected, and thus feel even more lonely. Attention to the matter and a cognitive understanding of its content is usually not enough. Attention to emotional expressions is usually fundamental. This is especially important while caring for older adults having dementia.

Health-promoting interaction rests on health professionals' listening techniques and their ability to create rapport, i.e., to identify and care for the true essence of the resident's experience. In every health professional nurse–patient relationship, professionals are dependent on their attention skills. Nurses need attention to get a clear picture of what is at stake, so they can competently and ethically influence the resident's health and well-being. Not least, this applies to various physical signs such as pain, urinary infection, and pneumonia, or when caring for a wound. Nurses are aware of several small hints that give valuable information.

Health-promoting interaction is about competent influence, sustaining the boundaries between the two, so respect and dignity are maintained. Empathic listening providing unconditional acceptance, recognition, and empathy creates experiences of acceptance and respect and can lead to positive changes and thereby health and well-being. Nevertheless, attentional skills represent impact and thus signify a use of power [138]; such power is part of all relationships between health professionals and their patients. Openly or hidden, power, influence, and authority are always integrated aspects of any relationship between people [88, 137]. Thus, nurse–patient interaction requires that health care professionals are perceptive of one's power and how they use it. The consideration is not about *if or whether* power is being used, but *how* it is used. Wanting the resident well, unconditional acceptance, authenticity, and warmth are always the foundation on which health-promoting interaction is based.

10.9.2 Competent Health-Promoting Nurse–Patient Interaction

The focus of this chapter is nurse–patient interaction as a health-promoting resource in NH care; the relational qualities of the nurse–patient interaction signify essential influences on residents' well-being physically, emotionally, socially, functionally, and spiritually. Being attentive, communicating, and interacting respectfully and empathically while making all

possible effort to relieve the old persons' infirmities are relational qualities fostering dignity, wellbeing and confidence in the nurses [140], as well as encouraging personal goals, values, and comprehensibility. In light of limited staffing, taking time for "slow care" as well as emphatical listening might sometimes prove difficult. Nevertheless, because this includes the way professionals use their eyes, face, voice, hands, and their body which is not time-consuming by itself, an accepting and attending way of being present is not necessarily more time-consuming than an indifferent presence. Moreover, a relationship requires two partakers. That is, the NH resident does also have to contribute to the interaction. However, the professionals should be responsible for at least 75% of the contact qualities in the nurse–patient interaction, aiming at facilitating joy-of-life, sense of coherence, meaning-in-life, hope, self-transcendence and thereby well-being. Professional nursing care is determined by nurses' use of their knowledge, attitudes, behavior, and communication skills to appreciate the uniqueness of the person being cared for [141], which is fundamental for dignity [134], meaning-in-life [55], self-transcendence and well-being [44, 97], loneliness [129], anxiety and depression [45]. Frustration, suffering, hopelessness, meaninglessness, and loneliness result from the experience of not being attended to or treated with indifference [96, 102].

Consequently, health care professionals need knowledge and skills in health-promoting interaction; they should utilize their attentional and influencing skills competently and ethically as part of any caring situation. Moreover, an explicit and clear integration of the pathogenesis and salutogenesis into the health services is needed. Therefore, this chapter proposes a competence triangle where salutogenesis and pathogenesis constitute the sides, while the foundation of the triangle is relational competence, which usually determines how far health professionals can reach in their health-promotion work. Figure 10.5 illustrates the competence triangle, indicating that all three kinds of knowledge (relational, salutogenesis, pathogenesis) are essential parts of competence in NH care.

Fig. 10.5 The triangle of competence: salutogenesis and pathogenesis based upon the basis of relational competence. © Gørill Haugan

Professor Baldacchino [142] emphasized the "*being in the doing.*" Health professionals' way of being present while performing various tasks in collaboration with the NH resident determines the older adult's experience of care quality. Studies have shown that the perceived qualities in the nurse–patient interaction significantly influence on NH residents' loneliness, anxiety, depression, hope, meaning, and self-transcendence, as well as joy-of-life and sense of coherence. This means that by means of awareness, tenderness, and attentional skills, nurse–patient interaction can be used to positively influence on patients' health, QoL, and well-being, physically, emotionally, socially, and spiritually/existentially. Figure 10.6 illustrates a tentative theory of how the salutogenic and pathogenic knowledge together with relational competence, the "*being in the doing*," can influence on NH residents.

Health promotion in NHs should be based on integrated knowledge of salutogenesis and pathogenesis. Competence in pain and symptom management is central in NH care, together with relational knowhow based on awareness and influencing skills. Health workers, not only in NHs but in the entire health services, should be given the opportunity to further develop their knowledge, relational competence, and interactional skills, in order to "refine" their way of being present together with their patients and residents. Health professionals' competence

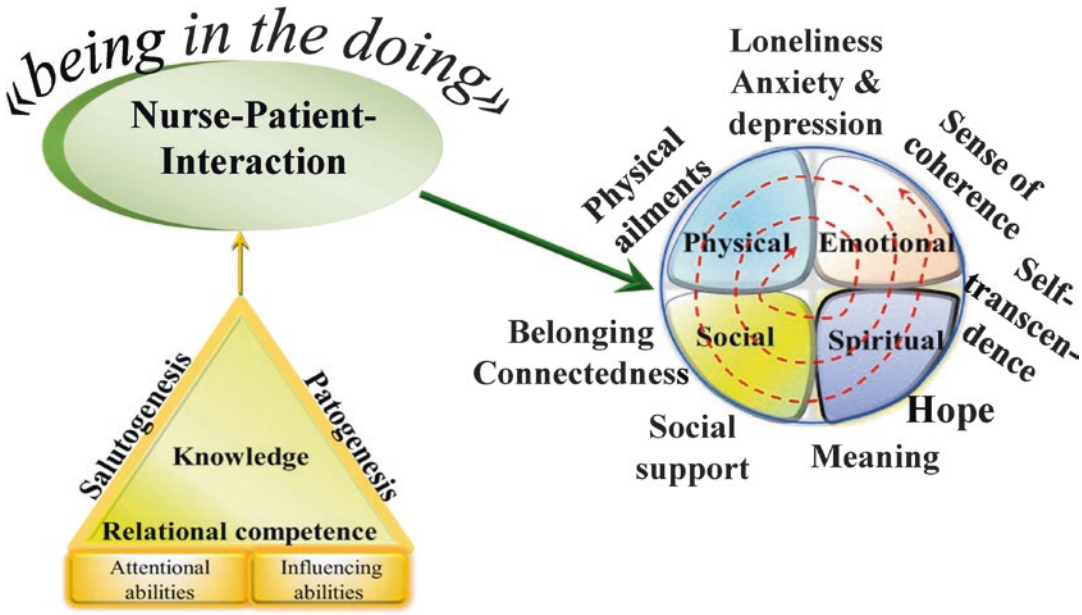

Fig. 10.6 Tentative theory of health promotion interaction in nursing. © Gørill Haugan

should include both the doing and the way of being in NHs and the health services.

Take Home Messages

- Salutogenesis represents the origin of health, while pathogenesis covers knowledge of disease, risk, and prevention. Salutogenesis and pathogenesis need to be integrated in a holistic understanding of human health and well-being.
- The importance of establishing the nurse–patient relationship as an integral component of nursing practice has been well documented. The nurse–patient interaction embodies the foundation of the nurse–patient relationship.
- Nurse–patient interaction has shown to influence on nursing home residents' perceived meaning-in-life, hope, inter- and intrapersonal self-transcendence, joy-of-life, sense of coherence, as well as loneliness, anxiety and depression.
- Accordingly, the nurse–patient interaction is a resource for health, quality-of-life, and well-being in nursing homes; by means of ethical and competent nurse–patient interaction, health professionals influence on older adults' well-being, physically, emotionally, socially, functionally, and spiritually.
- Empathic listening, awareness, tenderness, and attentional skills are key assets to positively influence on NH residents' health, quality-of-life, and well-being.
- Nevertheless, empathic listening, awareness, tenderness, and attentional skills also signify a use of power; thus, nurse–patient interaction requires that health care professionals are perceptive of their power and how they use it. The issue is not about if or whether power is being used, but how it is used, which is specified by the "*being in the doing*."

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