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**AUTHOR POST PRINT VERSION**

Plummer, M., & Molzahn, A. E. (2009). Quality of life in contemporary nursing theory: A concept analysis. *Nursing Science Quarterly*, 22(2), 134-140.

### Abstract

A critical appraisal of the concept, quality of life, as used in nursing theories, is presented in a historically situated context. This approach to concept analysis was selected to illuminate the subjective, contextual, and fluid nature of the concept. Based on this review, quality of life is defined as an intangible, subjective perception of one's lived experience. From a review of Peplau's, Rogers', Leininger's, King's, and Parse's conceptualizations of quality of life, it is concluded that it may be viable to replace health with quality of life as a metaparadigm concept for nursing.

## **Quality of Life in Contemporary Nursing Theory: A Concept Analysis**

### **Introduction**

Quality of life is a ubiquitous concept in social science and health literature. After World War II, the phrase “quality of life” appeared in response to rapid technological health care innovations prolonging quantity of life (Haas, 1999; Meeberg, 1993). Use of the concept has grown exponentially over time (Moons, Budts, & De Geest, 2006). By the late 20<sup>th</sup> century, a multitude of concept analyses had been undertaken in an effort to engender some conceptual clarity. A recent CINAHL search of the terms “quality of life” and “concept analysis” yielded citations for 41 articles, half of which were published from 1990 to 1999.

A whole host of definitions of quality of life exist. Described as experiences of life (Meeberg, 1993), satisfaction with life, and well-being (Ferrans, 1996; Haas, 1999; Meeberg, 1993), the definition of quality of life lacks precision and specificity. Consistency is important because “differences in meaning can lead to profound differences in outcomes for research, clinical practice, and allocation of health care resources” (Ferrans, 1996, p. 294).

Nurses have made important contributions to our understanding of this concept. Most commonly, quality of life has been examined in groups of people experiencing a particular illness or health deficit, such as cancer or heart disease (King, 1998). Quality of life concept analyses have focused on existential aspects of the concept. However, these efforts have met with limited success (Ferrans, 1996) due to multiple disciplinary perspectives of quality of life researchers and a lack of consensus on definition and measurement. Further, nurses tend to analyze the concept from a social science perspective, rather than from a nursing perspective. While this may be a practical approach, it doesn’t necessarily promote the development of a unique body of knowledge for the discipline of nursing. The purpose of this inquiry is to enhance conceptual

clarity from a *nursing perspective* by critically examining the concept, quality of life, as it has been used in contemporary nursing theories. To our knowledge, there have been no previous published analyses of the concept in relation to nursing theory. Hence, a critical review of quality of life in nursing theories is presented in historical context.

### **Method**

A concept analysis using critical appraisal of the literature (as described by Morse, 2000) was conducted. A critical approach, in contrast to other types of concept analysis, was selected to reflect the subjective, contextual, and fluid nature of the concept (Morse, 2000). By critically examining quality of life as embedded in nursing theories, new insights and questions are revealed and direction for further development in the discipline of nursing is provided. In this paper, the perspectives of various nurse scholars are compared, contrasted and critically appraised for pragmatic utility in the discipline of nursing.

The focus for this approach to concept analysis is on the usefulness of the concept to nursing science, which can provide direction for future research and/or concept development. Morse (2000) outlines the following principles that were used to guide this analysis: 1) “be clear about the purpose of the inquiry” (p. 337); 2) “ensure validity” (p. 338); 3. “identify significant analytical questions” (p. 330); 4. “synthesize results”; and 5) “establish pragmatic utility” (p. 343).

For this analysis, literature regarding quality of life was used as data. A search of the literature was conducted using the terms “quality of life” and “nursing theory” in CINAHL and Medline databases from 1950 to 2007. The phrase, “quality of life”, was also combined with the names of specific nurse theorists in other searches of the same databases for the same time period. In addition, “quality of life” was used in a search of a subset of nursing journals, and the

abstracts were reviewed for the names of nurse theorists. Theorists were excluded from the analysis if not enough substantive literature was available utilizing the concept (Morse, 2000). Finally, each scholar's original work was reviewed in order to clarify how "quality of life" is embedded in her theory. The search strategy resulted in 26 relevant articles published in English, the majority of which were written by Parse (1981) and Parse scholars. Other theorists who have incorporated quality of life into their theoretical perspectives include Peplau (1952; 1991), Leininger (1978), Rogers (1970), and King (1981).

Once relevant literature was retrieved, the information was analyzed to identify the theorist's assumptions, attributes of the concept, and conceptual gaps or boundaries (Morse, 2000). Each theorist's perspective of "quality of life" was considered in historical context in order to clarify the evolution of the concept within the discipline. The following analytical questions were asked in relation to each theorist's view of quality of life:

1. How is the concept used by the theorist?
2. How significant is the concept in the nursing theory?
3. Is the conceptualization of QOL consistent with the author's assumptions and theory?
4. What are the attributes of the concept?
5. What are the conceptual gaps, if any?

Then, each perspective was compared to the others in order to identify commonalities, similar themes, and differences. A matrix was constructed as an analytical tool (Morse, 2000) to facilitate this task (see Table 1). Finally, the results were synthesized.

## **Findings**

*Peplau's Interpersonal Perspective (1952; reprinted in 1991)*

Hildegard Peplau is heralded as one of the first nurse scholars to develop a theoretical perspective for nursing. Her career was forged and her theory developed at a time when a biomedical model of health prevailed and nursing was regarded as a series of functional roles. However, Peplau was progressive and visionary; she considered nursing to be a healing art (Peplau, 1991; Peplau, 1994).

According to Peplau (1991), nursing involves the therapeutic interaction between two or more individuals motivated to come together by the pursuit of a common goal, the product of which is mutual growth. The common goal provides the incentive for the therapeutic relationship between the nurse and patient. Goal attainment is achieved through a series of sequential phases: orientation phase, working phase, and termination phase. In the orientation phase, the nurse and patient come together with different backgrounds, knowledge, and life experiences which influence their different perceptions. During the working phase, the nurse observes, interprets, and decides on a course of action by employing different skills and assuming different roles, such as counselor, teacher, or resource. Over time, this sequence repeats itself and the relationship evolves and matures until it leads to termination phase. Peplau's theory resonates with contemporary theories that describe nursing as relational practice, and her ideas continue to contribute to research and practice, particularly in present-day mental health nursing.

Quality of life is embedded in Peplau's nursing theory as an intangible, all-encompassing phenomenon; it is the subjective perception of the condition of a person's life (Peplau, 1994). Quality of life "is synonymous with well-being or psychological wellness" (Peplau, 1994, p. 10) and it is often associated with health. While relationship is central to Peplau's theory, quality of life is a by-product of the relationship and it is significant to her theory.

Peplau contends that quality of life is primarily a subjective perception (Peplau, 1994). It varies with changing circumstances; it is time and situation-dependent. However, it has an

intangible quality. She states, “quality of life is not a static state, nor is it a firm goal, but rather it is more like a moving target – about the condition of a person’s life varying with changing circumstances” (Peplau, 1994, p. 10). Consistent with the assumptions underpinning Peplau’s theory, quality of life is primarily influenced by health, personal relationships and context (Peplau, 1994). Her detailed description of the attributes of the concept facilitates practical application in nursing.

*Rogers’ Science of Unitary Human Beings (1970).*

Two decades after Peplau postulated about the nature of nursing knowledge, Martha Rogers proposed her own conceptual framework for nursing. She was highly influenced by systems theory and an early liberal arts grounding (Rogers, 1970). According to Wright (2007), Rogers was one of the first nurse scholars to consider “people” to be the central phenomenon of interest to nurses.

According to Rogers’ theory, human beings and their environments are unified wholes, or open systems continuously exchanging energy with one another (Rogers, 1970). Indeed, this holistic view of human beings may be the aspect of Roger’s conceptual framework that resonates most for nurses in practice. Health and illness are not clearly defined concepts but are considered to be value-laden words used to express the evolving processes of life. Rogers defines environment as a continually changing, pandimensional energy field (Rogers, 1992). Nursing is considered to be the application of healing modalities to promote human interaction with the environment and the realization of potential (Wright, 2007).

Rogers originally formulated five assumptions to describe the relationship between human beings and their environment (Rogers, 1970). More recently, the original building blocks of Rogers’ conceptual framework evolved into four critical elements (energy fields, open

systems, patterns, and pandimensionality) to describe what can be characterized as a reciprocal relationship between human beings and their environment (Rogers, 1990).

Implicit in Rogers' theory is the notion of life satisfaction, a valuation of the life process (Rogers, 1990). Life satisfaction, or quality of life, fluctuates with the concerted interaction between the individual and the environment (Rogers, 1994). Quality of life is relative to one's circumstances. It is also boundless as it varies along the individual's entire life course (Rogers, 1990).

Rogers believes that life evolves along a space-time continuum (Rogers, 1990). Causal relationships or outcomes are not the primary focus of her theory. Hence, life satisfaction or quality of life is of secondary import and, conceptually, quality of life is not well developed in Rogers' original theory. For example, there is limited discussion as to how life satisfaction evolves over the life course, leaving an important conceptual gap (Ferrans, 1996). However, others have extended her work. For instance, Caroselli and Barrett (1998) contend that life satisfaction is influenced by an individual's perceived sense of power. Further investigation of factors that influence life satisfaction would also help to fill conceptual gaps and promote pragmatic utility of the concept.

#### *King's Systems Framework (1971; 1981).*

Imogene King's conceptual framework for nursing also emerged in the 1970's when general systems theory was pervasive. Over the succeeding decade, her conceptual framework evolved into a formal system for nursing.

Like Rogers, King believes that human beings are open systems in constant interaction with their environment (King, 1981). King represents this as three nested systems: the personal system (individuals), the interpersonal system (groups), and the social system (society) (King,

1981). A specific set of interrelated concepts correspond to each system and influence the transactions between humans and their environment (King, 1981). For example, nurses perceive patients in a given situation by collecting data through their senses. They transact with each other and their environment to attain their goals. Nurses help individuals maintain or regain health, and health is considered the product or outcome of an individual's ability to fulfill social roles. Goal setting is the vehicle through which system transactions take place (King, 1981).

According to King (1981, 1994), quality of life is equivalent to life satisfaction. It is influenced by one's ability to set and attain goals and perceive a sense of accomplishment (King, 1994). Life satisfaction is also influenced by communication, interaction, and transaction between individuals (King, 1994). It is timeless and not culture bound (King, 1994). Quality of life may also be considered a force that motivates an individual's performance (King, 1994). In this way, it serves as a source of energy and a derivative of energy.

It would seem then, that this concept would play a fairly significant role in King's theory. However, quality of life is not conceptually mature in King's theory, only coming to light in recent work (King, 1994). It seems to be embedded in the notion of well being and life satisfaction, without explicit description or significant form, limiting its pragmatic utility.

### *Leininger's Transcultural Nursing Theory (1978)*

Madeline Leininger's transcultural theory of caring evolved during a time of competing ideological views of health; nurse scholars began to emphasize the healing properties of relationship while health services remained entrenched in a biomedical system (Leininger, 1978). Community-centered nursing care gained prominence, and an impending curriculum revolution foreshadowed a shift in nursing education.

Leininger's work is clearly influenced by her background in anthropology. She believes that "culture is the blueprint for man's way of living, and only by understanding culture can we hope to gain the fullest understanding of man as a social and cultural being" (Leininger, 1970, p. vii). Towards that end, she based her theory on the notion of "culture care": the learned values, beliefs, and patterned lifeways that assist, facilitate, or enable another individual or group to maintain well-being (Leininger, 1978; Leininger, 1994). She assumes that health is a state of well-being that is culturally defined and reflects individuals' abilities to fulfill their culturally ascribed social roles (Leininger, 1978). Health, illness, and caring are labels communicating culturally defined values and meaning. Nursing is the provision of culturally defined care, and the heart of nursing is the therapeutic nurse-patient relationship.

Consistent with the assumptions underpinning Leininger's theory, quality of life is a culturally constructed, abstract phenomenon (Leininger, 1994). It represents the values, beliefs, symbols, and patterned expressions of a particular culture (Leininger, 1978; Leininger, 1994). Leininger (1994) describes quality of life as a powerful force "to guide, maintain, and promote the health and well being of particular cultures" (p. 23). Quality of life is a stimulus rather than an outcome or by-product. In order to understand the significance of this stimulus, one needs to expand his/her scope of knowledge about the beliefs, values, and social patterns of specific groups of people.

Leininger (1994) provides examples from five different cultural groups to illustrate how quality of life is culturally constituted. However, the impact of individual lived experience on the subjective perception of quality of life remains to be explored in the discussion. Indeed, Leininger runs the risk of cultural essentialism by assuming within group sameness. For example, she describes a scenario of hundreds of Hindu people bathing at the banks of the Ganges River in one of her quality of life exemplars (Leininger, 1994). She states, "for these Hindu people,

quality of life is largely derived from their religious beliefs, values, and practices over many generations” (Leininger, 1994, p. 24). A sweeping generalization is made about the nature of a subjectively perceived phenomenon for hundreds of people. In addition, there is limited attention to the social, political, and historical forces that shape an individual’s culture and perception of quality of life in Leininger’s theory. For instance, in the Indian example, there is no discussion about the social status of Hindu people in India and the potential impact on perceived quality of life. These conceptual gaps limit the pragmatic utility of the concept.

#### *Parse’s Humanbecoming Theory (1981; 2007)*

Rosemarie Rizzo Parse’s theory emerged amid a global move towards individualism, health service reduction, and economic recession (Parse, 1981). Within a human science approach, Parse extended the work of Martha Rogers drawing from the tenets of existential philosophers, primarily Heidegger, Sartre, and Merleau-Ponty (Parse, 1981).

Parse, in the Humanbecoming Theory, asserts that human beings are considered individual wholes who are situated in-the-world and who act with intent and free will (Parse, 1981; 2007). The theory was originally guided by three principles incorporating the central ideas of cocreating meaning, rhythmicity, and transcendence (Parse, 1995). Recently, and within the context of rapidly changing technological developments and cost efficiencies in health care, Parse has further emphasized the idea of indivisible cocreation by joining the words “human” and “becoming” (Parse, 2007). The wording of the three principles has changed slightly for clarification, but the meanings remain unchanged; the three principles are: structuring meaning is the imaging and valuing of language; configuring rhythmical patterns of relating, and cotranscending with possibles (Parse, 2007). Underlying the three principles are the postulates of

illimitability (limitless knowing extending to infinity), paradox (lived rhythms), freedom (contextually construed liberation), and mystery (the unexplainable) (Parse, 2007).

Within the nurse-person process, nurses live true presence as people make choices according to personal preferences and values and beliefs. Parse (1995) discusses true presence as “a special way of being with another that recognizes the other’s value priorities as paramount (p. 82). When true presence is lived, the nurse bears witness to the individual’s rhythmical ebb and flow of life, and quality of life is the overarching goal of nursing (Parse, 1994; Parse, 1996).

According to Parse (1994), quality of life is “ the indivisible human’s view on living moment to moment as the changing patterns of shifting perspectives weave the fabric of life through the human-universe interconnectedness” (p. 17). Quality of life is explicit in Parse’s theory: it is a subjective, global perception of the meaning of one’s lived experiences in the moment. It fluctuates moment to moment in co-creation with the universe (Parse, 1994). Parse uses words like “shifting”, “changing”, and “in-the-moment” in reference to quality of life (Parse, 1994). The personal nuances of the nurse-person process enhance quality of life (Parse, 1994).

The concept has been well developed by Parse and Parse scholars. For example, Pilkington and Mitchell (2004) investigated the quality of life of women living with gynecological cancer. Two predominant themes related to quality of life emerged: treasuring loving expressions, and expanding fortitude for enduring. Hee (2004) sought to understand quality of life in people living with mental illness. Quality of life was expressed in three themes: dwelling with regret while surfacing new possibilities; staying with and moving on with fear and confidence; and changing while staying the same.

Through extensive research, Parse and colleagues have explicitly described quality of life in its various subjective forms. A multitude of exemplars have been provided by Parse scholars to inform our understanding of quality of life as it is constituted in different contexts. Understanding

promotes nurses' ability to be with people in ways that honor their lived experiences. Parse's contribution to quality of life has pragmatic utility for the discipline because it articulates the goal of nursing practice.

### **Discussion**

A thorough review of the literature revealed that five nurse theorists actively consider the concept of quality of life in, or as an adjunct to, their nursing theories. The work of other nurse theorists, such as Husted and Benner, who briefly address quality of life, was not examined for this paper due to a lack of substantive information on the concept.

Despite the different paradigms and philosophical underpinnings, all of the theorists addressed in this review have similar understandings of quality of life. This understanding is consistent with the way the concept has been used in the social sciences since the 1980s (Meeberg, 1993). Broadly speaking, in the social science literature, quality of life is described in terms of achieving personal goals (Ferrans, 1996; Moons et al., 2006). King and Leininger also perceive quality of life to be a motivating force.

Rogers and King specifically refer to quality of life as life satisfaction. Several quality of life researchers concur with this perspective (Haas, 1999; Ferrans, 1996; Moons et al., 2006). For example, Moons et al. (2006) state, "satisfaction with life is the most suitable approach for defining quality of life" (p. 899). Others consider life satisfaction to be a similar but related concept (King, 1998). Meeberg (1993) clearly distinguishes between quality of life and life satisfaction, and it remains debatable, in the literature, whether life satisfaction is a synonym for quality of life.

Historically, one of the most contested points in the quality of life literature is whether quality of life is a subjective assessment, or both a subjective *and* objective evaluation. Typically

nurse researchers suggest that quality of life is subjective in nature. For example, Meeberg (1993) states, “subjective indicators directly address life experiences whereas objective ones only address things that influence those experiences” (p. 34). On the other hand, there are a number of instruments available to measure objective proxies of quality of life (e.g., functional status, health status) in the context of disease, disability, or loss (Haas, 1999; Moons et al, 2006). However, objective measures often reflect subjective assessments or indicators of physical conditions. Although used as proxies, they are separate and distinct from quality of life. In relation to nursing theory, Leininger contends that quality of life is based on a person’s values, beliefs, and patterned expressions. Parse refers to it as an individual’s personal rhythm. All of the nursing theories reviewed for this paper describe quality of life as subjective.

Quality of life has been described from a social science perspective as “dynamic” (Haas, 1999) and “ever-changing” (Moons et al., 2006). Similarly, many of the nurse-theorists found quality of life to be an intangible concept. For example, Rogers refers to it as “relative and infinite”. Leininger calls quality of life “abstract”, and Peplau describes it as “a moving target”. In contrast, other nurse and health science researchers have described the concept as multidimensional with interrelated domains, such as health, functioning, psychological well-being, spirituality, and family functioning (Ferrans, 1996; Haas, 1999). Consensus regarding a universal set of domains has yet to be achieved. In the nursing theory literature reviewed, quality of life was also found to be related to one’s perceived health and the provision of nursing care. For example, Parse explicitly states that quality of life is the goal of nursing. Biomedical and health science researchers use the term “health-related” quality of life to refer to functional status (i.e., an individual’s ability to perform daily activities) and overall perceptions of life in light of their potential or actual health deficits.

There is a lack of clarity regarding the differences between health and quality of life and the relationships between the two concepts, both in social science and in nursing theory literature. While strong correlations have been found between the two concepts in empirical studies, they are generally considered to be conceptually distinct and it has been found that health influences quality of life (e.g., Low & Molzahn, 2007). In nursing theory, some of the theorists acknowledge a relationship between the concepts (e.g., Peplau, King). Rogers and Leininger are less clear about the differences between health and quality of life, while Parse is clear that the goal of nursing is quality of life; she does not separate the concepts health and quality of life.

The nurse theorists reviewed in this paper consider quality of life to be contextual. Context, or the environment, is connected to quality of life in various ways. For instance, Parse characterizes quality of life as lived experience, and Peplau (1994) describes it as “time-related and situation-dependent” (p. 10). Rogers (1990) noted that quality of life fluctuates with the concerted interaction between the individual and the environment. Considerable research also supports the relationship between a healthy physical environment and quality of life. For instance, Paschoal (2005) found that good living conditions (water supply, discharging system, security, comfort) and a pollution-free physical environment were important contributors to perceptions of quality of life in Brazil. External and environmental factors, including preoccupation with noise, pollution and congestion on living community and protection against crime are generally considered to be important.

In the nursing theory literature, it is hypothesized that personal relationships have an influence on quality of life. While much of the previous quality of life research has been focused in mental health, long-term care, and palliative care settings, discussion about a relational aspect to quality of life is emerging in the literature. For example, Scott, Setter-Kline, and Britton (2004) found that engaging in mutual goal setting between nurses and clients resulted in

significantly improved quality of life. Erci, Sayan, Tortumluoglu, Kilic, Sahin, and Gungormus (2003) used Watson's caring model to guide their inquiry into the impact of caring relationships on quality of life for people with hypertension. Nurse researchers have begun to investigate the influence of relational connections on quality of life from a nursing perspective. More work in this area is needed to further develop the knowledge base for nursing.

With the breadth of the concept, quality of life, and the many purported definitions, it is often difficult for researchers to separate what is part of quality of life from the causes or predictors of quality of life. The dimensions of quality of life in one study are considered to be factors influencing quality of life in another. The conceptualization, measurement, and study of the concept quickly become tautological. While it may be evident to many nurses that health, environment, and relationships with others (including the nurse) are related to quality of life, one can argue that they are not easily separated.

In contrast to the overall lack of consensus in quality of life research, Peplau, Rogers, King, Leininger and Parse were remarkably consistent in their definitions of quality of life and in the identification of concept attributes (see Table 1.0). Based on this synthesis, the authors of this paper provisionally propose a definition of quality of life as *an intangible, subjective perception of one's lived experience*. A unitary perspective of people underpins this definition, which is appropriate for contemporary nursing in that it embraces a perspective in which aspects of quality of life are intertwined and not divisible into discrete parts. This definition is strongly influenced by Parse's Theory of Humanbecoming because it is the only nursing theory in which "quality of life" as a concept is developed to the extent that it affords pragmatic utility in nursing.

It is advanced here, that the concept, quality of life may be a more useful and inclusive metaparadigm concept than health. Although formal definitions of health are often broad and all-encompassing, many lay people understand health primarily in terms of physical status. While

health professionals understand health to include physical, psychological and social well-being, it is rare that spiritual and environmental aspects of human experience are considered. This particulate view of health fragments the human experience, which limits its utility within a holistic perspective. Nursing practice involves caring for the whole person and their environment rather than selected parts. Use of a broad indivisible and unifying metaparadigm concept such as quality of life could refocus nursing practice on a wider range of life experiences of individuals and groups. Given the breadth of nursing practice and the value of the concept, quality of life for nursing, as well as the synonymous relationship between quality of life and health, the view that quality of life could be considered a metaparadigm concept is offered for consideration. Further theory development using this concept could enhance knowledge development across paradigms.

### **Conclusion**

The findings from this critical appraisal of the nursing theory literature have been synthesized in order to define and clarify the concept of quality of life for the discipline of nursing. A definition was derived from the attributes identified in the data to guide future work in this area. A clear definition of quality of life is important to nursing knowledge development because it guides the art of practice. Defining quality of life from a holistic perspective is also important to nursing because it reflects contemporary practice and it helps nurses to understand the inherent indivisibility of life and its quality (Phillips, 1995).

Given the breadth of nursing practice, it is appropriate to consider replacing health as a metaparadigm concept with quality of life. While the distinctions between these two concepts are not always clear, exploration of quality of life as an intangible subjective perception of one's lived experience opens possibilities to address a wider range of human conditions or circumstances. This review of nursing theories has contributed to our understanding of the

interconnectedness or associations of the person, relationships and environment with quality of life. More research is needed in this area to help nurses and others involved in health care delivery to develop greater understanding of the nature of quality of life for different people. In particular, Parse's Theory of Humanbecoming is recommended as a theoretical framework because it is conceptually mature and offers an indivisible perspective. Rather than using perspectives from other disciplines, nurses assuming a nursing perspective in quality of life research could contribute further to the development of a unique body of nursing knowledge for the discipline.

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