Dialogue

IMAGE *welcomes letters in response to previously published articles. Letters should be addressed to the Editor, should be typed double-spaced and should not exceed two typed pages. The Sigma Theta Tau International affiliation (if applicable) of the letter writer should be noted. Anonymous letters will not be considered for publication, but names may be withheld upon request. In general, letters in response to articles published more than two issues previously will not be considered. The original authors may be asked to respond to letters.*

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To the Editor:

Vincent and Coler's ["Unified Nursing Diagnostic Model," IMAGE, Summer, 1990] presents an interesting solution to the problem of multiple nursing diagnostic classification systems. Although the solution is appealing, they did not account for the different and potentially incompatible philosophic assumptions underlying the NANDA and ANA systems, which, granted, have never been made explicit. Analysis of the diagnostic labels, however, suggests that the NANDA system is based on an externally driven biomedical perspective with an emphasis on pathology, whereas the ANA system is based on an internally oriented perspective with an emphasis on intrapsychic processes. If the analysis of implicit assumptions is correct, then Vincent and Coler's failure to reconcile differences has resulted in a logical flaw that renders the diagnostic tree pragmatically useful but theoretically problematic.

The urge to integrate diverse perspectives is strong in nursing. But we must resist these urges if we are to have a body of knowledge that is logically sound.

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The Authors respond:

The NANDA and ANA diagnostic systems both address phenomena of concern to nurses. Neither system claims to be (nor is) externally or internally driven, nor is one system more biomedical or intrapsychic than the other.

NANDA's definition for nursing diagnoses addresses ". . .individual, family, or community responses to actual or potential health problems/life processes. . .." In Archives of Psychiatric Nursing, *O'Toole and Loomis of the ANA Task Force defined the phenomena of concern to nurses as human responses to actual or potential health problems.*

They also wrote that the ANA Task Force was originally convened to identify the phenomena of concern to psychiatric/mental health nursing from an atheoretical perspective. NANDA is also atheoretical as is evidenced by Hinshaw's 1988 keynote speech at the biannual NANDA conference, in which she addressed the fact that each clinical specialty has adapted nursing diagnoses to its own framework.

The refinement of a taxonomy or several taxonomies for nursing science is dependent on continued research and analysis. The diagrammatic tree is one such avenue of analysis, based on the evidence that the two taxa have the same underlying assumptions with different outcome.

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References

O'Toole, A. and Loomis, M. (1989). Revision of the Phenomena of Concern for Psychiatric Mental Health Nursing. **Archives of Psychiatric Nursing, 3** (5), pp. 289-299.

North American Nursing Diagnosis Association: Definition of Nursing Diagnosis Approved at the Ninth Conference on Nursing Diagnosis, Orlando, FL., Unpublished.

To the Editor:

Berne et al.'s article ["A nursing model for addressing the health needs of homeless families, IMAGE, Spring 1990] adds a much needed comprehensive approach to a body of literature on homelessness that has historically been atheoretical. There is no question that these authors view societal issues as key factors in homelessness. Both individual and community factors ("environmental") are at the top of their model, being "mediated" by public policy and social support. It is interesting, however that the outcome in this model is an individual one and the health of the community is not addressed in the adaptive responses. Outcomes in this model need to reflect the "true primary prevention" these authors call of at the end of their article. To change this model to a community health model, public policy and social support need to be described as *moderating* factors (versus mediating) as defined by Baron and Kenny (1986), as their role is much stronger than mediating.

If homelessness is conceptualized from an individual model, it is the victim's problem and the social system/community does not have to deal with the structural problems that need to be addressed. When it is conceptualized from a community health perspective, the societal/community factors cannot be ignored and will influence interventions and research in the area of homelessness in a new way.

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Reference

Baron, R.M. & Kenny, D.A. (1986). The moderator-mediator variable distinction in social psychological research: Conceptual, strategic and statistical considerations. **Journal of Personality and Social Psychology, 51,** 1173-1182.

The Authors respond:

Pesznecker's model provides a sound starting point for understanding the complex and interactional nature of poverty, and thus family homelessness even though we identified several of the arrows in the model convey a linear process, when it should be portrayed as more interactional with more indications of feedback loops.

Ms. Pohl's point regarding meditating versus moderating factors as defined by Baron and Kenny is interesting from a conceptual standpoint. Our reading of this differentiation suggests public policy and social support could indeed be labeled as moderating factors, although some arguments could be advanced for conceptualizing them as a mediating variables. We do not believe that it is this differentiation which determines whether the model is an individual or community one.

We agree the outcomes represented in this model are individual and need to be broadened to reflect community outcomes. For example, one health outcome for a community may be whether it tries to integrate homeless families into the community or works to keep them out (i.e., "NIMBY" - "not in my back yard"). However, we do believe the model includes the concept of community in other ways, whether defined as the aggregate or geographically. The "individual/group factors" can be viewed in the aggregate. The "environmental factors" can describe the extent of stress and stigmas in communities. The "moderating" (or mediating) factors of public policy and social support are certainly community-level variables, although one could also interpret social support as an individual-level variable.

Perhaps most importantly, Ms. Pohl raises the issue of who is to blame for poverty and homelessness and whether this or any nursing model blames the victim versus society. Pesznecker's model does not attempt to explain poverty per se, but rather how individuals/groups adapt to poverty. As Ms. Pohl notes, models that portray poverty as an outcome solely of individual behavior promote public policies that blame the victim and perpetuate unequal systems and structures. Mason (1981) has critiqued theoretical