Social Scripts: A Concept Analysis

by

Donna Lynn Ward

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by

Donna Lynn Ward

Supervisory Committee

Dr. Bernie Pauly
University of Victoria, School of Nursing
Associate Professor, Co-Supervisor

Dr. Lenora Marcellus
University of Victoria, School of Nursing
Assistant Professor, Co-Supervisor

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Abstract

BACKGROUND. Women experiencing poverty, homelessness, and using drugs cannot achieve the same health outcomes and access to health care as women in the mainstream population. Personal agency is enacted in a set of structural constraints including social norms. Decisions made in relation to sexual behaviour and sexual health are constrained or enabled by structure, and individual agency is exercised in connection with social rules or codes that implicitly or explicitly dictate appropriateness and preferences. Social scripts are learned directives for personal actions and values which then play out in the personal and social lives of those who have learned the script. Social script theory may provide an alternative lens through which to look at women's health and in particular, sexual health, in the population of women who are experiencing poverty and/or homelessness, and using drugs.

AIM. The aim in this paper is to define and describe the concept of social scripts as they pertain to sexuality, sexual health, and accessing health care. I will explicate the attributes and characteristics of social scripts and discuss the viability of the concept as a dimension to improve health equity and appropriate health care access for the population of women experiencing poverty, homelessness, and drug use.

SIGNIFICANCE. Gain clarity and understanding of the concept of social scripts by examining attributes and characteristics using the method of concept analysis. The results of the concept analysis could enhance our understanding of the concept and could potentially lend theoretical and practical applications for providing improved nursing care.

METHOD. Using the concept analysis method described by Walker and Avant (1995), a framework of defining attributes, identifying antecedents, consequences, model cases, and empirical referents, the concept of social scripts will be explored.

CONCLUSION. Social scripts may provide a depth of understanding in relation to the personal beliefs and behaviours of women who have been marginalized and may provide insight when working with women in an individually focused manner. Scripting theory may not however provide an appropriate way of approaching care with vulnerable populations within the context of health inequities and the production and reproduction of health inequities. Cultural safety is offered as one possible solution as a more relevant and appropriate way of informing care for a marginalized and vulnerable populations.

Key Words: Concept analysis, social scripts, theory development, health inequities, health care access, women, personal agency, vulnerable populations

Social Scripts: A Concept Analysis

Women who are disadvantaged by poverty, homelessness and drug use experience poorer health, including sexual health, than the general population. These women often experience a disproportionate burden of acute and chronic health issues. The term *drug use* will be used throughout this project as it encompasses the use of illicit drugs—both illegal drug use and the use of legal drugs in unintended ways (i.e. prescription drug misuse). *Drug use* as defined by the World Health Organization refers to "...psychoactive drugs, and often, even more specifically, to illicit drugs, of which there is non-medical use in addition to any medical use..." (World Health Organization, 2013).

In a study conducted in Vancouver, British Columbia, researchers found that deaths among women who engaged in injection drug use had mortality rates that were nearly 50 times that of the general female population in British Columbia (Spittal, Hogg, Li, Craib, Recsky, Johnston, Montaner, Schechter, & Wood, 2006). Specifically, these researchers found that unstable housing and HIV infection caused a large proportion of deaths within their study cohort, with other significant causes being overdose and homicide. In an earlier study of women in Toronto, it was found that mortality rates among women who were homeless to be significantly higher than women in the general population; with women under the age of 45 years having the highest excess mortality, and the mean age at death being 39 years (Cheung & Hwang, 2004). Cheung and Hwang (2004) found the most common cause of death for women between the age of 18 and 44 and similarly disadvantaged was HIV/AIDS infection and drug overdose. Thus, studies have demonstrated that HIV/AIDs related illness continues to be a significant factor in the death rates of women who are disadvantaged by poverty, homelessness and drug use.

Common risk factors for HIV and STI infection within the homeless female population in Canada include inconsistent condom use, multiple sexual partners, and sex work (Hwang, 2001; Marshall, Kerr, Shoveller, Patterson, Buxton, and Wood, 2009). A large percentage (82%) of the women in Spittal et al.'s 2006 study were involved in sex trade—which was defined as "trading sex for money, drugs, shelter, or anything else in exchange" (p. 106). These vulnerable women are more likely to become ill or die; and are less likely to receive appropriate and timely care than other Canadians who are not similarly socially located (Khandor, Mason, Chambers, Rossiter, Cowan, & Hwang, 2011; Hwang, Ueng, Chiu, Kiss, Tolomiczenko, Cowan, Levinson, & Redelmeier, 2010; Pauly, MacKinnon, & Varcoe, 2009). For example, Spittal et al. (2006) point out that significant health care barriers remain for disadvantaged women with some British Columbia women dying without ever accessing free HIV treatment and care. Women disadvantaged by poverty, homelessness, drug use continue to face significant barriers to accessing primary care and continue to suffer from poor health.

Conceptual Framework

Social script theory, a sociologically-based theory, is thought to provide explanation for individual behaviours and beliefs (Wiederman, 2005). Wiederman argues that social scripts are learned through being raised in a particular culture and/or through a significant attachment to a particular cultural group (Wiederman, 2005). Social scripts are learned directives for personal actions and values which then play out in the personal and social lives of those who have learned the script. Social script theory may provide an alternative lens through which to look at women's health and in particular, sexual health, in the population of women who are experiencing poverty and use drugs.

Social script theory, which has also been labelled as scripting theory and sexual script theory (Wiederman, 2005)) has been widely used in contemporary research, and especially contemporary feminist research on sexuality (Frith & Kitzinger, 2001). This theory has been used to study gendered sexual behaviour, covering varied topics pertaining to sexuality, including both sexes behaviour in relation to dating, behaviours leading to intercourse, sexual harassment and various forms of rape (Frith & Kitzinger, 2001; Wiederman, 2005). The central idea behind social script theory is the belief that sexuality is learned from the culture in which we live or were raised in (Frith and Kitzinger, 2001). Script theory is appealing to many researchers as there is a departure from the notion that sexuality need be explained as biological drives, evolutionary explanations, or individualistic approaches, offering instead a much more social view to sexuality (Frith & Kitzinger, 2001). It is for this reason that I have chosen to explore the concept of social scripting in relation to providing care for this population of women. Social scripts may provide another layer of understanding for nurses and other health care professionals who provide care and services for the population of women who are experiencing poverty and drug use.

Social script theory does not appear to be used in nursing or medicine as it was difficult to find examples of such in terms of application in either discipline. By completing a concept analysis as described by Walker and Avant (1995), greater clarity and understanding of social scripts will be developed for consideration and potential application within a health care context. Moreover, social scripts will be examined and analysed as a concept and considered for application to nursing for the purpose of potential theory and clinical development. The results of this analysis could enhance our understanding of the concept and could potentially lend

theoretical and practical applications for providing nursing practice that is more insightful, as well as areas for further theoretical development.

Purpose

The purpose of this project is to undertake a concept analysis of social scripts. I will examine the viability of the concept social scripts for the purpose of improving health care access and equity in health status for women experiencing social disadvantages including poverty, homelessness, and harms of drug use. With the aim of adding to what is already known with respect to providing the most appropriate nursing care for this population of women, I will borrow the concept of social scripts from the science of sociology, to analyze and contextualize within this area of nursing care.

Significance

By completing this project, it is hoped that further definition and description of the concept of social scripts is gained and secondly, to examine how they may pertain to sexuality, sexual health, and accessing sexual health care. By examining the attributes and characteristics of social scripts, the viability of this concept as a dimension to improve equity of health and appropriate health care access for the population of women can be explored. The results of the analysis could enhance our understanding of the concept, and could potentially lend theoretical and practical applications for providing better nursing care in general and specifically, for marginalized and vulnerable populations. An exploration of social scripts as a director or modifier of behaviour and decision-making may provide nurses with greater insight and understanding in regards to assisting women who experience poverty, homelessness, and drug use to achieve a greater level of sexual health and health care. A concept analysis of social

scripts may provide the foundation for utilizing this theory to create a deeper understanding of how to provide the best manner and structure of care for this population of women.

Background

Shaping Inequities in Health and Health Care Access

For women who are experiencing social disadvantages such as homelessness, risk of homelessness, poverty, and who use drugs, inequities in health cannot be attributed solely to lifestyle or behavioural choices. Inequities in health are created by unfair and unjust, socially produced practices that in turn create a systemic pattern of differences in health status between different socioeconomic populations (Whitehead & Dahlgren, 2006). Ubiquitous differences in health status found within this disadvantaged segment of the population are produced by social processes as opposed to a biological determination; and these social processes are considered to be unfair and unjust. The factors that shape access to healthcare services, influence health status, and create health inequities can be attributed to the unjust actions and policies embedded within a population's political, historical, economic, and social conditions (Marmot, 2007; Pauly et al., 2009). For example, Spittal et al. (2006) reports a large percentage (82%) of the women in their study (female injection drug users; aged 24 – 39) reported involvement in street level sex trade work. Women involved in street level sex trade work are forced to work in remote, unlit areas which put them at increased risk of violence. The current laws in Canada make sex trade work illegal and as such, women are forced to work in hidden, remote environments. Furthermore, street level sex trade workers have reported decreased access to necessary services at night (Spittal et al., 2006). These factors are presented as an example of the unjust actions and policies imposed upon women who are disadvantaged by poverty, homelessness and drug use. In the Spittal et al. (2006) study, it was found that these

unjust actions and policies contributed to health inequities among a large proportion of this population. These women were more likely to be HIV-positive than the general female population in British Columbia (BC) and carried a death rate 50 times higher than that found in the general female population in BC.

Absolute homelessness or relative homelessness commonly creates a situation wherein women are more susceptible to a wide range of health problems, including sexual health concerns, and an increased risk of premature death (Frankish, Hwang, & Quantz, 2005; Hwang, 2001; Khandor et al., 2011; Pauly et al., 2009). Health inequities are the result of socially constructed systems that prevent marginalized populations from accessing appropriate and available housing (Marshall et al., 2009; Spittal et al., 2006). Marshall et al. (2009) reported a direct correlation between precarious housing and increased rates of HIV and STI among street involved youth. Specifically, Marshall et al. (2009) found that shelter living was positively associated with an increased number of sexual partners and absolute homelessness correlated directly with elevated rates of unprotected sexual activity. It was thus proposed that "precarious housing environments may act synergistically to increase sexual HIV and STI transmission among street-involved populations (Marshall et al., 2009, p. 788).

Racial, gender and class barriers embedded within the social, political and health services systems can prevent marginalized women from using available services (Egan and Gardner, 2005). Marmot (2007) argues that all societies form castes according to race, ethnicity, gender, education, occupation, income and class. It is the unequal distribution of resources (monetary and power) amongst the castes that creates health inequities. Equitable health care access refers not only to the availability of health care services, but also availability of *appropriate* health care services (Marmot, 2007; McGibbon, Etowa, & McPherson, 2008).

Violence and Sexual Health

Rew et al. (2002) offer an additional element in relation to the associated risks which can lead to STIs and HIV within the population of homeless and impoverished women. These researchers suggest that within this population of women, risk of acquiring STIs and/or HIV is highly correlative to a history of physical and sexual abuse, early initiation of sexual intercourse, and a lack of a social support system, in addition to the use of alcohol and illegal drugs. Women who are homeless or street involved are at significant risk for sexual exploitation, harassment and sexual violence. Sexual exploitation and sexual violence can significantly increase the difficulties this population of women faces in protecting their sexual health (Huey and Berndt, 2008; Wenzel, Koegel, & Gelberg, 2000; Wenzel, Leake, & Gelberg, 2000).

Holland, Ramazonoglu, Sharpe, and Thomson (1992) explain that when young women begin to negotiate their sexuality and manage sexual relationships, "many have little emotional or practical information which they can use to define the boundaries of their own pleasure or their own safety" (p. 647). Further, these authors explain that when personal experience or knowledge in relation to sexuality and sexual safety is absent or lacking, women will draw on the information from their own childhood experiences, their parents and siblings, their peers, and mass media. When young women, or women forced to adapt to new situations (i.e. poverty, drug use, homelessness) are not able to explore and practice their sexual identities in conditions where they are safe, their sexual health and safety is at risk. Reid et al. (2005) found that within this population of women, violence was an integral part of both their family history, as well as their current reality. In her qualitative study, the participants confirmed that "violence was, and continues to be, a central context of their lives with multiple effects on their health and well-being" (Reid et al., 2005, p. 249).

A study conducted in Vancouver, B.C. explored the experiences of 50 women who self identified as experiencing poverty and use drugs. These women reported that sexual abuse and violence was a significant factor in their lives, and had direct impact on their physical, sexual, and mental health. Approximately 80% of the women in the study reported experiencing violence and trauma in the form of childhood sexual abuse, assault by a peer, abuse from a relationship partner, and/or rape (VANDU Women CARE Team, 2009). A further study conducted by Shannon, Kerr, Strathdee, Shoveller, Montaner, and Tyndall (2009) documented evidence that gender based violence was wide-spread and common among their participants. There was an alarmingly high prevalence of rape experienced by the women sex workers over the two year period of the study. This act of violence in connection with sexual penetration is noted with particular concern in relation to sexual health, as there is an increased likelihood of acquiring sexually transmitted infections and/or HIV owing to the high likelihood of vaginal and/or rectal tissue trauma. The combination of homelessness, poverty, drug use, and violence that contextualizes the lives of many women creates a situation wherein the women are at greater risk than women in the mainstream population of STI's and HIV, as well as unwanted pregnancy (Ensign, 2000; Hwang, 2001; Rew et al., 2002; Shannon et al., 2009).

Decision Making and Personal Agency

Decision making in accessing care. Social structures refer to the existing social factors found within a culture; the circumstances that one is born into; and, the circumstances that one is dealt throughout their lives. Personal agency is the basis of decision making, and is exercised in the life choices that people make within the life chances available to them (Cockerham, 2005). "Choices and chances operate in tandem to determine a distinctive lifestyle for individuals,

groups, and classes. Life chances (structure) either constrain or enable choices (agency)…" (Cockerham, 2005, p. 61).

Structural determinants impact sexual health decision making—providing a contextual basis from which individual behaviours and actions arise. Many women who are disadvantaged by poverty, homelessness and substance use experience challenges related to available services, personal confrontations ranging from disrespect to blatant expressions and acts of hostility from health care personnel, and a lack of resources required to access care or to follow through on treatment (Gelberg, Browner, Lejano, & Arangua, 2004; Hwang et al., 2010; Palepu & Tyndall, 2005; Pauly et al., 2009; Reid, Berman, & Forchuk, 2005).

Oppressive social conditions, such as classism, racism, and sexism create significant difficulties for women attempting to access healthcare; and similarly, these social factors also produce health inequities (Pauly et al., 2009). Women may feel discomfited by their social location or their health issues and may delay or avoid seeking preventative or restorative health care for fear of marginalizing discourses of blame, and lack of system capacity (Christiani, Hudson, Nyamathi, Mutere, & Sweat, 2008; McCall & Pauly, 2012; Palepu & Tyndall, 2005; Pauly et al., 2009). Women who are experiencing poverty and some form of homelessness, and who engage in drug use face pervasive forms of social stigma (Beiser & Stewart, 2005; Palepu & Tyndall, 2005). Social stigma exists when there is a social selection of human difference and that difference is then labelled. The label is linked to a 'stereotype' that conveys an identity that is considered to be of lesser social value (Link & Phelan, 2001). Stigma is present "when elements of labeling, stereotyping, separation, status loss, and discrimination co-occur in a power situation..." (Link & Phelan, 2001, p. 367). The women within this population are subjected to social stigma that is multilayered by nature of their

class, drug use, gender, and potentially their race or ethnicity, possible existence of a stigmatizing disease process, as well as many other characteristics (i.e. physical, mental, or social). Christiani et al. (2008) found that:

> the most profound and debilitating barriers were ... related to personal issues involving fears of being discriminated against, misunderstood, treated with disrespect, lectured by healthcare providers, or otherwise dehumanized and the pervasive sense of being overwhelmed and lost in the complexity of the healthcare system without a "home" or mentor to assist them in accessing needed services. (p. 158)

Social factors that contribute to decreased access to health care, contribute to conditions wherein women are more at risk than women in the mainstream population of STI's and HIV, as well as unplanned pregnancy (Ensign, 2000; Hwang, 2001; Rew, Fouladi, & Yockey, 2002).

Decision making in personal relationships. All women who are participants of a sexual pairing or activity must manoeuvre the personal social dynamics involved between herself and her sex partner(s). Male condoms, when used correctly and consistently during sexual activity, are an effective method for reducing the transmission of STIs and the incidence of unwanted pregnancies. However, this typically requires women to engage in a complex negotiation of power, from a disadvantaged position. Condom use is typically viewed as negative by male partners and by either insisting on the usage of condoms, or by providing her partner with condoms, she challenges the patriarchal definition of her sexuality in terms of being responsive and permissive (Holland et al., 1992). Secondly, women within this vulnerable population are at a gender-related disadvantage as many feel compelled to survival sex or exchange sex, using sex as a commodity in exchange for basic personal needs such as protection, nutrition, housing, cigarettes, money, and/or drugs (Chettair, Shannon, Wood, Zhang, & Kerr, 2010; Ensign, 2000; Reid et al., 2005; Bungay, Johnson, Varcoe, & Boyd, 2010). Consistent condom use is a choice

that may not be available to many women within this population for reasons which all funnel down to the social structures present and the ability to assert personal agency within the context of the social structures present.

Decision making and ability to assert personal agency in relation to sexuality, and specifically sexual safety, can be difficult and problematic for women who are experiencing homelessness, poverty, and drug use. Cockerham (2005) discusses the limitations imposed on individuals and their ability to exercise agency. He argues that not only are decisions constrained or enabled by structure, but that agency is exercised in connection with social rules or codes that implicitly or explicitly dictate appropriateness and preferences in exercising agency. According to Simon and Gagnon (1986; 2003) these social rules, in conjunction with a woman's personal experience and knowledge, contextualized by her structural environment, create social scripts. Social scripts provide instruction and direction for behaviour within a particular culture or location, and for attaching meaning to certain behaviours within that culture (Wiederman, 2005). However, there has been little examination of social scripts in nursing and health care.

Incorporating Social Scripts into Community Primary Care

Studies demonstrate a need for enhanced access to community based primary health care services that are responsive and respectful; and secondly, the manner in which women's experiences can be improved when accessing primary health care services (Bungay, Kolar, Thindal, Remple, Johnston, & Ogilvie, 2013; Daiski, 2005; VANDU Women CARE Team, 2009). The women in the VANDU (2009) study indicated a preference for a holistic approach to care–where each woman could be honest about herself, her drug use, and her health issues; receiving care in a manner that demonstrated care for the 'whole' person. If social scripts are

culturally learned directives of behaviour and values, then understanding the role of social scripts as part of the 'whole' person could provide further insight to improving health care access and equity in health status for women experiencing social disadvantages including poverty, homelessness, and drug use.

A holistic approach to care is not only preferable to the women, it is also what is needed given the impoverished living conditions, poorer nutrition, and lack of general medical resources that the women are disadvantaged by. The clients who accessed the Health Bus, an innovative outreach program that served the marginalized population in downtown Toronto, were able to receive primary care and health promotion services from nurses and other Health Bus community workers (Daiski, 2005). Clients were able to access supplies, basic healthcare, including sexual health supplies and care, as well as harm reduction supplies and services. Additionally, the clients felt they received care in a manner that was respectful and dignified; the nurses were professional and competent; and access was easy (Daiski, 2005). An understanding of how social scripts play a part in decision making and actions would only enhance the nurses understanding of the women as a 'whole'.

Method

The Beginnings of Nursing Theory Development

In this next section, I will review the common ways of conducting a concept analysis; the strengths and limitations of the methodology; and, the manner in which I will conduct the analysis. Within the nursing profession, nursing theory enables understanding of many aspects of nursing, and as well, nursing theories have encouraged alternative systematic views about a particular phenomenon. Nursing theory contributes to the development of nursing knowledge by providing a framework through which to observe and incorporate new insights in relation to

substantive nursing knowledge (Rogers, 2005). Nursing theory, however, has not always played a major role in the practice of nursing. It was not until the 1960's that nursing theory development became a prominent theme in nursing.

Beginning in the 1960's, nurse leaders believed that through the development of nursing theory, a substantive foundation would be built for the profession of nursing (Rogers, 2005). Developing a distinct nursing knowledge base through theory development (as well as research and practice) was viewed as foundational to changing the role of nursing—from handmaiden to medicine to a health care professional. In many instances, nursing borrowed theories from other natural and behavioural sciences (i.e. psychology, philosophy, and sociology) to assist in building multidimensional nursing theory (Munhall, 2010; Rogers, 2005). In the early 1970s, there was a surge in nursing theory development; and with the proliferation of nursing theory, came the beginnings of an emphasis and need for concept development (Duncan, Cloutier, & Bailey, 2007).

Strengths and Limitations of Concept Analysis

Walker and Avant (1995) argue that a well formulated theory is developed by starting at the 'concept' level of any phenomenon. "The very basis of any theory depends on the identification and explication of the concepts..."(Walker and Avant, 1995, p. 58). Without a clear understanding of the concept first, it is difficult to explain or predict the theory phenomena. According to Walker and Avant (1995), a well formulated theory can potentially provide a phenomenological description, an explanation, a prediction, and/or may have prescriptive potential. Commonly concept analyses are developed using a phenomena of interest to assess its viability for theory development within nursing and other health care disciplines (Risjord, 2009; Cronin, Ryan, & Coughlan, 2010). Therefore, a careful analysis of the concept of social scripts

may provide a well formulated theory, providing direction for nursing care within the population of impoverished, street-entrenched women.

Risjord (2009) cautions the analyst in the gathering and use of the chosen concept for the analysis, as its meaning may vary significantly. Risjord (2009) explains that there may be problems associated with mixing scientific and colloquial sources in gathering usages of the chosen concept; and argues that "[s]cientific concepts are ... more precise than their colloquial counterparts and when similar terms appear in different theories they may have different meanings" (p. 687). Further, Risjord explains that when there is a mixing of scientific, literary, and colloquial sources in the process of defining a concept, "authors dilute their evidence base to the point that it is impossible to justify any selection of attributes" (2009, p. 687). In the course of collecting sources for the purposes of this concept analysis, scientific, and professional sources will be accessed in order to provide clarity and credibility to the attributes derived. Risjord (2009) explains that a concept analysis that "does not carefully attend to a specific context of use is robbed of its power to justify a nuanced analysis" (p. 687).

Duncan et al. (2007) also express concern over the contextual basis of the chosen concept undergoing analysis. These authors feel that the method of concept analysis purported by Walker and Avant (1995) creates a 'fixed' truth in relation to the concept—a truth created through a realist method of analysis. It is believed that while Walker and Avant (1995) "recognize the potential impact of context on concept meanings, their process of analysis is an attempt ... to transcend context, and thereby accommodate the requirement of a product useful for empirical work" (p. 297).

Duncan et al. (2007) argue that to gain an understanding about a concept, it is important to understand the ontological foundation of the methodology chosen to perform the analysis. Further, these authors explain that an understanding of the ontological underpinnings of the method chosen is one consideration in achieving an outcome that is meaningful for knowledge building and theory development. Rodgers (1989) concurs with this statement and argues that without a clear understanding of how the method functions, or the ontological foundation of the method, it may not be entirely clear how the analysis of a concept lends to the building of nursing knowledge.

Caution and criticisms in regards to this method of concept analysis have been put forth by researchers and theorists (those referenced and others). The lack of delineation in regards to the philosophical or ontological underpinnings, and secondly, failure to contextually ground the concept in the process of defining the concepts are two criticisms noted (Rodgers, 1989; Duncan et al., 2007; Risjord, 2009; Walker & Avant, 1995). Walker and Avant (1995) argue that this method of concept analysis is often used as a first step in theory development with meritable results. They explain their approach to theory development, as a process of concept derivation, data synthesis, and analysis, where there is a clarification and refinement of the concept. These authors propose that the results of a concept analysis performed using this method is most useful for:

> refining ambiguous terms in theory, education, research, and practice; providing operational definitions with a clear theoretical base; providing an understanding of the underlying attributes of a concept; facilitating instrument development in research; and providing assistance in the development of nursing language. (p. 172)

Today, nursing theories continue to provide a solid position and purpose for nursing, and its philosophy and values (Rogers, 2005). Walker and Avant (1995) explain that through theory

development, nursing has and will continue to develop their own distinct knowledge base. Building on nursing knowledge and developing nursing theory is aimed at promoting nursing practice in a manner that is more complete and insightful; and, encourages nurses to think about practice in a reflective and theory-oriented way. Walker and Avant (1995) further explain that not only does theory development provide direction and guidance to individual nurses, theories "serve as broad frameworks for practice [and] may also articulate the goals of a profession and its core values" (p. 3).

Steps in Concept Analysis

Step 1: Defining the concept. By utilizing the concept analysis method described by Walker and Avant (1995), I will first clearly define the structure and function of the concept of social scripts. Defining characteristics that make this concept unique from other concepts will assist in determining the defining attributes of the concept of social scripts. A broad search will be conducted to search for and identify the uses of the concept of social scripts, including dictionaries, thesauruses, and available literature. A broad review of the literature will support and validate the chosen attributes for the concept and provides the evidence base required for the concept analysis. According to Walker and Avant (1995), determining the defining attributes is a key aspect of the analysis process. The aim in defining the attributes is "to show the cluster of attributes that are the most frequently associated with the concept and that allow the analyst the broadest insight into the concept" (p. 160).

Walker and Avant (1995) acknowledge that there are other ways in which an analyst can engage in the process of finding clear definition of a chosen concept. Paley (1996) suggests that by analyzing the summative characteristics of the whole, a composite definition or attribute can be arrived at. Further, Paley (1996) argues that one of the first criterions for arriving at the

correct characteristic is to assess which of the characteristics (or concepts) occur frequently in the data. Paley (1996) warns however that there is no guarantee that frequency of characteristics will lead to less ambiguity. In this sense, Paley (1996) agrees with Walker and Avant (1995) that pitfalls in analysis are possible, however the goal is to identify the clearest possible definition of the chosen concept.

Step 2: Concept derivation. The next step, concept derivation, is the process described by Walker and Avant (1995) where "by looking to a defined source or parent field for an analog to aid in developing a new field of interest, concepts in the new field may be derived" (p. 73). By redefining the concept in the new field, a new set of concepts—in this case for nursing care within vulnerable populations of women, is created. At this point, the newly defined concepts no longer require structural and functional meaning from the original or parent field. By completing the concept derivation process, new ways of thinking about the phenomenon of social scripts will be generated.

The concept of social scripts is widely utilized in the social sciences of psychology and sociology. However this concept has not been utilized or developed in nursing. Therefore, concept derivation may be particularly useful. The second situation where concept derivation is useful according to Walker and Avant (1995) is "in fields in which currently existing concepts have contributed to advancing inquiry about the phenomenon of interest, either in practical or theoretical terms....[however]... a new perspective [is needed]" (p. 75). Nursing has developed much knowledge through research in this area of nursing care with women who are impoverished and using drugs—particularly in relation to the social and structural barriers involved in attaining safer sex services and products (Browne & Fiske, 2001; Bungay et al., 2010; Chettiar et al., 2010; Ensign & Panke, 2002; Gelberg et al., 2008; Pauly et al., 2009). However, it appears that there

may be a lack of understanding in how women within this vulnerable population negotiate their sexuality and manage sexual relationships (Holland et al., 1992; East, Jackson, O'Brien, & Peters, 2011). If this is the case, then concept derivation may be helpful in generating a new way of thinking about or looking at this phenomenon.

Step 3: Case studies. Once the attributes have been defined, the next step in concept analysis is the development of 'cases' which will use the attribute definitions to more or less degree. The case studies will lead to a better understanding of "what 'counts' as the core meaning of the concept" (Walker & Avant, 1995, p. 162). Using a series of case studies, namely a model case, a borderline case, a related case, and a contrary case, clarity will be brought to the defining attributes of the concept social script. The model case is a case study wherein all the defining attributes of the concept, social scripts, are present. Walker and Avant (1995) explain that a model case should be "a pure case of the concept, a paradigmatic example, or a pure exemplar" (p. 163). The model case assists in ensuring that the defining attributes are correct and they are also clearly observable.

The remaining three case types provide the opportunity to examine cases which are either similar to, or contrary to the concept social scripts. Walker and Avant (1995) argue that by examining cases which are either similar or contrary to the defining attributes in the model case, clarity is brought and judgments can be made as to which defining attributes are more appropriate. A borderline case is one which contains "most of the defining attributes of the concept being examined but not all of them" (Walker & Avant, 1995, p. 164). The one significant difference, or where the defining attributes contained in the case prove inconsistent from the model case, will assist in building clarity of the concept under analysis.

A related case is one which is "related to the concept being studied but do[es] not contain all the defining attributes. They are "similar to the concept being studied; they are in some way connected to the main concept" (Walker & Avant, 1995, p. 165). Typically, during the phase of attribute definition, delineating definitions of the concept can be difficult. Often attributes or definitions which are very close to, or related to the concept being studied, are found and put aside. It is in the related case where these related attributes can be used. Only through close examination will the true defining attributes be prominent next to the network of non-defining attributes (Walker & Avant, 1995).

Lastly, the contrary case will provide a clear example of what the concept 'is not'. Walker and Avant (1995) argue that contrary cases are helpful as "[d]iscovering what a concept is not helps us see in what ways the concept being analyzed is different from the contrary case" (p. 166). It is often the case that when something is clearly missing from a scenario, clarity of what components should be present is magnified (Walker & Avant, 1995). An example of each of these cases along with an analysis of what makes each case study an appropriate example will assist in clarifying the defining attributes of the concept of social scripts.

Step 4: Antecedents and consequences. Lastly, concept analysis as described by Walker and Avant (1995) includes a discussion in relation to the antecedents and consequences of the concept. Walker and Avant (1995) define antecedents as the "events or incidents that must occur or be in place prior to the occurrence of the concept" (p. 167). These authors explain that by identifying the antecedents, further refinement to the defining attributes may occur. Cronin et al. (2009) explain that antecedents are important to assess as part of a concept analysis, as the antecedents can expose the social context in which the concept is generally used.

Antecedents are also useful in identifying any potential underlying assumptions in relation to the concept (Walker & Avant, 1995).

Consequences are "events or incidents that occur as a result of the occurrence of the concept... the outcomes of the concept" (Walker & Avant, 1995, 167). These authors explain that by assessing the consequences of a concept, often neglected variables or ideas come to light.

Step 5: Empirical referents. The final step in the concept analysis is to assess the methods, or ways that a measure can be applied to determine if the concept exists in reality. Walker and Avant (1995) explain that empirical referents are "classes or categories of actual phenomena that by their existence or presence demonstrate the occurrence of the concept itself" (p. 168). These scholars explain however, that the empirical referents are directly related to the defining attributes of the concept—not the entire concept itself. Therefore, the empirical referents are a measurement of the defining characteristics or attributes. Lastly, a discussion of the results of the analysis in relation to building nursing knowledge and providing nursing care within this population of vulnerable women will be provided.

The Concept of Social Scripts

Theoretical Application of Social Scripts

To begin, I will discuss various conceptions of social scripts and identify which concept has been selected for this analysis. Secondly, I will discuss the different theoretical approaches to script theory, the sociological approach and the approach based in the discipline of cognitive psychology. Lastly, I will explain the theoretical framework of the concept of social scripts.

The concept of social scripts has been referred to by researchers utilizing this theory in a number of ways including: sexual scripts, social scripts, scripts, and scripting theory (Simon & Gagnon, 1986; Frith & Kitzinger, 2001; Wiederman, 2005). While Gagnon and Simon are

noted as being the first to apply social scripting theory to study human sexuality (Wiederman, 2005), 'script' theory has played an extensive role in sexuality research. Presumably, it was the extensive use of script theory in sexuality research that coined the term 'sexual scripts'—which appears to have been adopted by other researchers (i.e. Frith & Katzinger). Within the works of Simon and Gagnon (1986; 2003) the term 'scripts' is used interchangeably with the other forms of the term noted earlier. For this reason, I have chosen to proceed with this analysis using only the root word of 'script(s)'.

Two commonly proposed theories that provide explanation for gendered behaviour differences are rooted in evolutionary accounts and, alternatively, in socialization and social scripting depictions (Wiederman, 2005). Wiederman (2005) explains that an evolutionary based explanation is anchored with inherent biological roots, whereas social scripting theory is based in socialization, cultural, and learning explanations. This author states that inherent to the theory of social scripting "is the assumption that people learn scripts as a function of being raised in a particular culture" (p. 496).

Firth and Kitzinger (2001) explain that there are two basic approaches to social script theory. One approach is based in the discipline of psychology, specifically cognitive psychology, and the other is based in the sociological perspective. These authors explain that script theory as it pertains to the issues of sexuality is typically drawn upon from the sociological perspective as opposed to the approach which is based in cognitive psychology. These authors explain that researchers involved in sexology and sexuality research have typically chosen this method as it follows the idea that "sexuality is *learned* from culturally available messages that define what 'counts' as sex, how to recognize sexual situations, and what to do in sexual encounters" (p. 210). Furthermore, scripts are adapted by each individual to their own particular

interpersonal contexts. Lastly, script theory based in the sociological perspective takes into account the importance of a person's immediate social context in which scripted beliefs and behaviours are produced (Frith & Kitzinger, 2001; Simon & Gagnon, 2003). The sociological approach to social scripts is more consistent with addressing women's health and health inequities as it is the social conditions that shape the inequities that these women face. Health inequities are created by the social and structural barriers that this population of women face (Pauly et al., 2009).

Sexuality research that is consistent with cognitive psychology approach is based in a biological, evolutionary, or individualistic model. Typically, this research approach relies heavily on cognitive constructs and takes a fundamentally individualistic and a-social approach (Firth & Kitzinger, 2001). Mainstream cognitive psychology is rooted in individualistic cognitive assumptions and tends to "ignore the social context in which scripted accounts are produced by participants (Frith & Kitzinger, 2001, p. 211). Cognitive psychology approaches based in individualistic cognitive approaches do not focus on, or acknowledge significance of the social conditions (political, historical and economic); and, do not observe the power and control exerted over women's ability to make decisions and function within a contextually oppressive situation.

The concept of social script theory in this analysis will follow the assumptions, which align with the sociological perspective, and specifically those of Simon and Gagnon (1986; 2003). William Simon and John H. Gagnon (1986; 2003), scientists who have investigated and reported extensively on script theory as it pertains to sexuality, explain that sexuality is learned from cultural available messages in regard to sexual behaviours and situations, and what to do in response to these situations. These cultural scripts are individually adapted to interpersonal

contexts, and thereafter modified and internalized as ‘intrapsychic’ scripts (Frith & Kitzinger, 2001). The intrapsychic experience does not function alone however; there is synonymous interaction between interpersonal relationships and the intersubjective cultural surround (Firth & Kitzinger, 2001; Simon & Gagnon, 1986; 2003). Each of these sociological concepts will be explored in further detail.

Simon and Gagnon (2003) rejected the biological explanation that sexuality was internal to the body and instead, looked at the conceptual space outside of the body to locate the explanations for either sexual desire or the behaviours in relation to sex within the context of specific interpersonal and intrapsychic conditions, as well as the historical situation of the body. Simon and Gagnon (2003) believed that:

> [w]hile the commonsensical view of sex is that it is a spontaneous and ungovernable form of behavior that presses against social norms, in our view the sexual takes on its shape and meaning from its social character. Even though most actual sexual activity in contemporary societies goes on in private settings, often devoid of apparent social costuming, the sexual encounter remains a profoundly social act in its enactment and even more so in its antecedents and consequences. Implicit audiences and explicit audiences (i.e., the self and others as audience) are present in every sexual encounter and the judgments and views of these audiences are considered, even if only in their denial. (p.492)

Simon and Gagnon (1986) espouse that all behaviour is scripted. Social scripting theory according to Simon and Gagnon (1986) is underpinned by the assumption that people follow internalized scripts when constructing meaning in relation to behaviours and emotions. Although the central notion of script theory is that each individual learns their script through being raised in a particular culture, it is thought that within a particular culture, each individual typically adapts the construction of the script in accordance with their particular interpersonal contexts. Therefore, the larger cultural group may share many commonalities, however there

may be numerous subcultures within that group (Firth & Kitzinger, 2001; Simon & Gagnon, 2003; Wiederman, 2005).

The cultural surround or scenarios, according to Simon and Gagnon (1986) are the "instructional guides that exist at the level of collective life" and further, "they provide for the understandings that make role entry, performance, and/or exit plausible for both self and others: providing the 'who' and 'what' of both past and future without which the present remains uncertain..." (p. 98). The roles that all people play in life "must reflect either directly or indirectly the contents of appropriate cultural scenarios" (p. 98). Furthermore, it is important to note that all behaviour or conduct consistently involves, albeit to varying degrees, all three levels of scripting—cultural scenarios, interpersonal scripts, and intrapsychic scripting.

The cultural surround contextualizes only a piece of the script however. Social behaviour almost always involves the inclusion of others and thus the necessity for 'interpersonal scripts'. Simon and Gagnon (1986) explains that the interpersonal script demonstrates the individual's abilities and actions as he/she becomes more than a single individual within the culture, and takes on the task of creating or shaping new or existing culture. Simon and Gagnon (1986) explain that it is the interpersonal script that:

> transforms the social actor from being exclusively an actor trained in his or her role(s) and adds to his/her burdens the task of being a partial scriptwriter or adaptor as he/she becomes involved in shaping the materials of relevant cultural scenarios into scripts for context-specific behaviour. (p.99)

In terms of one's own scripted behaviour, interpersonal scripts represent the mechanism through which appropriate identities are made congruent with desired social and personal outcomes (Simon & Gagnon, 1986).

However, where complexities and/or conflict become prevalent at the level of the cultural surround, and the script demands become too great for the adaptive possibilities of the interpersonal script, Simon and Gagnon (1986) explain that the intrapsychic script will provide the third level needed n the making of social scripts. The two components necessary for the intrapsychic script are self awareness of one's own personal aspirations and a presented conflict. These authors explain that a person's most private wishes and desires "must be bound to social life: the linking of individual desires to social meanings" (p.100).

Creating internal dialogue or engaging in a personal internal discussion as to the various options or strategies which may be available within a scenario comes into play. Simon and Gagnon (1986) explain that when people are developing scripts that will guide actions—an important step to making decisions, or in other words, scripting behaviour, they will create meaningful internal dialogue and practice the behaviour or action through internal rehearsal. The internal dialogue will rehearse the various outcomes that will potentially arise from following the different decision paths available. These authors stress the importance of alternative outcomes, as the act of developing and recounting an internal dialogue can only become significant where alternative outcomes are available. Simon and Gagnon explain that intrapsychic scripting originates from "a private world of wishes and desires... [and] must be bound to social life: the linking of individual desires to social meanings" (1986, p.100).

Decision making and ability to assert personal agency to attain the individual desires in relation to sexuality, can however be difficult and problematic for women who are experiencing homelessness, poverty, and drug use. Cockerham (2005) reminds us that decision making, and the ability to exercise agency is directly connected to the social rules or codes that implicitly or explicitly dictate appropriateness and preferences in exercising agency.

Simon and Gagnon (1986) have provided a conceptual framework that may have utility in examining the complexities that inform agency, dictating and confirming appropriate actions and behaviours in the population of women who are experiencing homelessness, poverty, and drug use. However, what seems precarious on this initial look at scripting theory is the differentness of the cultural rules and expectations within the interpersonal relationships found where many of the women were raised and now live, and the cultural scenarios of the health care milieu and those who work within. The women may have a well established intrapsychic script however when attempting to play out a well rehearsed script in a totally different play or production, the script does not fit and has no cohesiveness to the foreign environment. In a healthcare environment structured with marginalizing policies and practices that is fraught with racist and discriminating discourse, the interpersonal scripts within the context of this disempowering and intolerant cultural surround will likely become stifled and ineffective. An understanding of the concept of social scripts as a modifying component to informing agency is an important step to improving healthcare delivery practices for disadvantaged women. The first step in understanding this concept is to collect and examine a broad range of uses and definitions of social scripts.

Step 1: Defining 'Social Scripts'

Defining the concept of social scripts will be done by first looking to various resources for dictionary definitions. A discussion will then follow as to how various disciplines define and use the concept of social scripts. A review of the literature in disciplines outside of the science of nursing exposes a number of disciplines wherein the use of scripts is documented. A discussion of the uses of the concept will be provided—first looking at disciplines outside of the health care milieu, followed by a discussion of scripts within health care, medicine, and

lastly, nursing. The idea of scripts is used in educational psychology, speech and language pathology, business and specifically organizational business, the study of ancient art, archeology, drama, medicine, and computer science. This list is not meant to be exhaustive but does draw attention to the broad use of the word 'script' in many different disciplines.

Electronic databases including CINAHL, Academic Search Complete, JSTOR, PsycINFO, Business Source Index, and the Humanities Index were searched using the keyword *script(s)* for publications dated 1970 to September 2012. These parameters were chosen to cover a wide range of possible disciplines and a more lengthy time span in hopes of capturing uses in a more historical sense. I also wondered if this concept may have had a role in the earlier years of nursing theory development. Broad inclusion criteria for articles included being printed in English, and peer reviewed articles. The reference lists from relevant articles were reviewed to identify references not captured by the initial search. The search results yielded a narrower focus for scripts in the nursing literature and similarly in the field of medicine.

Dictionary definitions. According to the Oxford English Dictionary (Oxford English Dictionary, 2013, online), the word *script* originates from the Latin use as a noun, *scribere*. In late Middle English times, the word *script* was used to describe 'something written'—designating a play script specially prepared for actors' use (i.e. provided with full stage directions, cuts, etc.), as acting copy or acting edition. The English form of *script* was a shortening of the Old French word *escript*, which took on the same meaning. Modern use of the English word *script* can also take the form of a noun, meaning: written characters; handwriting as distinct from print—for example, 'her neat, tidy script'; or the written text of a play, film, or broadcast.

The Merriam-Webster Dictionary (Merriam-Webster, Inc., 2013, online) provides similar information to that provided in the Oxford Dictionary. However, an additional definition is provided: 'a plan of action'—as in 'to provide carefully considered details for'. Lastly, this definition as provided by Merriam-Webster, (2013), provides the reference of *script* used as a noun to mean a 'prescription' which did not come into use until the middle 1900's.

Synonyms can also provide some clarity in relation to the definitions of words. Synonyms for the word *script* when used as a noun to mean 'the written study of a subject' are: argument, commentary, discourse, review, exposition, and work. Similarly, when used as a noun, however with the definition 'talk', the synonyms found are colloquy, communication, exchange, repartee, discussion, and parley (Roget's Thesaurus, 2013, on-line). These synonyms provide a further element of definition in relation to the word script when used in context of script as set out in this project. This examination of different definitions highlights the long-term use of the word script, as well as the variances of the word when used as a noun or a verb.

Application of social scripts outside of nursing. In the study of *ancient art*, a distinctive form of historic writing style and calligraphy is defined as script. For example, the evocative shapes found in the principal text of the Buddhist Tendai sect, the Lotus Sutra provide many examples of Chinese characters (kanji) and the Japanese syllabary script (kana). Heian period (A.D. 794-1185) calligraphers scripted representational forms—especially those of rocks, birds, grasses or reeds, and flowing water with the Chinese and Japanese script characters. However, different writers using the same symbol or script might transcribe the representational form using three to seven different symbols—each of which would be derived

from a different Chinese character with similar pronunciation. The range of kanji and kana available for expressing each syllable permitted the calligrapher a visually pleasing and diversified script (Meech-Pekarik, 1977/1978).

Archaeologists are able to build knowledge with respect to ancient civilizations by analysing ancient handwriting—script found on an ancient potsherd, a stone monument, or a piece of papyrus. The technique of dating script analysis is extremely technical with the scientist paying heed to not only the shape of each letter, but the relative size and angle of the letter form is in relation to the writing line (Hanson, 1985)

In *business*, the learning of scripts guides purposeful behaviour in organizations; cognitive knowledge structures that serve two purposes: assist in the process of interpreting the behaviour of others, but they are also instrumental in generating behaviour (Lord & Kernan, 1987; Gioia & Poole, 1984). Scripts are held in memory in a prototypical fashion—an abstract set of representative features that define members of a category. Exposure to new situations that share some common elements with previous experiences will cue a comparison to previously learned scripts (Gioia & Poole, 1984).

Within the technical field of *computer science*, a **s**cript is a term used to mean either a small program written for a command interpreter or other scripting language. In website programming, scripts are used to allow a visitor to a website to maneuver through the site. Scripting is used to enhance the performance of computer game artificial intelligence—a structure for representing procedural knowledge, or respond to human player tactics (Spronck, Sprinkhuizen-Kuyper, & Postma, 2004). A computer programmer can write computer script, or system administrator can be charged with scripting or editing the application program. Scripting

languages have become more effective and efficient in many computer programming tasks and can connect large, powerful components (Ousterhout, 1998).

Within the discipline of *educational psychology*, research on the use of collaboration scripts in the process of collaborative learning was performed. Prior to using the scripts, research demonstrated that people do not often collaborate well in their process of learning. A number of reasons are suggested for this apparent lack of ability to collaborate spontaneously and effectively. Learners tend not to participate equally, do not engage in equal or high level argumentation strategies, and rarely collaborate on an equal level of knowledge acquisition (Kollar, Fischer, & Hesse, 2006). Collaboration scripts have been useful in supporting participation and coordination, and have demonstrated a higher quality of collaborative learning processes and individual learning outcomes (Kollar, Fischer, & Hesse, 2006).

Scripts are perhaps most well known for their use in the *dramatic arts*. In a qualitative study published in 2008, Davies explored how a script functioned as a mediating artifact between the users of the script and the telling of the story of a play. In this study, the script was considered the mediating artifact to the performance of a particular activity—it was the "*sine qua non"* (an essential condition or prerequisite) (Davies, 2008, p. 182). All those who used the script (director, assistant director, lighting designer, sound designer, stage manager, actors, actresses), the research participants, were interviewed to determine "in general terms how the script mediates their work activities and ... were asked to identify specific instances of epistemic practices" (Davies, 2008, p. 183). The results of this study indicated that a script was an artifact used by many different players involved in the final object, the play, and that each used the script for different purposes. Secondly, that while the script produces an activity that provides for an activity that is inherently social in character, the script reveals a number of different epistemic

practices carried out by the different participants to accomplish the telling of the story—performing the play.

The seven epistemic practices identified during the study were: reading, classifying and inscribing, gathering, representing, learning, remembering, and standardizing. During the reading phase, each participant is "engaged in the same epistemic practices but the individual actions for each one is different" (Davies, 2008, p. 187). Each participant is reading analytically for different reasons—the actor to learn about the character he will play; the designers read to define their role in stage design and production. Classifying and inscribing are again individual functions performed by all participants as each makes their own role-specific working document out of the original identical script. Gathering refers to the collection and accumulation of working documents, as well as any background research gathered to aid in the telling of the story. Each participant collects information and documents throughout the period of time from first reading to production, pertinent to their role in the production. Representing refers to the renderings created by the design participants—in the form of drawings, three dimensional models, or costume designs. Plans and diagrams impose order on space and appearance that is then shared with the others on the team. Learning and remembering occurred for each of the participants in that they acquired new skills in order to either portray a certain character or learn about a different geographical setting in order to realistically portray this on stage. Lastly, standardizing is the sharing of documents in an acceptable format for the purpose of transparency by making paperwork and the inscriptions added available to all participants (Davies, 2008).

The last two findings identified by Davies (2008) are the two different affordances the script offer depending on when it is used and by whom. Specifically, a script can be used as work, or a script can be used as *a work*. A script as work is used at the beginning of a production

as a job offer, and once accepted, becomes a 'to-do' list for all production professionals. In the post production phase, it becomes a personal resume of the work performed. The script as *a work* is a piece of literature that can take on a variety of different forms depending on which production professional is using or inscribing it. Davies (2008) describes the script as the principal mediating artifact in theatre. It is a product of the accumulation and growth of social knowledge that has been revealed through the social epistemic practices of all production professionals.

Speech and language pathologists report that script training has been found to be useful for people who have been affected by aphasia. Researchers have found that by re-learning scripts (monologues or dialogues), people suffering from aphasia are able to learn segments of automatic and fluent speech (Cherney, Halper, Holland, Cole, 2008; Goldberg, Haley, & Jacks, 2012). The purpose of learning the script segments is to achieve production automaticity through repeated practice. Goldberg et al. (2012) demonstrated that scripts have enabled aphasic persons who otherwise communicate with effort and frustration to be able to express themselves in a number of settings. Furthermore, these scholars suggest there is emerging evidence to suggest that script learning contributes to an improvement speaking ability in natural conversation, language and communication testing, and increased communicative confidence. Youmans, Youmans, and Hancock (2011) found similar results in their study with script training treatment in adults with apraxia of speech as described in study with adults with aphasia.

In *medicine*, and particularly medical education**,** Charlin, Boshuizen, Custers, and Feltovich (2007) discuss scripts in the context of clinical encounters and the mobilization of organized subsets of knowledge. Medical practitioners upon being presented with a patient complaint are taught to follow this method in order to reach a correct diagnosis and treatment

plan. The method includes an assessment phase wherein the practitioner draws out the relevant features of the medical concern and quickly draws relevant hypotheses from the many subsets of stored knowledge. Signs and symptoms are then observed in order to confirm or rule out competing hypotheses. The appropriate investigations and treatments are then guided by the proposed hypothesis' knowledge subset. Each of these subsets of knowledge is referred to as an 'illness script'. These authors purport that illness script acquisition is of crucial importance at the beginning of a medical career and require continuous updating as a result of changes in medicine and a doctors' care population (Charlin et al., 2007).

Application of social scripts within nursing. Greenwood (2000) uses the concept of script in a discussion promoting the acquisition of evidenced-based nursing scripts to be used in practice to "replace inappropriate and maladaptive sub-routines and strategies with those based on valid research ..." to deal with everyday nursing care functions automatically and effortlessly. This in turn would free up limited attentional resources to enable nurses to engage in critical thinking skills to deal with atypical, problematic aspects of care.

Billings, Kowalski, and Smith (2011) explain that scripts can be effectively useful in the exercising of cognitive rehearsal—a strategy used to improve communication and as a learning strategy to promote confidence and critical thinking among student nurses. Scripts in this case are used as a tool for cognitive preparation, to improve communication in critical patient or family encounters, situations where interpersonal conflict may exist or develop, and for standardized communication for patient safety and care. These authors suggest that nursing students or new employees in a health care setting are "often anxious about and fearful of the unfamiliar, stressful, or contentious encounters that occur; and lack competency in communication techniques to effectively confront and respond to others" (p.535). Thus,

scripts are seen to have a useful function in communicating important yet sensitive information and, aid in building confidence and knowledge on the part of the one imparting the message.

My search for script usage within the discipline of nursing, and specifically in relation to sexuality yielded only one case. In this study, Gondek (1999), a former Cardiac Care Nurse states that scripts can be useful tools when counselling patients on sensitive, sexually related topics. The topic of this study related to resuming sexual activities after having a myocardial infarction (MI). This author states that nurses tend to neglect sexual counselling with their MI patients for fear of embarrassing the patient or being too personally intrusive; whereas patients felt this topic should be addressed in the hospital. Gondek (1999) found through a survey of cardiac patients that patients felt that sexuality should be addressed in the hospital setting. According to Gondek (1999), using a script in health teaching guides instruction and enables the nurse to measure the success of the education session. This study provides a good example of where scripts assist in communicating important yet sensitive information and, aid in building confidence and knowledge on the part of the nurse.

In summary, scripts have been used in many different disciplines and over a significant period of time through history. What is clear however is that scripts have not been used prolifically in nursing. In step two of this concept analysis, I will define the attributes most frequently associated with the uses found within the disciplines discussed.

Step 2: Concept Derivation

Defining the conceptual attributes of social scripts. By defining the attributes most frequently associated with all the uses of the concept social script, a broad insight can be developed as to the key features of this concept (Walker & Avant, 1995). The review of

literature noted earlier has provided the evidence base for my choice of defining attributes. In making this decision, all instances of the concept were used in the analysis. The three key defining attributes chosen were most frequently associated with the concept, and secondly, provide the broadest insight into the concept. The defining attributes I have identified for the concept of script are: (1) a script provides the ability to guide and assist, or to improve or gain something (i.e. learning, production, participation); (2) a script functions to guide, generate, and/or interpret behaviour; and (3) a script inherently possesses the ability to recognize, compare and adapt as needed. After a lengthy analysis of the concept of social script, I have synthesized the defining attributes as follows: a cognitively stored process that is easily retrievable, recognizable, and versatile, which either guides self behaviour, or interprets other's behaviour, and has the ability to create positive results, an improvement, or a gain in something.

With these attributes and the synthesized definition in mind, the constructed case studies will demonstrate all, some, or none of the defining attributes of social scripting. Particular attention will be given to defining the three levels of behaviour production. The cultural scenarios are the abstract but collective life situation experienced by the actor/actress in the case studies, which guide the narrative requirements of the personal role within a given situation (Simon & Gagnon, 1986). When the actress fails to find congruence between the internal cultural scenario and the concrete interactional situation occurring, interpersonal scripts are needed. The interpersonal script requires the actress to move from acting exclusively in her role and adds the burden of shaping the relevant and internal cultural scenarios into scripts for the context-specific interactional situation (Simon & Gagnon, 1986). At the level of the intrapsychic script, the actress who is aware of her own personal wishes is presented with a conflict that is

bound to the abstract and collective life situation. It is the intrapsychic script that is created to connect individual desires to the social meanings within a situation (Simon & Gagnon, 1986).

Step 3: Case Studies

In the third step of concept analysis, a series of cases are presented to provide insight into the key elements of the concept being explored. Below, I will present a model case, a borderline case, a related case, and a contrary case. A description of each of these case types will precede the case study. Following the actual case study, an analysis will follow, addressing the key attributes within the context of the three levels of social scripting: the cultural scenarios, the interpersonal script, and the intrapsychic script.

Model case and analysis. I will describe a model case which will demonstrate all of the defining attributes of the concept. A model case is an example of a situation that contains the clearest example of the synthesized definition. The model case is typically provided first as it reinforces the defining attributes, making any deviations from the use of all attributes in the correct manner more easily evident (Walker & Avant, 1995).

Model case**.** Maddy had run from an abusive home life and had been living homeless for the past three months. She had been the victim of sexual and physical abuse a few times while trying to find her way on the streets. Through the friends Maddy had made, she was particularly attracted to Sam and he seemed to like her. After a short time, Maddy and Sam began hanging out together and Sam invited her to stay with him at his cousin's house downtown. For the first time, Maddy felt happy and safe.

Unfortunately, this feeling was short-lived. Soon after Sam became her boyfriend, Maddy found that she was treated differently by Sam. Sam began to hit her and make demands that made her angry and scared. She didn't know what else to do but concede to his demands in

order to avoid violence. If she didn't, she would be kicked out and alone again. Sam refused to use condoms and when Maddy brought some from the clinic and when she asked him to use them he broke out into a fit of rage. She knew she would not raise that subject again. She did not want to anger him for fear of him 'dumping' her. It was not long before Maddy had contracted an STI and became pregnant.

Maddy was terrified to subject herself to the staring eyes and judgmental voices that she knew she would receive if she went to the hospital for treatment. Although Sam was mean to her sometimes, she felt that he was the only person she had now. Sam would look after her and the baby.

Analysis of model case. Within this model case, all three of the defining attributes of the concept are demonstrated. First, a script can be cognitively retrieved, recognized, compared and adapted as needed. Maddy retrieves her cognitively stored information that is recognizable and versatile in regards to how she manoeuvres her situation with Sam. Her new experiences with Sam are similar to the family environment from which she came. In this regard, the cultural scenario is similar to that which she experienced at home. The second attribute is demonstrated as her interpersonal script comes into play. This attribute requires that a script functions to guide, generate, and/or interpret behaviour. Maddy's interpersonal script guided her behaviour, allowed her to interpret Sam's behaviour, and gave her the ability to create positive results—to gain something within the relationship. Initially, her script knowledge guided her through the process of meeting Sam and consequently, becoming his girlfriend. She felt protected and loved. Her interpersonal script knowledge and actions were familiar with the controlling and abusive situations within her relationship as she had experienced and learned this script while living at

home. The third attribute was met as Maddy's script guided her actions and she was able to improve her situation.

Where script theory may not be helpful in this scenario however is where Maddy is required to utilize her scripts in accessing health care within a system that is complicated, immense and frightening in order to seek treatment for STI(s) and pregnancy. Maddy is not able to recognize a previously formed script within her cultural environment that is helpful or positive that would guide her through the process of accessing appropriate health care services in a positive manner. In many cases, equity in health access has not been experienced by disadvantaged women who are experiencing poverty, homelessness, and substance use. The reasons for this include stigma, marginalizing discourses of blame and individual responsibility caste upon the women who have been marginalized due to poverty, drug use, and their lack of knowledge in relation to institutional access (Pauly et al., 2009). This case study demonstrates Maddy's script with respect to the cultural scenario—which makes it very difficult to draw upon a positive interpersonal or intrapsychic script.

It is the structural and social determinants of health however that presents the larger picture in terms of health inequities within the subgroup of population of women, like Maddy who are facing poverty, homelessness and drug use. The determinants of health are known as the social conditions that influence health including: income and employment, housing, healthcare services, food security, early child development, education, social status and ethnicity (Raphael, 2004). Maddy does not benefit positively from having access to these social determinants of health. Secondly, I would propose that she has not learned positive social scripting to enable her to influence or overcome the lacking economic and social conditions that influence her health status. For these reasons, I would question the use of the concept of social

scripts as the most useful process in making changes in health equity and equity in access to health care.

Borderline case and analysis. In the case of a borderline case, Maddy's experiences will demonstrate that most of the defining attributes of the concept are included, but not all of them. Walker and Avant (1995) argue that by looking at the case in a light that does not quite demonstrate all the attributes, clarity of the concept can more easily be observed.

Borderline case. Finding herself pregnant, Maddy knows she needs to go to the hospital at some point. She believes however, that hospitals are horrible places and that she will be treated poorly there. She has already had one baby and the nurses were really mean to her. She knows if she goes there again, she will be treated the same way. Maddy's friend Sara tells her of another place where she can get health care during her pregnancy; where they are really nice and fully understanding and accepting. However, Maddy never does check this place out and in the end, goes back to the hospital where she was treated so poorly the first time.

Analysis of borderline case. In this borderline case, two of the three attributes are present. Maddy's cognitively stored beliefs about hospitals and healthcare providers are easily retrievable and recognizable, which demonstrates the first attribute required for the concept of script. At the first level of a script, the cultural scenario, Maddy sees her role within the culture of the hospital. These memories then guide her beliefs and actions—the second defining attribute of script. Maddy is able to retrieve both the interpersonal and intrapsychic scripts that replay in her mind in relation to the poor treatment and structural barriers she experienced the last time she had a baby in the hospital. The internal dialogue as to the various options open to Maddy unfortunately does not create a positive scenario for her. Instead of being able to see a positive strategy that involves adequate and positive health care, her internal dialogues reinforce

her past negative experience. Maddy's intrapsychic script is active in that she wishes there was somewhere she could access health care in a positive environment. Her friend Sara provides her with a contact and an invitation to attend at the new clinic however Maddy never follows through. It is at this point where this case study fails to include all three defining attributes as it does not demonstrate the ability to create positive results, an improvement, or a gain in something. Maddy goes to the hospital when she goes into labour and experiences the same racist, discriminating discourse as she did the first time instead of acting on the intrapsychic script and achieving her wishes for a positive experience. Nothing positive comes out of this second event to the hospital.

Related case and analysis. During the process of analysing a concept, related concepts are developed that are similar to and connected to the main concept however do not contain all of the defining attributes (Walker & Avant, 1995). It is the close observation that is required to recognize the slight differences between the main concept and the related concept that will help the analyst and reader to understand the differences between the related concept and the true main defined concept (Walker & Avant, 1995).

Related case. Maddy and her boyfriend Sam have been together for three months when she finds out she is pregnant. They have been having unprotected sexual relations. Maddy is upset as she wanted to use condoms however Sam refused. Maddy was pregnant before; had a child; and, the child was taken and put into foster care. Maddy also felt she was treated poorly by the doctors and nurses at the hospital and did not want to go through that again.

While Sam was not happy that Maddy was pregnant, he knew she would need medical help at some point and also knew what it was like to go to the hospital. He had been in many

times for different health problems. He had heard of another clinic in town however that was more accepting and the nurses and doctors were not judgmental.

When the time grew nearer that Maddy would have the baby, Sam took Maddy to the maternity clinic in town. Sam had been given information as to when and how to access this service. Maddy and Sam visited a number of times prior to Maddy going into labour. Each time they attended, they were both received in a positive and caring manner. As the time drew nearer that Maddy would have the baby, Maddy had been able to come to feel more comfortable with the nurses at the health care clinic. Sam felt that he had done the right thing in bringing Maddy there.

Maddy eventually went into labour and she and Sam made their way to the clinic. She had a long difficult labour and after 15 hours, Maddy was able to deliver the baby. The process was very difficult for Maddy and her coping abilities were low due to the pain and her fatigue level. Unfortunately although Maddy had developed a respectful care relationship prior, she was unable to see this environment as any better than the first time in the hospital due to her pain, fatigue and stress. She viewed the experience as negative and was unable to see otherwise despite Sam supporting a more positive view.

Analysis of related case. In this related case, a scenario is portrayed that demonstrates a concept that is related to and similar to the concept of scripts however does not have all the defining attributes. In this related case, Maddy's cognitively stored beliefs about hospitals and healthcare providers from her past experiences are easily retrievable and recognizable, which demonstrates the first attribute required for the concept of script. These memories do not however guide her beliefs and actions—the second defining attribute of script; instead, she looks to Sam to direct and assist her in accessing an alternative health care facility. It is Sam that meets

the second attribute and guides Maddy into action. Maddy is willing to accept Sam's help and guidance however we cannot positively say that Maddy has met this defining attribute. Maddy goes to the new health care centre a number of times in the prenatal period and then when she goes into labour. She and Sam experience a much different reception and manner of care. Unfortunately Maddy is unable to maintain this positive outlook with the care she receives from the clinic staff.

Maddy eventually goes into labour and experiences an extremely difficult time during the delivery that her view of the birth experience becomes less positive. She does not recognize the different care environment from that which she experienced the first time at the hospital. Sam tries to help her see that it was much better however Maddy is unable to acknowledge this. Although she agrees that her experience was better initially, she does not believe that this improvement carried on to the end. In this regard, she is unable to meet the third attribute in its pure form.

At the first level of a script, the cultural scenario, Maddy begins to envision her past experience at the hospital. She subsequently is able to cautiously alter that cultural experience while making visits to the clinic when they attend for prenatal care. Maddy's intrapsychic script is active in that she wishes there was somewhere she could access health care in a positive environment and is optimistic that the clinic will provide that experience. Maddy is able to retrieve both the interpersonal and intrapsychic scripts that replay in her memory in relation to the poor treatment and structural barriers she experienced the last time she had a baby in the hospital. Her internal dialogue is able to slowly change as she learns about and experiences the new clinic. Cautiously, Maddy begins to create a more positive script. Unfortunately her belief about the experience does not end well and the positive scenario does not solidify. Instead of

being able to see a positive experience that involves appropriate and positive health care, her internal dialogues and interpretations of the experience reinforce her past negative experience.

Contrary case and analysis. A contrary case is described by Walker and Avant (1995) as an example case study wherein the concept presented clearly contradicts the concept defined. None of the three critical attributes are present in the case.

Contrary case. In this contrary case, we will once again use the scenario of Maddy and Sam. Maddy's family has a nice but modest home, attended public school and her parents both worked full time. Maddy felt her parents were too strict and would not let her go out at night during the week, insisting that she stay home and do homework. Although her parents were never abusive and loved her, Maddy felt she was not treated as well as her sister and that her parents liked her more. Maddy has run away from home, leaving her parents and sister. Shortly after Maddy leaves she meets Sam and he invites her to stay with him at his cousin's house downtown. Maddy is happy and feels loved and safe with Sam.

Soon after moving in, Maddy feels that Sam treats her differently. Sam hits her and makes demands that make her angry and scared. Maddy contracts an STI and becomes pregnant as Sam refuses to use condoms, even when Maddy gets them for free from the clinic. She does not understand why he treats her badly and refuses to have protected sex.

Maddy does not know how to deal with Sam or her situation. Sadly, Maddy is found the next morning after having taken an overdose of drugs.

Analysis of contrary case. Within this contrary case, none of the three defining attributes of the concept of script are demonstrated. The first attribute of a script is the ability to recognize, compare and adapt as needed. Maddy is unable to retrieve any cognitively stored information that remotely resembles this experience or what to do in this situation with Sam. There is no

likeness between her new experiences with Sam compared to the family environment from which she came. In this regard, the cultural scenario has no likeness and therefore does not provide her with anything to draw from.

The second attribute requires that a script functions to guide, generate, and/or interpret behaviour. As Maddy does not possess any cognitively stored information that could direct her in this new situation, she is at a loss for how to function or interpret her relationship with Sam or the environment she finds herself in. She does not have the ability to create a positive environment as she is unable to interpret the behaviour or generate any positive actions to change the situation. Maddy's interpersonal script is non-existent as she has not had to interact in this type of relationship with either her parents or anyone else in her life. Initially, her cultural scenario and interpersonal script knowledge recognized and guided her through the process of meeting Sam and becoming his girlfriend. However, once she had moved in with Sam and his cousin, she was at a loss with respect to both her cultural scenario and interpersonal script.

The third attribute of scripts—the ability to gain something or improve her situation was also not met in this case study. As Maddy is at a loss for how to function or change her situation, and finds herself pregnant, she can only think of running from the situation. With the belief that she is not able to improve her situation; and the belief that she has nowhere to turn, she ends up taking too many pills –either inadvertently or on purpose—and experiences an overdose and dies. Maddy is also unable to access a positive and helpful intrapsychic script by this point. She has not been able to draw upon the other aspects of a script to help her prior to this point and continues to be stymied in her situation. Now she only wishes that she had never left home in the first place.

Step 4: Antecedents and Consequences

The next step in the concept analysis is to identify the antecedents and consequences with respect to the concept (Walker & Avant, 1995). Not only do these two variables have the potential to shed light on the social context within which the concept is generally used, they may also be helpful in providing further refinement to the attributes. Specifically, an antecedent is an event or incident "that must occur or be in place prior to the occurrence of the concept" (Walker & Avant, 1995, p. 167). A consequence is an event or incident that transpires as a result of the occurrence of the concept, the outcome after the concept takes place.

One antecedent to the concept of social scripts is simply the acknowledgement that an action is required. Therefore, within the social context of sexual health and health care access inequities, the antecedent to the concept of scripts is the acknowledgement that there is a need for something or some action; there is a desire for preventative or curative health care. The defining attributes of the concept of social script is ability to guide self behaviour or interpret others behaviour and has the ability to create positive results through the use of a cognitively stored repertoire. In the case of accessing health care and attaining equity in health status, only one or two of the three attributes are likely. It will not always be possible to create positive results through the use of social scripts. Secondly, if women are unfamiliar with 'how things work' within the hospital and health care system, they may not be able to guide their actions. The attainment of health equity is dependent on many social and structural factors and the majority of these changes will require political, social, and economical drive.

In this concept analysis, the concept script has been analyzed and attributed the defining characteristics of a 'positive outcome'. However, perhaps a more plausible consequence in the population of women who have been subjected to marginalization would be just 'an outcome'.

Despite the possible behaviours or actions that are brought about by the enactment of a script by women within this impoverished environment, the outcome will not always be positive. The interpersonal script and the cultural surround of the healthcare environment is not one that can be controlled by the woman seeking care alone. In the case of sexual health, there are many social and structural determinants that are not within the woman's control and thus she does not have complete control of the outcome after the concept. A positive consequence of social engagement and interaction and resource mobilization would be positive consequences to the occurrence of listening to these women's scripts. However this is not typically the case at the present time. A likely occurrence within our present sociopolitical state would be continued marginalization, stigmatizing, individualizing, and general status quo. Until there is sociopolitical acknowledgement and mobilization of change of the oppressive social conditions that shape access to health care and bring about equitable health, I believe that the social scripts that have been culturally learned will likely fall upon those who are unable or unwilling to hear them. Social justice is needed to enable all to experience equity in health care and health. Perhaps an understanding of the concept of social scripts is useful in nursing to the extent that nurses should look at the possibility that all people are guided by culturally learnt scripts however the concept of scripts is not going to achieve health equity. I would propose that other forms of nursing philosophy and care could result in greater action and advancement in the direction of equality in health and health care access.

Step 5: Empirical Referents

Empirical referents are what Walker and Avant (1995) say is the final step in a concept analysis and indicate that at this point, it is necessary to determine whether the defining attributes can be recognized or measured. The empirical referents are "classes or categories of actual

phenomena that in their existence or presence demonstrate the occurrence of the concept itself" (Avant & Walker, 1995, p. 168). These authors explain that it is important to distinguish between the concept and the defining attributes—the empirical referents do not measure the concept, but "are the means by which you can recognize or measure the defining characteristics or attributes" (p. 168). Empirical referents are a useful means to use in assessing whether the concept exists in the real world, or, to what degree. A concept analysis is an effective tool for both nursing theory development and practice development. The purpose of this concept analysis is to build knowledge in relation to the theoretical and practical applications for providing nursing care to women who are impoverished, homeless, and using illegal drugs. The ability to observe and measure the defining attributes of social scripts within the real world could perhaps demonstrate the applicability of this concept within this segment of nursing practice; or, alternatively, changes in the defining attributes may be required if used in this context (Walker & Avant, 1995).

Three key defining attributes that I have identified for the concept of social scripts are that they will: (1) provide an ability to guide and assist; or to improve or gain something (i.e. learning, production, participation); (2) function to guide, generate, and/or interpret behaviour; and (3) inherently possess the ability to recognize, compare and adapt as needed. All of the defining attributes are difficult to observe or measure within this particular context of nursing. Perhaps some of the attributes could be measured through discussion with women within this population however the concept of social scripts as it is defined in its entirety here. If women living within this cultural and contextual location are using social scripts to guide behaviour, secondly, if the script is adaptable and recognizable, I would propose that the social script does not provide an improvement or gain in their social or health related circumstances. Poor health

status and poor health care access is not created by individual means. Inequitable health status and access to health care is a social and structural barrier that requires more than understanding as to the individual social scripts that women may have learned and may incorporate into their thoughts and actions. However, social scripts may be useful to enhance the ability of nurses to work with women to create new social scripts.

Implications for Nursing Practice

Women who are experiencing poverty and using illegal drugs suffer from the same sexual health related disease and illness as can be observed in women within the general population (Wenzel, Andersen, Gifford, & Gelberg, 2001). However, the structural and social inequities associated with poverty, homelessness, and drug use impacts both the health and the ability of women to access health care services (Ensign, 2000; Ensign, 2001; Ensign and Panke, 2002; Gelberg, Leake, Lu, Andersen, Nyamathi, Morgenstern, & Browner, 2002; Gelberg et al., 2004; Gelberg, Lu, Leake, Andersen, Morgenstern, & Nyamathi, 2008; Killion, 1998; Pauly et al., 2009; Reid et al., 2005; Wenzel, Leake et al., 2001).

I used Walker and Avant's (1995) five step model to delineate the defining characteristics or attributes of the concept script was utilized in order to learn more about this concept in relation to the behaviours and beliefs of a marginalized population of women. I developed this concept analysis to produce an enhanced understanding of social scripts and, how this concept might shed light as to how women within this vulnerable population could achieve equity in their sexual health. If as Wiederman (2005) suggests, that social scripts provide guidance for women in relation to gender-appropriate actions and reactions in relation to sexually related scenarios, then enhancing our understanding seems appropriate and potentially helpful. It was anticipated that social scripts—as a director or modifier of behaviour and decision-making may have provided insight and a greater understanding in regards to assisting women who experience

poverty, homelessness, and drug use achieve a greater level of sexual health and access to health care. However, an analysis of the concept of scripts appears to have provided a lens that is more individually focused and perhaps provides a basis upon which to work with women individually.

Social scripts may be a driving force in the decision processes and activities in relation to living within the context of poor socio-economic constraints. However, social scripts do not appear able to change the social and structural inequities that are imposed by institutions and individuals. This population of women therefore are forced to utilize or modify their scripts to attempt to fit with a social philosophy and model of care that creates many barriers.

Equitable health care access refers not only to the availability of health care services, but also availability of *appropriate* health care services (Marmot, 2007; McGibbon et al., 2008). The health care system in Canada enacts policies and provides services that are "tailored to the Eurocentric cultural beliefs on health and illness of the 'two founding peoples' [English and French populations of Canada]..." (Racine, 2003, p. 93). The dominant organizational values found within most Canadian health care centres is lacking with respect to their ethical mandates to provide care that is equitable and just to all—including those who have been marginalized and are drug users (Ensign & Panke, 2002; Gelberg et al., 2004).

The purpose of this concept analysis was to gain clarity on the concept of scripts in the hope of building understanding for nurses who provide care and services for the population of women who are experiencing poverty and substance use. What has been discovered is that while people within a population may base their actions and beliefs on internal, interpersonal, and cultural based scripts, script theory may not provide an answer to the broader issue of incongruent relational processes. Perhaps equally important is that health care providers and health care policy makers analyze their own scripts and endeavour to create new scripts in this

culture of health inequities and inequitable health care access. Nurses and other health care professionals must be encouraged to consciously think about vulnerable populations; people seeking help and who require care and respect. Health care should be provided it in a more holistic manner with the knowledge that each person may be enacting their own social script while trying to maneuver our complex and unjust structural and social system.

In a recent study, McCall and Pauly (2012) identified one holistic method of providing care that may encourage nurses and other health care workers to seek a deeper understanding of culture—to realize that culture is much more than the ethnic traditions and practices that one associates with different societies but is the very culture of health care itself. Culture includes the "relational process with accompanying power differences"; and is contextualized by meanings and variables related to history, social structure, economics, and political practices (McCall & Pauly, 2012, p. 133). Relational processes refer to "not only the interpersonal processes but also to the organizational and systemic processes that produce structural inequities" (McCall & Pauly, 2012, p. 133).

The concept of cultural safety prompts nurses to be cognizant of the relational processes and reflect on the health care provider and organizational practices that impact the care of each person. McCall and Pauly (2012) explain that nursing care that is culturally safe "allows us to form a relationship with patients that is based on the values and beliefs that each patient holds as an individual" and equally important, "the service user is given the power to say when he or she feels that an encounter is safe or unsafe" (p. 134).

Conclusion

According to Walker and Avant (1995), the process of concept analysis can positively contribute to the development of nursing theory. A concept analysis will assist in providing

clarification of ideas and terms in existing theory, as well as provide operational definitions and the underlying attributes of a concept. Furthermore, a concept analysis has proven to be useful in the development of nursing language, in nursing education and nursing practice (Walker & Avant, 1995).

Walker and Avant's (1995) method of concept analysis was used to develop a more in-depth understanding of the meaning of the term 'scripts' from the main concept of 'social scripts'. In nursing, where the meaning of script differs from that which is found in sociology, and the wider society, there is need to analyse and clarify the concept to discover consistency of meaning and understanding (Cronin et al., 2009). The concept of scripts was analyzed with the hope that a further dimension of understanding in relation to the lives of women disadvantaged by poverty, homelessness, and substance use would be realized.

Traditionally, health inequities and inequities in relation to health care access have been attributed to individualistic behaviours (Link & Phelan, 1995). Contemporary public health discourse now asserts that while the role of the individual is important, it must be observed through a wider social context, one that is largely determined by a broad base of social factors (Link & Phelan, 1995; Marmot, 2007; Pauly et al., 2009). If social factors include everything from intimate relationships at the personal level, to a persons' situatedness within the social and economic structure of society, then social scripts are important to analyze in the attempt to build understanding achieving sexual health equity and equitable health care access within this population of women.

Social scripts may provide a further depth of understanding to the personal beliefs and behaviours of women who have been marginalized due to poverty, homelessness, and drug use. An understanding of social scripts can be useful for nurses in order to examine their own social

scripts in relation to their beliefs and actions in providing care to women who are disadvantaged. When working with women on an individual basis, nurses are in an excellent position to understand and assist these women in strengthening their current social scripts and/or in developing alternative social scripts. Social scripts may be helpful on an individual basis to bridge the gap between the care that is required, that each person is entitled to, and the care that is commonly described in research (Pauly et al., 2009; McCall & Pauly, 2012; Christiani et al., 2008).

Knowledge of social scripts may provide further understanding in relation to providing care to women disadvantaged by poverty. However, social scripting is an individual approach and does not necessarily address the broader structural determinants of health. Health care providers, health care administrators, and politicians should consider cultural safety where the emphasis is on the culture of health care and the environment in which care is provided. Providing care from a position of cultural safety while being mindful of the individual social scripts that guide individual women will promote care that is based on the values and beliefs of the patient and in a manner that is safe, therapeutic, and respectful.

References

Beiser, M., & Stewart, M. (2005). Reducing health disparities: A priority for Canada. *Canadian Journal of Public Health, 96*, S4-S5.

Billings, D.M., Kowalski, K., & Smith, C.M. (2011). Scripts: A tool for cognitive rehearsal. *The Journal of Continuing Education in Nursing, 42,* 535-536.

Browne, A.J., & Fiske, J. (2001). First Nation's women's encounters with mainstream health care services. *Western Journal of Nursing Research, 23,* 126-147. doi: 10.1177/019394590102300203.

Bungay, V., Johnson, J. L., Varcoe, C., & Boyd, S. (2010). Crack cocaine in context: Structural and 'everyday' violence. *International Journal of Drug Policy, 21,* 321-329.

Bungay, V., Kolar, K., Thindal, S., Remple, V. P., Johnston, C. L., & Ogilvie, G. (2013). Community-based HIV and STI prevention in women working in indoor sex markets. *Health Promotion Practice, 14,* 247-255. doi: 10.1177/1524839912447189.

Charlin, B., Boshuizen, H.P.A., Custers, E.J., & Feltovich, P.J. (2007). Scripts and clinical reasoning. *Medical Education, 41,* 1178-1184.

Cherney, L.R., Halper, A.S., Holland, A.L., & Cole, R. (2008). Computerized script training for aphasia: preliminary results. *American Journal of Speech-Language Pathology, 17,* 19-34.

Chettiar, J., Shannon, K., Wood, E., Zhang, R., & Kerr, T. (2010). Survival sex work involvement among street-involved youth who use drugs in a Canadian setting. *Journal of Public Health*, 32, 322-327. doi:10.1093/pubmed/fdpl26.

Cheung, A.M., & Hwang, S.W. (2004). Risk of death among homeless women: a cohort study and review of the literature. *Canadian Medical Association Journal, 13,* 1243-1247.

Christiani, A., Hudson, A., Nyamathi, A., Mutere, M., & Sweat, J. (2008). Attitudes of homeless and drug-using youth regarding barriers and facilitators in delivery of quality and culturally sensitive health care. *Journal of Child and Adolescent Psychiatric Nursing, 21,* 154-163.

Cockerham, W.C. (2005).Health lifestyle theory and the convergence of agency and structure. *Journal of Health and Social Behaviour, 46,* 51-67. doi: 10.1177/002214650504600105.

Cronin, P., Ryan, F., & Coughlan, M. (2010). Concept analysis in healthcare research. *International Journal of Therapy and Rehabilitation: Research Methodology Series, 17,* 62-68.

Daiski, I. (2005). The health bus: Healthcare for marginalized populations. *Policy politics nursing practice, 6,* 30-38.

Davies, Elisabeth. (2008). The script as mediating artifact in professional theatre production. *Archival Science, 8,* 181-198.

Duncan, C., Cloutier, J.D., & Bailey, P.H. (2007). Concept analysis: the importance of differentiating the ontological focus. *Journal of Advanced Nursing 58*(3), 293–300. doi: 10.1111/j.1365-2648.2007.04277.x

East, L., Jackson, D., O'Brien, L., & Peters, K. (2011). Condom negotiation: experiences of sexually active women. *Journal of Advanced Nursing, 67,* 77-85. doi: 10.1111/j.1365-2648.2010.05451.x.

Egan, C., & Gardner, L. (2005). Racism, women's health, and reproductive freedom. In V. Zawilski & C. Levine-Rasky (Eds.), *Inequality in Canada: A reader on the intersections of gender, race, and class* (pp. 241-251). Don Mills, ON: Oxford University Press.

Ensign, J. (2000). Reproductive health of homeless adolescent women in Seattle, Washington, USA. *Women & Health, 31*, 133-151.

Ensign, J. (2001). "Shut up and listen": Feminist health care with out-of-the-mainstream adolescent females. *Issues in Comprehensive Pediatric Nursing, 24*, 71-84.

Ensign, J., & Panke, A. (2002). Barriers and bridges to care: voices of homeless female adolescent youth in Seattle, Washington, USA. *Journal of Advanced Nursing, 37*, 166-172.

Firth, H. & Kitzinger, C. (2001). Reformulating sexual script theory: Developing a discursive psychology of sexual negotiation. *Theory & Psychology, 11,* 209-232.

Frankish, J.C., Hwang, S.W., & Quantz, D. (2005). Homelessness and health in Canada: Research lessons and practice. *Canadian Journal of Public Health, 96,* S23-S29.

Gioia, D.A. & Poole, P. P. (1984). Scripts in organizational behavior. *The Academy of Management Review, 9,* 449-459.

Gelberg, L., Browner, C.H., Lejano, E., & Arangua, L. (2004). Access to women's health care: A qualitative study of barriers perceived by homeless women. *Women & Health, 40*, 87-100.

Gelberg, L., Leake, B., Lu, M. C., Andersen, R., Nyamathi, A. M., Morgenstern, H., & Browner, C. (2002). Chronically homeless women's perceived deterrents to contraception. *Perspectives on Sexual and Reproductive Health, 34*, 278-285.

Gelberg, L., Lu, M. C., Leake, B. D., Andersen, R. M., Morgenstern, H., & Nyamathi, A. M. (2008). Homeless women: Who is really at risk for unintended pregnancy? *Maternal & Child Health Journal,* 12, 52-60.

Goldberg, S., Haley, K. L., & Jacks, A. (2012). Script training and generalization for people with aphasia. *American Journal of Speech-Language Pathology, 21,* 222-238.

Gondek, M.C. (1999). Talking about sex: A post-MI script. *RN, 62,* 52-54.

Greenwood, J. (2000). Critical thinking and nursing scripts: the case for the development of both. *Journal of Advanced Nursing, 31,* 428-436.

Hanson, R.S. (1985). Ancient scribes and scripts and the clues they leave. *The Biblical Archaeologist, 48,* 83-88.

Holland, J., Ramazonoglu, C., Sharpe, S., & Thomson, R. (1992). Pleasure, pressure and power: some contradictions of gendered sexuality. *The Sociological Review, 40,* 645-674.

Huey, L. & Berndt, E. (2008). 'You've gotta learn how to play the game': homeless women's use of gender performance as a tool for preventing victimization. *The Sociological Review, 56,* 177-194.

Hwang, S.W. (2001). Homelessness and health. *Canadian Medical Association Journal, 164*, 229-233.ollar, I., Fischer, F., & Hesse, F.W. (2006). Collaboration scripts – A conceptual analysis. *Educational Psychology Review, 18,* 159-185.

Hwang, S.W., Ueng, J. J. M., Chiu, S., Kiss, A., Tolomiczenko, G., Cowan, L., Levinson, W., & Redelmeier, D. A.. (2010). Universal health insurance and health care access for homeless persons. *American Journal of Public Health, 100*, 1454-1461.

Khandor, E., Mason, K., Chambers, C., Rossiter, K., Cowan, L., & Hwang, S.W. (2011). Access to primary health care among homeless adults in Toronto, Canada: results from the Street Health survey. *Open Medicine, 5,* E94-E103.

Killion, C. M. (1998). Poverty and procreation among women: An anthropologic study with implications for health care providers. *Journal of Nurse-Midwifery, 43*, 273-279.

Kollar, I., Fischer, F., & Hesse, F.W. (2006). Collaboration scripts – A conceptual analysis. *Educational Psychology Review, 18,* 159-185.

Link, B., & Phelan, J. (1995). Social conditions as fundamental causes of disease. *Journal of Health and Social Behaviour, 35,* 80-94.

Link, B., & Phelan, J. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27,* 363-385.

Lord, R.G. & Kernan, M. C. (1987). Scripts as determinants of purposeful behaviour in organizations. *The Academy of Management Review, 12,* 265-277.

Marmot, M. (2007). Achieving health equity: from root causes to fair outcomes. *Lancet, 370,* 1153-1163. doi: 6736(07)61385-3.

Marshall, B.D.L., Kerr, T., Shoveller, J.A., Patterson, T.L., Buxton, J.A., & Wood, E. (2009). Homelessness and unstable housing associated with an increased risk of HIV and STI transmission among street-involved youth. *Health & Place, 15,* 783-790.

McCall, J. & Pauly, B. (2012). Providing a safe place: Adopting a cultural safety perspective in the care of aboriginal women living with HIV/AIDS. *CJNR, 44,* 130-145.

McGibbon, E., Etowa, J., & McPherson, C. (2008). Health-care access as a social determinant of health. *The Canadian Nurse, 7,* 23-26.

Meech-Pekarik, J. (1977/1978). Disguised scripts and hidden poems in an illustrated Heian Sutra: Ashide and Uta-E in the Heike Nogyo, *Archives of Asian Art, 31,* 52-78.

Merriam-Webster Dictionary. (2013) In *Merriam-Webster Dictionary.* Retrieved from http://www.merriam-webster.com/dictionary/script.

Munhall, P. (2010). The landscape of qualitative research in nursing. In P. Munhall (Ed.), *Nursing research: A qualitative perspective (*5th ed., pp. 3-33). Sudbury, MA: Jones & Bartlett.

Ousterhout, J.K. (1998). Scripting: higher level programming for the 21st Century. *Computer, 31,* 23-30.

Oxford English Dictionary. (2013). In *Oxford English Dictionary.* Retrieved from http://www.oed.com.ezproxy.library.uvic.ca/search?searchType=dictionary&q=script&_searchBtn=Search.

Paley, J. (1996) . How not to clarify concepts in nursing. *Joumal of Advanced Nursing 24*, 572-578.

Pauly, B. (2008). Harm reduction through a social justice lens. *International Journal of Drug Policy. 19*, 4-10.

Pauly, B. M., MacKinnon, K., & Varcoe, C. (2009). Revisiting “who gets care?” Health equity as an arena for nursing action. *Advances in Nursing Science. 32*, 118-127.

Palepu, A., & Tyndall, M.W. (2005). Providing health services to marginalized urban populations. In S. Galea, & D. Vlahov (Eds.), *Handbook of urban health populations, methods, and practice* (pp. 561-571). New York, NY: Springer Science & Business Media Inc.

Racine, L. (2003). Implementing a postcolonial feminist perspective in nursing research related to non-Western populations. *Nursing Inquiry, 10*, 91-102.

Raphael, D. (2004). Social determinants of health. In: Raphael D, ed. *Social Determinants of Health: Canadian Perspectives*. 1–18. Toronto, Ontario: Canadian Scholar's Press Inc.

Reid, S., Berman, H., & Forchuk, C. (2005). Living on the streets in Canada: A feminist narrative study of girls and young women. *Issues in Comprehensive Pediatric Nursing, 28*, 237-256.

Rew, L., Fouladi, R. T., & Yockey, R. D. (2002). Sexual health practices of homeless youth. *Journal of Nursing Scholarship, 34*(2), 139-145.

Risjord, M. (2009). Rethinking concept analysis. *Journal of Advanced Nursing, 65,* 684-691.

Rodgers, B. L. (1989). Concepts, analysis and the development of nursing knowledge the evolutionary cycle. *Journal ofAdvanced Nursing. 14*, 330-335.

Rogers, B.L. (2005). *Developing nursing knowledge: Philosophical traditions and influences.* Philadelphia, PA: Lippincott Williams & Wilkins.

Roget's Thesaurus (2013). In *Roget's Thesaurus*. Retrieved from http://thesaurus.com/browse/script?page=2&qsrc=121.

Shannon, K., Kerr, T, Strathdee, S. A., Shoveller, J., Montaner, J. S., & Tyndall, M. W. (2009). Prevalence and structural correlates of gender based violence among a prospective cohort of female sex workers. *BMJ: British Medical Journal (Overseas & Retired Doctors Edition),* 339, 442-445.

Simon, W. & Gagnon, J.H. (1986). Sexual scripts: Permanence and change. *Archives of Sexual Behaviour, 15,* 97-120.

Simon, W. & Gagnon, J.H. (2003). Sexual scripts: Origins, influences and change. *Qualitative Sociology, 26,* 491-497.

Spittal, P.M., Hogg, R.S., Li, K., Craib, K.J., Recsky, M., Johnston, C., Montaner, J.S.G., Schechter, M.T., & Wood, E. (2006). Drastic elevations in mortality among female injection drug users in a Canadian setting. *AIDS Care, 18,* 101-108.

Spronck, P., Sprinkhuizen-Kuyper, I., & Postma, E. (2004). *Entertainment computing – ICEC 2004: Enhancing the performance of dynamic scripting in computer games*. Retrieved from http://www.springer.com/978-3-540-22947-6

Taylor, B.M. (1995). Gender-power relations and safer sex negotiation. *Journal of Advanced Nursing, 22,* 687-693.

VANDU Women CARE Team (2009). "Me, I'm living it" The primary health care experiences of women who use drugs in Vancouver's downtown eastside: Summary of findings from the VANDU WOMEN'S CLINIC ACTION RESEARCH FOR EMPOWERMENT (VANDU) Women CARE) Study. Retrieved from: http://www.bccewh.bc.ca/publications-resources/documents/MeImLivingit.pdf

Walker, L.O. & Avant, K.C. (1995). *Strategies for theory construction in nursing.* Norwalk, CT: Appleton & Lange.

Wenzel, S. L., Andersen, R. M., Gifford, D. S., & Gelberg, L. (2001). Homeless women's gynecological symptoms and use of medical care. *Journal of Health Care for The Poor and Underserved, 12*, 323-341.

Wenzel, S.L., Koegel, P., & Gelberg, L. (2000). 'Antecedents of physical and sexual victimization among homeless women: A comparison to homeless men'. *American Journal of Community Psychology, 28,* 367-390.

Wenzel, S.L., Leake, B.D., & Gelberg, L. (2000). Health of homeless women with recent experience of rape. *Journal of General Internal Medicine, 15*, 265-268.

Wenzel, S.L., Leake, B.D., & Gelberg, L. (2001). ‘Risk factors for major violence among homeless women’. *Journal of Interpersonal Violence, 16*, 739-752.

Whitehead, M. & Dahlgren, G. (2006). *Concepts and principles for tackling social inequities in health: Levelling up Part 1.* WHO Regional Office for Europe, Copenhagen, Retrieved from: http://www.enothe.eu/cop/docs/concepts_and_principles.pdf October 31, 2013.

Wiederman, M. W. (2005). The gendered nature of sexual scripts. *The Family Journal: Counselling and Therapy for Couples and Families, 13,* 496-502. doi: 10.1177/1066-480705278729.

World Health Organization. (2013). *WHO / Lexicon of alcohol and drug terms* Retrieved from http://www.who.int/substance_abuse/terminology/who_lexicon/en/

Youmans, G., Youmans, S.R., & Hancock, A.B. (2011). Script training treatment for adults with apraxia of speech. *American Journal of Speech-Language Pathology, 20,* 23-37.