

MARTHA RAILE ALLIGOOD

5
EDITION

Nursing Theory

UTILIZATION & APPLICATION

ELSEVIER

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UTILIZATION & APPLICATION

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3251 Riverport Lane
St. Louis, Missouri 63043

Nursing Theory: Utilization and Application, ed 5

ISBN: 978-0-323-09189-3

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Library of Congress Cataloging-in-Publication Data

Nursing theory (2013)

Nursing theory: utilization & application / [edited by] Martha Raile Alligood. –Fifth edition.

p. ; cm.

Includes bibliographical references and index.

ISBN 978-0-323-09189-3 (pbk.)

I. Alligood, Martha Raile, editor of compilation. II. Title.

[DNLM: 1. Nursing Theory. 2. Models, Nursing. 3. Philosophy, Nursing. WY 86]

RT84.5610.7301–dc23

2013010390

Senior Content Strategist: Yvonne Alexopoulos

Associate Content Development Specialist: Emily Vaughters

Publishing Services Manager: Jeff Patterson

Project Manager: Jeanne Genz

Design Direction: Karen Pauls

Printed in the United States

Last digit is the print number: 9 8 7 6 5 4 3 2 1



To my grandchildren,
Hunter Kent, Charlie Nicholas, John Kent Jr.,
Raymond Charles, and Kendall Lynn Alligood,
who are very special to me.

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Preface

The first edition of this book was developed to provide a text that demonstrated the theory-practice relationship and illustrated how theory guides nursing practice. The second edition added 10 new chapters and expanded the professional premises of the first edition. The third edition updated each chapter and set forth the following three areas: the explicit value of theoretical knowledge for professional nursing practice, the widespread recognition of middle-range theory as practice theory, and the theory utilization era as significant in nursing history. The fourth edition, like each of the previous editions, was designed to demonstrate to faculty and students how nursing philosophies, models, and theories (and particularly middle-range theories) guide the critical thinking and decision making of professional nursing practice and therefore is especially applicable in clinical practice courses. This updated fifth edition continues to demonstrate utility and applicability for professional nursing practice. It is useful in courses that introduce students and new nurses to the theories of the discipline of nursing, as well as in those that address the nature of nursing thought and action, and those that emphasize the processes of patient care. This text illuminates the role of theory in theory-based nursing practice for nursing programs, in-service education programs for nursing staff development, and especially advanced practice nursing courses in master's and doctor of nursing practice (DNP) programs.

Nursing Theory: Utilization & Application illustrates the role of theory for patient-focused nursing. It serves as a companion text for *Nursing Theorists and Their Work*, eighth edition, by Martha Raile Alligood, which provides a more comprehensive overview of the history and development of nursing's theoretical works. As a companion text, *Nursing Theory: Utilization & Application*, fifth edition, leads the reader beyond an introduction to the nurse theorists and their works to an understanding of praxis, as the purpose of theory in professional nursing practice is illustrated with patient-focused care of patients. Therefore, this text exposes the structure and purpose of theory with explanations and case applications from actual nursing practice, written by authors with expertise in the use a particular theory in their professional practice. The content of the book is presented in three parts.

Part I, Conceptualization, provides background and context for the major premise of the text, which is the essential nature of theory application for professional nursing practice. Chapter 1 sketches the history of more than a century of nursing profession development that brought us through eras of nursing history to the current theory utilization era. It is proposed that the quest for nursing knowledge on which to base nursing practice has been the criterion of a profession and driving force that shaped the nursing profession. Chapter 2 presents the major nursing models and theories with interpretations of "normal science" according to Kuhn's (1970) criteria. An extensive bibliography leads the reader to research

literature reporting theory-based nursing practice applications, with tables that illustrate its wide use. Chapter 3 presents philosophies, models, theories, and middle-range theories and the relationship among them in a “structure of knowledge” and as critical thinking structures for the thought and action of nursing practice. A guide is presented in Chapter 3 to help students select a model to guide their practice. Chapter 4 is a unique feature of this text that has been highly acclaimed. The chapter is developed by a nurse ethicist who presents the moral obligations inherent in nursing philosophies, models, and theories and theory-based nursing practice.

Part II, Application, is the “heart and soul” of the text. The 16 chapters (Chapters 5 through 20) present philosophies, models, and theories as critical thinking structures, illustrating how they guide the thought and action of nursing practice with application in case presentations. These chapters are written by advanced practice nurses with expertise in clinical knowledge of the philosophy, model, or theory on which they write. Another unique feature of this text is the development of the plan of care for two cases that illustrate actual guidance by the philosophy, model, or theory with the case of “Debbie” and a case from the author’s own practice. (The theory is not applicable in Chapter 17, which presents pregnancy). Each chapter in Part II concludes with Critical Thinking Exercises. Those who use the text report many uses for the exercises, such as posting as weekly discussion threads for online theory course instruction or selecting a certain exercise for class discussion or a clinical conference. The exercises are included to provide additional experiences of application and facilitate student understanding of the unique characteristics of each philosophy, model, or theory.

Part III, Expansion, features two chapters. Chapter 21 presents areas for more theory-based nursing practice applications to be used in research and practice and documented in the nursing literature. Tables are presented that are mirror images of the tables in Chapter 2. Many of the blank areas have been filled in from literature reporting on expanding use of theory in nursing practice. The tables point out the areas where opportunities still exist to document theory-based nursing practice. Examples of middle-range nursing theories derived from nursing models are presented, with suggestions that illustrate how the details of nursing practice combines to form the shell for middle-range nursing theory development, such as nursing actions, patient/client population, area of practice, and nursing intervention. Chapter 22 highlights the essential nature of theory-based nursing practice for the discipline and continued professional development. This chapter addresses contemporary nursing practice issues of safety and quality in relation to theory use and recognizes the patterns of knowing (empirical, esthetic, ethical, personal, and sociopolitical) as types of theory.

Special Features

- Logical organization that flows: past history to present practice applications and the future
- Relates nursing thought and action to nursing praxis
- Presents a chapter on moral obligations inherent in theory-based nursing practice
- Utilization of 16 nursing philosophies, models, theories, and middle-range theories

- Application of cases that illustrate theory-based, patient-focused nursing practice
- Comparison of nursing applications in 15 theoretical works with the case of “Debbie”
- Illustrates how knowledge structure levels address critical thinking and decision making
- Critical thinking exercises at the end of application chapters foster experiential learning
- A glossary of terms provides deeper understanding for student development

This fifth edition is an exciting and useful text I have developed for teaching students how to understand and practice theory-based nursing. The current emphasis on safety and quality makes patient-focused care and utilization of theoretical works of nursing even more important for the professional practice of nursing. The role of nursing theory in praxis, critical thinking and decision making for nursing practice are the hallmark of this text. Nursing faculty who want to take their students beyond learning about the theorists and contemplation of theory to its application will find that this text guides students in using nursing approaches that are clear and direct, giving guidance to achieve that quality practice outcome.

Faculty and students at all levels of nursing have reported that this text was vital to increasing their understanding of theory-based practice. Faculty said that this text improved the quality of their undergraduate teaching by clarifying their communication about theory to students. It helped them teach students how theory guides nursing thought and action. A student in a master’s program said, “I have been a nurse for 7 years, and your text has helped me learn what it really means to be a nurse and not just a helper of physicians.” Doctoral students report that the text helped them understand the nature of middle-range theory from a knowledge structure perspective and to develop their dissertation research ideas into a testable middle-range theory. This feedback and published reviews of the text have served as evidence for me to understand the utility of the text for faculty and students of all levels of nursing. I salute them (faculty, students, and practicing nurses) in their efforts to learn nursing and improve patient care, and I offer this fifth edition for their continued growth.

Acknowledgments

I would like to thank the staff at Elsevier for their work and support on this new fifth edition. This text would not be possible without the contributions of the application chapters by the expert authors. I am humbled by their knowledge and offer heartfelt thanks and appreciation to each of them. A special thank-you to Dr. Kenneth D. Phillips, who developed the case of Debbie from his practice for the first edition of the text; its usefulness continues.

Finally, I continue to thank to my colleague and mentor Ann Marriner Tomey, who many years ago saw authorship of a nursing theory textbook focused on application of theory in practice in me when I didn’t see it myself and challenged me to design this text. After I did so she invited me to be co-author/editor of *Nursing Theorists and Their Work* from the fourth through seventh editions. She has been a dear mentor and colleague and I continue to wish her the very best in her retirement.

Martha Raile Alligood

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PART

I

Conceptualization

The following conceptualizations provide the context for the premises of this text:

- Nursing's long search for a substantive body of knowledge led to the development and discovery of nursing science for quality professional practice in the twenty-first century.
- Applications of conceptual models of nursing and nursing theories produce evidence of "normal science" for the thought and action of professional nursing practice (praxis).
- Theory utilization and application publications are increasing in all areas of nursing practice.
- Nursing's theoretical works, philosophies, models, and theories specify approaches to practice that generate positive patient outcomes and satisfaction for practicing nurses.
- The empirical, esthetic, ethical, personal and sociopolitical knowledge needed for evidence-based nursing practice is in nursing works: philosophies, conceptual models, and theories.
- Nursing's theoretical works include values that specify the moral and ethical obligations inherent in the work.
- Evidence indicates that this is the "theory utilization era" of nursing history.



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The Nature of Knowledge Needed for Nursing Practice

Martha Raile Alligood

The systematic accumulation of knowledge is essential to progress in any profession... however, theory and practice must be constantly interactive. Theory without practice is empty and practice without theory is blind.

(Cross, 1981, p. 110)

This chapter highlights developments in nursing history that advanced nursing toward the goal of substantive knowledge for practice and recognition of nursing as an academic discipline and a profession. The historical achievements by nursing leaders are reviewed in successive eras toward the challenge of developing a body of substantive knowledge to guide nursing practice. The significance of these achievements may be better understood when considered in relation to the challenges the nurses faced in the eras of the twentieth century. Factors are emphasized within each era of this brief history that contributed to progress toward substantive knowledge and recognition of nursing as a discipline and a profession. In this twenty-first century, many nurses understand the vital role of conceptual and theoretical knowledge structures for quality nursing practice and nursing research. We have theoretical structures that provide nurses with a patient focus and frameworks to identify and interpret patient data for evidence-based practice. Whereas nursing had been understood as an art and a science, the theory era strengthened understanding of the vital nature of coordinated thought and action in practice now referred to by many as nursing praxis. Praxis is descriptive of knowledge-guided action and action-guided theory (Chinn & Kramer, 2011; Kagan, 2009; Kilpatrick, 2008). This understanding of the theory, research, and practice relationships is different from earlier nursing eras, when they were

considered separately. Today their interrelationships are better understood, that is, the vital nature of theory-research and theory-research-practice relationships. Given the challenges nursing faces today, disciplinary thought and action in the utilization of theoretical works is vital for professional nursing practice.

Early in the twentieth century nurses recognized the need to establish nursing as a profession and began the transition from vocation to profession (Alligood, 1997, 2010; Judd, Sitzman, & Davis, 2010; Kalisch & Kalisch, 2004; Meleis, 2007; Rogers, 1961). Guided by the words of Florence Nightingale and the goal of professionalism, American nurses began entering academia, first in individual courses and finally in collegiate nursing programs. This movement toward professionalism provides a context to understand the eras as nursing's march toward achievement of a body of nursing knowledge.

Despite different emphases in each era, one criterion became a constant force—the one specifying that nursing practice be guided by a body of specialized knowledge (Bixler & Bixler, 1959): the criterion for specialized nursing knowledge and transition from vocation to profession. Today that criterion calling for recognition of a specialized body of knowledge for nursing practice is more relevant than ever as the discipline of nursing embraces challenging changes in society and health care.

Reviewing some of the efforts that were made to address the criterion helps us understand the struggles of these eras and demonstrates how events led us back to practice as nursing's central concern. Nursing's answer to the question of the nature of knowledge needed for the practice of nursing is viewed as a driving force that has shaped our profession. Their drive for nursing knowledge led nurses and student nurses in directions that, although unclear and not fully understood at times, contributed to recognition of nursing as a learned profession.

Eras of Nursing Knowledge

As the beginning of the twentieth century drew near, nurses began to express the need for communication with other nurses to improve their practice. Signs of a national consciousness for nursing may be seen in the first national gathering of nurses at the World's Fair in Chicago in 1893 and in the publication of the first edition of the *American Journal of Nursing (AJN)*, the first national organ of communication for nurses, in October 1900 (Kalisch & Kalisch, 2004). These initial efforts by nurses began the transition toward a profession. At this early time the focus was clearly on practice and on teaching the practice of nursing to students. There was recognition of the need for specialized knowledge to guide the practice of nursing from the beginning. *AJN* was one early symbol of nursing's movement toward professional status, and another was their need to communicate with other nurses about their practice and about teaching nursing. With the boom of the industrial age, hospital training schools flourished as America grew, and the curriculum era of the 1900s to the 1940s followed (Judd, et al., 2010; Kalisch & Kalisch, 2004).

Curriculum Era: The 1900s to the 1940s

In the curriculum era, evidence of efforts to understand what knowledge was needed for the practice of nursing led to an emphasis on curricular content and

progression toward standardizing curricula. The focus of this era was evident in state activities such as the 1933 curriculum survey of New York training schools (Kalisch & Kalisch, 2004). This emphasis on what nurses needed to know to practice nursing led to an expansion of curricula beyond physiological and pathophysiological knowledge to include social sciences, pharmacology, and formal classes on nursing procedures (Judd, et al., 2010). It is interesting to note that courses to teach content were called *fundamentals*, a term that means “basic essentials,” and that the term is still used in nursing education today. This early appreciation of essential content specific to nursing action and beyond knowledge of the illness of the patient is an observation that is pertinent to the progress of this era. The differences between the medical view of the patient and those of the nurse were obvious in these developments, as had been emphasized by Nightingale (1946).

It is also interesting to note that nursing procedures were taught in class and practiced in large wardlike rooms called “nursing arts” laboratories. Reference to the art of nursing was common in this era. In later decades, with the research and science emphasis in nursing curricula, these rooms came to be referred to as “skills or simulation labs.” The change in terminology may be related to nursing’s movement into colleges and universities and the transition from vocational nurse training to professional nursing education with emphasis on science. The discipline of nursing is indebted to those scholars who maintained a focus on the art of nursing as science gained popularity (Judd, et al., 2010; Kalisch & Kalisch, 2004).

Nursing curricula taught mostly in diploma programs in this era became standardized and some nurses began to seek higher education courses related to nursing in colleges and universities. The idea of developing nursing programs in colleges and universities soon followed. The transition of nursing into schools of higher learning brought with it a significant change in the search for a substantive body of knowledge. Those nurses introduced to research process began to recognize and write about its value as an essential process for the progression toward a body of substantive knowledge (Kalisch & Kalisch, 2004), leading to the research era.

Research Era: The 1950s and the 1970s

In the 1950s, research emerged as a beginning force. Nurses were encouraged to learn how to conduct research, developing the role for nurses for that specialized body of knowledge. The task of embracing this new content was so great that rather than being a means to an end it often became an end in itself. Learning to conduct research led to an emphasis on statistics and research methods introduced as new curriculum areas in baccalaureate programs. The general level of understanding was such that some thought just by conducting research, the body of knowledge would be formed as a basis for practice.

This era saw the development of scholarship and the dissemination of early research findings. *Nursing Research*, the first nursing research journal, was established for this purpose in 1952. In addition, two programs funded by the federal government were instituted in 1955 to prepare nurses as researchers and teachers of research—the U.S. Public Health Service predoctoral research fellowships and the Nurse Scientist Training Program (Schlotfeldt, 1992).

This development began a major shift that affected all levels of nursing. Nurses had to consider what that change in nursing education meant with regard to their level of nursing preparation, and the question of the nature of the knowledge needed for nursing practice persisted.

Selection of nursing education programs for potential students was difficult at this time. Although the transition of nursing education into schools of higher learning was a key development for the nursing profession, the effects of that transition are still felt today in debates about multiple levels of nursing education and the failure to establish differentiated practice.

The research and graduate education eras overlap, as other reviewers have noted (Judd, et al., 2010; Meleis, 2007; Styles, 1982). The developments in research influenced nursing education, emphasizing graduate education with nursing research courses. Emphasis on faculty nursing scholarship during the research and graduate education eras undoubtedly contributed to their interrelationship, as well as the close ties of knowledge and research. Master's programs were being introduced in universities across the country and nursing knowledge or concept development courses were being taught and emphasized in most programs, along with introductory courses in the research process by the late 1950s and early 1970s.

Graduate Education Era: The 1950s and the 1970s

During the graduate education era, curricula for master's-level preparation were becoming standardized through accreditation that most schools were seeking by the National League for Nursing (NLN). Nurse educators came together at national meetings where accreditation criteria were approved. By the end of the 1970s, most accredited master's programs included courses in nursing research, clinical specialty practice, leadership, and concept development or nursing theory in a core curriculum organized with a nursing philosophy and conceptual or organizing framework. A major task of this era was carving out a role in health care for the master's-prepared nurses who were graduating.

Only three nursing doctoral programs existed at the beginning of this era, and the federally funded programs established in the 1950s as a result of the post-World War II shortage of nurses were still in place. Nurses were being prepared for research and teaching roles in nursing with doctorates in education and a range of related science disciplines. The American Nurses Association (ANA) set forth the need for nursing theory development in 1965; however, there were various perceptions among nursing leaders as to what that meant because most had advanced degrees from various disciplines and perspectives of knowledge and theory.

During this era a series of national conferences united nurses to exchange ideas and evaluate knowledge obtained from non-nursing doctoral programs that could address nursing's knowledge-building needs. The papers and discussions from these conferences were published in *Nursing Research* in 1968 and 1969 and were republished by Nicoll (1986) in her first edition under the unit heading *Three Landmark Symposia* (p. 91). Those conferences centered on nursing science and theory development and facilitated discussion of the application of knowledge from the various disciplines in nursing. The Nurse Scientist Training Program is noteworthy in this history because that program addressed the question of the nature of the

body of nursing knowledge—that is, will nursing be based on applied knowledge from other disciplines or nursing science? Dealing with this question was a major turning point in nursing history regarding graduate nursing education because it led to the realization that the nature of knowledge needed for nursing practice was nursing knowledge. Doctoral education in nursing began to flourish, and by the late 1970s, 21 nursing doctoral programs existed and several more universities indicated intent to develop programs. A driving force in this era was the need for nursing knowledge and an awareness that the knowledge should be developed by nurses prepared in the discipline of nursing. It is not surprising that recognition of the difference between nursing knowledge and borrowed knowledge surfaced in the nursing literature at this time (Johnson, 1968). This differentiation emerged from recognition that theory from other disciplines was specific to that discipline and not specific to nursing (Johnson, 1968; Rogers, 1970). Rogers (1970) reasoned that nurses needed to clarify the phenomenon of concern for the discipline and use frameworks that addressed nursing's phenomenon of concern to frame their research and develop nursing knowledge. Rogers (1970) specified people and their environment as nursing's concern.

It was during this era that early versions of nursing frameworks began to be published. The works by Johnson (1974, 1980), King (1971), Levine (1967), Neuman (1972), Orem (1971), Rogers (1970), and Roy (1970) are evidence of the general recognition that nursing theoretical approaches were needed. Research continued to develop during this era of graduate education; however, nurse scholars soon noted that much of the research being published lacked form and direction. In fact, *Nursing Research* celebrated its twenty-fifth anniversary in 1977 (volume 26, number 3) with published reviews of progress in its first 25 years. These reviews presented recommendations for development in five practice areas of nursing: medical-surgical, community, maternal-child, psychiatric, and gerontological. Lack of conceptual or theoretical direction or conceptual connections in the research was identified as a weakness of the studies. It was also noted that the research focused on nurses or student nurses rather than patients. The headings of the reviews were noted to reflect medical practice specialties as evidence of the struggle throughout nursing history to move beyond a medical view to the nursing view.

Batey (1977) conducted a comprehensive review of those first 25 years of published nursing research, and identified conceptualization as the greatest limitation of the projects. She emphasized the importance of the conceptual phase of research to provide a content basis as well as connection with other studies in order to develop nursing science. It should be noted that reference to concepts and conceptualization was common in that era and a forerunner to the theory era. The general understanding that a group of related concepts is a theory or that theory derives from a conceptual framework came later.

Indications of the theory emphasis in nursing education at the national level were with the Nurse Educator conferences in Chicago (1977) and New York (1978). The theme for the Chicago conference was Nursing Education; however, Sister Callista Roy's workshop illustrating the use of her adaptation conceptual framework as a guide for nursing education was so popular that the theme for the New York conference a year later was Nursing Theory. This conference brought nurse theorists

onto the same stage for the first time in history. It was the New York conference that underscored a growing awareness that the nature of knowledge needed for nursing practice was theoretical knowledge. This was an exciting time in nursing as scholarly works of nurse scholars from across the country began to be recognized as theoretical frameworks for research and practice. In this era, nursing publications began to proliferate and time has shown three publications of this era to be particularly important to this history: Carper's (1978) patterns of knowing, Fawcett's (1978) description of the helical relationship between theory and research, and the first edition of *Advances in Nursing Science* (1978) where Carper and Fawcett's seminal articles were published.

Carper (1978) presented a summary of her dissertation research describing four types of nursing knowledge and their contexts. Her work is significant in this history for recognition that nursing knowledge went beyond empirical to include ethical, personal, and esthetic knowledge. Clarifying types of nursing knowledge at the time nursing began to embrace qualitative approaches opened nurses to a broader view of research. Fawcett (1978) presented a description of the vital relationship between theory and research in the development of science with her classic double-helix metaphor, ushering in the 1980s and 1990s theory era.

Theory Era: The 1980s and 1990s

The theory era began with a strong emphasis on knowledge development. Although in the previous two decades proponents of nursing theory and nursing theorists had begun to publish their works, it is noteworthy that they denied being theorists when they were introduced as such at the 1978 Nurse Educator Conference in New York with the Nursing Theory theme. There was understanding among those attending the conference that the presenters were theorists, and by the second day, the audience responded to their denials with laughter. This seems strange today, but this was the first time most of the theorists even met each other. Their works had grown out of content organization in nursing education courses, nursing practice administration in large agencies, and structures for the thought and action of practice. It was clear that their works were nursing theoretical structures even before they recognized them as such. The theory era, coupled with the research and graduate education eras, led to understanding of the scientific process beyond production of a scientific product (Kuhn, 1970).

First editions of several nursing theory texts in this era included contemporary nursing theorists, some with chapters written by students in master's programs (Marriner Tomey, 1986; Meleis, 1985; Riehl & Roy, 1980). Proliferation of nursing literature; new nursing journals; regional, national, and international nursing conferences; and new nursing doctoral programs were evidence of exponential growth in this era. Schlotfeldt (1992) concluded that this period stimulated growth in nursing scholarship in ways never before experienced in nursing history.

Fawcett (1984, 1989) contributed significantly to our understanding of the nature of nursing knowledge. She proposed a metaparadigm of nursing knowledge for nursing, specifying discipline boundaries of person, environment, health, and nursing. Her application of this metaparadigm in criteria for analysis and evaluation of nursing theoretical works in early publications clarified types of nursing

conceptual and theoretical works and a structure of knowledge at different levels of abstraction. Fawcett's use of the structure demonstrated how nursing theory linked to conceptual models which then led to an understanding of conceptual-theoretical-empirical linkages for nursing knowledge development and the development of nursing science (Fawcett, 2005). Fawcett (1984, 1989) led the way by presenting a collective view of nursing's theoretical works using criteria to clarify their conception as a metaparadigm (person, environment, health, and nursing) in a uniform structure of knowledge.

Theory Utilization Era: The Twenty-First Century

Nursing is now in the era of theory utilization—nurses using philosophies, models, and theories for *theory-based nursing practice*. Soon after we entered the twenty-first century sufficient evidence of theory-based practice existed to declare a *theory utilization era* (Alligood, 2010). This important era in the history of nursing continued to thrive and be recognized as vital to nursing's future (Algase, 2007; Alligood, 1994; Colley, 2003; Pearson, 2007). Bond and colleagues (2011) recently researched “who uses nursing theory?” (p. 404), and reported... “increasing numbers, both in quantity and in the use of nursing theory” (p. 407).

Continued theory development is essential for our progress as a profession, and as a discipline this is especially important. Theory development with analysis and critique of syntax and the structure of theory is how knowledge development is learned in nursing doctoral programs, especially PhD, which are vital to the discipline. Theory courses in practice-focused master's and doctor of nursing practice (DNP) programs focus on the application of theory in nursing practice. Experiences of nursing practice with holistic nursing frameworks led to in-depth understanding of the theories and their utility for practice. The genesis of this text in the early 1990s grew out of the doctoral education focus on development and testing of theory. This led to revision of master's-level courses to focus on applications and utilization for advanced nursing practice and all other courses throughout the curriculum. Theory is not just to know but is to use.

Therefore, in this fifth edition we continue to celebrate the shift to a theory emphasis in this theory utilization era. With the current emphasis on evidence-based practice, inquiry-based practice, best practices, and the consistent quality outcomes, the purpose of this text takes on added value. Quality care is a prominent theme in Institute of Medicine reports, health care regulatory policies, the call for nursing education reform, and nurse researchers themselves (Benner, et al., 2010; Bigbee & Issel, 2012; Burhans & Alligood, 2010; Ellerbe & Regen, 2012; Sherwood & Barnsteiner, 2012). The connection between this emphasis and nursing theory is especially important. As Nola Pender (personal communication, April 2008) shared, “Middle-range theories that have been tested in research provide evidence for evidence-based practice, thus facilitating translation of research into practice.” Whether the emphasis is evidence, best practices, translation to practice, or quality care, all are facilitated by theory (Bigbee & Issel, 2012; Bond, et al., 2011; Fawcett & Garity, 2009). It has been reported that the absence of structure (framework) to specify outcomes creates the risk of a deficit in quality patient care and hampers the growth of nursing science (Conn, et al., 2008; Fawcett & Garity, 2009;

Pearson, et al., 2007). Theory utilization is in concert with national goals for quality health care. This text presents philosophies, nursing models, and theories of nursing to guide logical reasoning, thoughtful action, and efficient information processing. Table 1-1 summarizes nursing's search for specialized knowledge.

Centrality of Nursing Practice

The centrality of practice to nursing is vital to understand the purpose of theory and this text. Each edition of this text addresses the following question: "What is the nature of the knowledge needed for the practice of nursing?" This question has been a driving force for development from the beginning of professional nursing. Nursing history suggests ways that nurses addressed this question in each era of growth of the twentieth century, and now in this twenty-first century we are in the theory utilization era. The discipline of nursing has reached a long-awaited period in nursing history. More nurses are reimbursed as primary care providers in the United States today than ever before as practice degree programs are developed across the country. Each era of our history was critical to growth of the discipline at that time.

It is vital to progress in the discipline for nurses to use nursing practice approaches in spite of pressure to embrace the biophysical view of medicine for their practice. Continued progress depends on demonstrations of quality outcomes with nursing perspectives. Why would any nurse forsake nursing practice approaches

TABLE 1-1 Summary of Historical Eras of Nursing's Search for Specialized Knowledge

| Historical Eras | Major Question | Emphasis | Outcomes | Emerging Goal |
|--|--|---|---|--|
| Curriculum era: 1900 to the 1940s | What curriculum content should student nurses study? | Courses taught in nursing programs | Standardized curricula for diploma programs | Specialized knowledge and higher education |
| Research era: 1950 to the 1970s | What is focus for nursing research? | Role for nurses and what to research | Problem studies and studies of nurses | Theory-based studies for unified knowledge |
| Graduate education era: 1950 to the 1970s | What knowledge is needed for nursing practice? | Carving out an advanced role and basis for nursing practice | Nurses have an important role in quality health care | Focus graduate education on knowledge development |
| Theory era: 1980 to the 1990s | How do these frameworks guide research and practice? | There are many ways to think about nursing | Nursing theoretical works clearly focus on the patient | These theories guide nursing research and practice |
| Theory utilization era: 21st century | What new theories are needed as evidence for quality care? | Nursing theory guides research, practice, education, and administration | Middle-range theories are from quantitative or qualitative approaches | Nursing frameworks are the knowledge (evidence) for quality care |

for that of another discipline when nurses have been recognized as excellent primary providers with nursing theory-based care? Master's-prepared nurses and doctors of nursing practice (DNP) have a responsibility and are leading the way with a style of professional nursing practice based in nursing thought and action. As in each era, there are opportunities and risks for the profession that cannot be overlooked (Bigbee & Issel, 2012; Fawcett & Garity, 2009; Mantzoukas & Jasper, 2008; Nelson, Gordon, & McGillian, 2002). For nurses to be recognized for their contribution to health care of individuals, families, and communities, it is essential that they practice professional nursing in a systematic manner with nursing approaches. This requires a consciously defined approach in nursing thought and action. Praxis does not occur automatically. Rather, a professional style of practice develops as knowledge is embraced, utilized, and experienced over time (Bigbee & Issel, 2012; Ellerbe & Regen, 2012). Daiski (2000) has suggested "practice based in nursing theories will give nurses the necessary foundation to restructure health care where it counts: improving quality of care at the practice level" (p. 79). Using nursing's theoretical works in practice not only provides a nursing approach but also guides reasoning and decision making for nurses to practice in a logical, organized manner (Algase, 2007; Arvidsson & Fridlund, 2005; Colley, 2003; Fawcett, 1999, 2005; Gallagher, 2004; Newman, 2002; Pearson, 2007).

Mathwig (1975) noted very early, before the theory era even began, that the first phase of translating theory into practice is the decision to do so. Similarly, use of a model in practice has been described as a habit to be formed (Broncatello, 1980), the practice of a true believer (Oliver, 1991), and the practice of one who has been properly persuaded (Levine, 1995).

Progression of nurses to theory utilization and theory-based practice is best explained by nursing history. Change comes slowly and is influenced by eras of development, but it does come. The words of Rogers are as true today as they were in 1970: "Nursing's potential for meaningful human service rests on the union of theory and practice for its fulfillment" (Rogers, 1970, p. viii). This text is dedicated to realization of that premise.

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Nursing Models: Normal Science for Nursing Practice

*Angela F. Wood**

In the sciences, the formation of specialized journals, the foundation of specialist societies and claim for a special place in the curriculum have usually been associated with a group's first reception of a single paradigm.
(Kuhn, 1970, p. 19)

Nursing Models and Their Theories in Nursing Practice

The use of nursing models and their theories in nursing practice is presented in this chapter, documenting various areas of application and utilization of the models as reported in the nursing literature. As the premise in the third edition (2006) set forth, the shift from theory development to theory utilization restores a proper relationship between theory and practice for a professional discipline such as nursing. The importance of this shift was supported by Levine's (1995) comment, when she stated in regard to Fawcett's clarification of models from theories, "It may be that the first prerequisite for effective use of theory in practice... rest[s] on just such a clarification" (p. 12). The literature continues to verify that nursing models and their theories have practical utility for nursing with specific details in areas of practice (Bond, Eshah, Bani-Khaled, et al., 2011; Donohue-Porter, Forbes, & White, 2011; Im & Chang, 2012; McCrae, 2011).

Based on a review of the nursing literature, this chapter begins with examples of practice areas where nursing models and their theories guide nursing. Although all three tables present the use of the nursing models and their theories in nursing practice, these applications are described by their authors in various ways: (1) in terms of the medical conditions; (2) in terms of nursing based on human development, areas of practice, type of care, and type of health; and (3) in terms of nursing interventions or the nursing role. (See the Bibliography for references to applications of each model cited in Tables 2-1, 2-2, and 2-3.) This chapter concludes with a review of the

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TABLE 2-1 Areas of Practice with Nursing Models Described in Terms of a Medical Conditions Focus

| Practice Area | Johnson | King | Levine | Neuman | Orem | Rogers | Roy |
|------------------------------------|---------|------|--------|--------|------|--------|-----|
| Acute care | | | | | | • | |
| Adolescent cancer | | | | | | | • |
| Adult diabetes | | • | | | • | | |
| AIDS management | • | | | • | | • | • |
| Alzheimer’s disease | | | | | | | • |
| Ambulatory care | | | | | • | • | |
| Anxiety | | • | | • | • | • | |
| Breast cancer | | | | • | | | • |
| Burns | | | • | | | | |
| Cancer | • | | • | | • | • | • |
| Cancer pain management | • | | | | | | |
| Cancer-related fatigue | | | | | • | | |
| Cardiac disease | • | • | | | • | • | • |
| Cardiomyopathy | | | | | | | • |
| Chronic inflammatory bowel disease | | • | | | | | |
| Chronic pain | | | • | | | • | • |
| Chronic sorrow | | | | | | | • |
| Cognitive impairment | | | | • | | | |
| Congestive heart failure | | | • | | | | |
| Critical care | | | • | • | • | • | • |
| Cystitis | | | | • | | | |
| Diabetes | | • | | • | • | | |
| Guillain-Barré syndrome | | | | | • | | |
| Heart | | | | | • | • | |
| Hemodialysis | • | | | | • | | |
| Hypnatremia | | | | | | | • |
| Intensive care | | | | • | • | • | • |
| Kawasaki disease | | | | | | | • |
| Leukemia | | | | | | | • |
| Long-term care | | | • | | • | | |
| Medical illness | | • | | • | | • | |
| Menopause | | • | | | | • | |
| Neurofibromatosis | | • | | | | | |
| Obesity | • | • | | | | | |
| Oncology | • | • | | | • | • | |

TABLE 2-1 Areas of Practice with Nursing Models Described in Terms of a Medical Conditions Focus—cont'd

| Practice Area | Johnson | King | Levine | Neuman | Orem | Rogers | Roy |
|-------------------------|---------|------|--------|--------|------|--------|-----|
| Orthopedics | | • | | • | | | |
| Osteoporosis | | | | | | | • |
| Ostomy care | | | • | | • | | |
| Pediatrics | | • | • | • | | • | • |
| Perioperative | | • | • | | • | | • |
| Polio survivors | | | | | | • | |
| Postanesthesia | | | | | | | • |
| Postoperative | | | | • | • | | • |
| Postpartum | | | | | | | • |
| Posttrauma | | | | | | | • |
| Preoperative adults | | | • | | | | |
| Preoperative anxiety | | • | | | • | | |
| Pressure ulcers | | | • | | | | |
| Renal disease | | • | | • | • | | |
| Rheumatoid arthritis | | | | | • | | |
| Schizophrenia | | | | | | | • |
| Stroke | • | • | | | | | |
| Substance abuse | | • | | | • | • | |
| Terminal illness | | | | | | • | • |
| Ventilator patient | | | | | | | • |
| Ventricular tachycardia | • | | | | | | |
| Wound healing | | | • | | | | |

TABLE 2-2 Areas of Practice with Nursing Models Based on Human Development, Type of Practice, Type of Care, or Type of Health Focus

| Practice Area | Johnson | King | Levine | Neuman | Orem | Rogers | Roy |
|-------------------|---------|------|--------|--------|------|--------|-----|
| Adolescents | | • | | • | | • | • |
| Battered women | | | | • | • | | |
| Caregiver stress | | • | | • | | | • |
| Case management | | • | | • | | | |
| Cesarean father | | | | | | | • |
| Child health | | • | | | | | |
| Child psychiatric | | | | • | | | |
| Dying process | | | | | | • | |
| Emergency | | • | • | • | | | • |

Continued

TABLE 2-2 Areas of Practice with Nursing Models Based on Human Development, Type of Practice, Type of Care, or Type of Health Focus—cont'd

| Practice Area | Johnson | King | Levine | Neuman | Orem | Rogers | Roy |
|------------------------|---------|------|--------|--------|------|--------|-----|
| Gerontology | | • | | • | • | • | • |
| High-risk infants | | • | • | | | | |
| Holistic care | | | • | | | | |
| Homeless | | | • | • | | | |
| Hospice | | | • | | • | | |
| Managed care | | • | | • | | | |
| Mental health | • | | | • | • | • | • |
| Neonates | | | • | | | | • |
| Nursing administration | | • | | • | • | • | • |
| Nursing adolescents | • | • | | | • | | |
| Nursing adults | | • | • | • | • | • | |
| Nursing children | • | | • | | • | • | • |
| Nursing community | • | • | | • | • | • | • |
| Nursing elderly | • | • | • | • | • | • | • |
| Nursing families | • | • | | • | | • | • |
| Nursing home residents | | | | | | • | |
| Nursing infants | • | | • | • | • | | • |
| Nursing in space | | | | | | • | |
| Nursing service | | | | | | • | |
| Nursing women | | | | | • | • | |
| Occupational health | | | | | • | | |
| Palliative care | | | | | | • | • |
| Pregnancy | • | | | | • | • | • |
| Psychiatric nursing | • | • | | | | • | |
| Public health | | | | • | | | |
| Quality assurance | • | | | | | | • |
| Rehabilitation | | • | • | • | • | • | • |
| Risk education | | | | • | | | |
| Transcultural | | • | | | | | |

nursing models using the criteria for normal science set forth by Kuhn (1970) in *The Structure of Scientific Revolutions* and a discussion of how the discipline of nursing has reached a period of normal science using the nursing models.

The literature review makes it apparent that nurses describe their practice in several ways. Some describe nursing practice in terms of the medical conditions. This view focuses on the patient or area of care, as noted in Table 2-1. Examples of

TABLE 2-3 Areas of Practice with Nursing Models with a Nursing Intervention or Role Focus

| Practice Area | Johnson | King | Levine | Neuman | Orem | Rogers | Roy |
|------------------------------|---------|------|--------|--------|------|--------|-----|
| Breastfeeding | | | | • | | | • |
| Community presence | | | | | | • | |
| Collaboration | | • | | | | • | |
| Counseling | | | | • | | | |
| Esthetic knowing | • | | | | | | |
| Family therapy | | • | | • | | | |
| Group therapy | | • | | | | • | • |
| Health patterning | | | | | | • | |
| Humor | | | | • | | • | |
| Imagery | | | | • | | • | |
| Intentionality | | | | | | • | |
| Knowing participation | | | | | | • | |
| Laughter | | | | | | • | |
| Leadership/scholarship | | • | | • | | • | |
| Life-patterning difficulties | | | | | | • | |
| Life review | | | | | | • | |
| Movement | | | | | | • | |
| Nutrition | | | | • | • | | • |
| Parenting | | • | | • | | | • |
| Relaxation | | | | | • | | |
| Spiritual intervention | | | | • | | • | • |
| Storytelling | | | | | | • | |
| Therapeutic touch | | | | | | • | |

this focus are the nursing of cardiovascular patients or of intensive care patients. Several observations have been made about this focus (see Table 2-1). First, it represents the largest body of literature. Second, each model is represented within this focus. This large group of studies is surprising in light of the efforts of the past 40 years to move nursing beyond the medical view to a nursing perspective. However, this focus reflects the practice area, of the largest single group (54%) of practicing nurses, who, according to the Department of Labor Statistics (2010) provide acute care or illness care in hospitals.

Table 2-2 presents model and theory use in publications in which nurses describe their practice in terms of a developmental or life-span focus, a particular

group in society, a type of care, or a type of health. Examples of this focus are nursing of children, homeless, holistic care, and child health. Table 2-2 reflects the second largest group of articles. Like Table 2-1, Table 2-2 represents articles based on all seven of the nursing models. Although Table 2-2 is large, it represents a grouping of several perspectives nurses use to describe their practice: nursing groups according to a developmental category, areas of practice, types of care, and types of health or health promotion.

Table 2-3 presents model and theory use in publications that focus on nursing intervention or nursing role. Examples of this focus are life review and counseling. This table is smaller than Tables 2-1 and 2-2 and differs in that not all of the nursing models are represented in Table 2-3. Certain nurses practicing from the perspective of nursing models seem to describe their practice in terms of nursing intervention or nursing role. It is noted that the specificity of the language in Rogerian science has created several unique categories in this focus. This is not surprising, considering the following:

- The development of a science calls for specific language.
- A purpose of nursing science is to develop knowledge specific to the discipline perspective; therefore, one would expect new intervention categories to be created rather than continuing to fit interventions into other previously used categories.
- One would expect categories that are descriptive of the uniqueness of the nurse's perspective.

The nursing categories in Tables 2-1, 2-2, and 2-3 can be considered in the context of Kuhn's (1970) discussion of normal science. Paradigms (or nursing models) not only are frameworks to guide thinking about nursing and research but also the thought and action of practice. As such, their use by members of the profession produces knowledge that is evidence for practice as well as further research and theory development. Normal science verifies the growing maturity of a discipline as it moves beyond a knowledge development focus and focuses on knowledge use. Model-based nursing literature now reflects the characteristics of normal science. Middle-range theories and societies have been developed from nursing philosophies and theories in recent years that are beyond the scope of this chapter. The reader is referred to Part III of this text on expansion and Chapter 21 for a brief discussion of those developments.

In his book *The Structure of Scientific Revolutions*, Kuhn (1970) examines the nature of scientific discovery. He defines normal science as “research firmly based upon one or more past scientific achievements that some particular scientific community acknowledges for a time as supplying the foundation for its further practice” (p. 10). From this definition, Kuhn describes criteria that might be used for evaluation of a given paradigm (nursing model). The following are some of the characteristics of a model as it approaches normal science:

- To be accepted by a community of scientists
- To provide a basis for practice
- To be open-ended—that is, provide a guide for research that would broaden the scientific knowledge base of the discipline

Thus Kuhn's philosophy of science is useful to examine the science of the discipline of nursing. Three possible interpretations are presented.

Examination of the Models

Kuhn (1970) describes a paradigm that results in normal science as “an achievement sufficiently unprecedented to attract an enduring group of adherents away from competing modes of scientific activity” and as “leaving all sorts of problems for the redefined group of practitioners to resolve” (p. 10). In the attempt to develop nursing science, theory from numerous modes of scientific activity including medicine, social and physical science, education, and even industrial management had been utilized (Wald & Leonard, 1964). However, it was not until the development of formal conceptual nursing models that nurses had “a systematic approach to nursing research, education, administration, and practice” (Fawcett, 1995, p. 5) that ultimately resulted in normal science for the discipline of nursing. Nursing theory continues to supply the foundation for knowledge development and generate evidence for practice (Bond, et al., 2011; Canavan, 2002; Colley, 2003; Im & Chang, 2012; Kikuchi, 2003; McCrae, 2011). Each of the models is reviewed with regard to Kuhn's definition and criteria of normal science.

Johnson

First presented in its entirety in the 1980 edition of *Conceptual Models for Nursing Practice* (Riehl & Roy, 1980), the Behavioral System Model, developed by Dorothy Johnson, was a work in progress since 1959 (Fawcett, 1995). Beginning as a basis for development of nursing core content, Johnson's work focuses on common human needs, care and comfort, and stress and tension reduction (Johnson, 1992). With its origins in Nightingale's work, as well as in General System Theory (Fawcett, 2005), Johnson's model attracted nurse scientists who linked her model with work from other disciplines to generate new theory (Fawcett, 1995). Use of the Behavioral System Model by educators, researchers, and practitioners across the country (Fawcett, 2005; Meleis, 2007) suggests that a significant number of nurses favor Johnson's Behavioral System Model. There is currently no organized group of nurses who support the use of Johnson's Behavioral System Model; however, Bonnie Holaday reports that nurses who use the model “stay in touch.” She has future plans for a Johnson model book (B. Holaday, personal communication, January 2012).

King

King (1964) first published work that would evolve into the General Systems Framework. Like many other theorists, King combined her own observations about nursing with knowledge from other disciplines and the theory from General System Theory to form a new conceptual framework for the discipline of nursing (King, 2006). With its focus on personal, interpersonal, and social systems, King's conceptual framework and Theory of Goal Attainment that springs from it are widely used in nursing today (Alligood, 2010; Bond, et al., 2011; Sieloff & Frey, 2007). King's emphasis on the role of the client as well as the nurse in the planning and implementation of health care has been noted as consistent with evolving philosophies of health care (Meleis, 2007). The King International Nursing Group (KING) provides an organization for support and

communication among nurses using King's General Systems Framework and Theory of Goal Attainment.

Levine

As is seen in Table 2-1, many nurse educators, researchers, and practitioners continue to rely on the medical model as their organizing framework. Levine very early perceived this as a problem for the development of nursing science and, in 1966, introduced a new paradigm to direct nursing away from the limitations of the medical view and provided nurses with a way to describe nursing care using a broader scientific view (Levine, 1966). Called the Conservation Model, Levine's work provides an organizing framework that can be used in a variety of nursing settings to facilitate nursing education, research, and practice (Levine, 1988). Focusing on adaptation as a way to maintain the integrity and wholeness of the person, Levine's work has attracted a large number of followers among nurse researchers, educators, administrators, and practitioners (Fawcett, 2005). Recent work with Levine's Conservation Model in combination with the North American Nursing Diagnosis Association (NANDA), Nursing Interventions Classification (NIC), and Nursing Outcomes Classification (NOC) demonstrates the practical aspects of this model (Cox, 2003). There is evidence of current use of Levine's work in the nursing literature (Delmore, 2006; Mefford & Alligood, 2011a,b). There is no Levine scholar organization.

Neuman

Like many of the nursing models, the Neuman Systems Model had its beginnings in an educational setting, where it was developed and implemented to facilitate advanced practice in graduate education. Developed around the same time as several other nursing models, Neuman first published a description of her model in 1972 (Neuman & Young, 1972). Influenced by a variety of nurse scholars, as well as knowledge from other disciplines, Neuman's model incorporates, among others, the concepts of adaptation and client wholism, with a strong emphasis on stress in the client environment.

The Neuman Systems Model continued its evolution and development for more than 40 years. Nurse educators, researchers, administrators, and practitioners from around the world have made the Neuman Systems Model one of the most recognized and used of the nursing paradigms (Im & Chang, 2012; Neuman & Fawcett, 2011). The Neuman archives are located at the library of Neuman College in Aston, Pennsylvania. Nurses who have attained a graduate degree may join the Neuman Systems Model Trustees Group, Inc. (<http://neumansystemsmodel.org/index.html>).

Orem

A clinical nursing background in medical-surgical nursing of adults and children, combined with studies in a variety of disciplines and her own personal reflection, contributed to Orem's development of the three-part theory of self-care (Orem, 2002). An early advocate of nursing conceptual models, Orem's work first began to develop in the early 1970s. From the beginning, Orem balanced the task of defining the domain of nursing while providing a framework for nursing curricula

development (Fawcett, 2005). Although a variety of nurse scholars and Orem herself continued to refine her work, the basic conceptual elements from 1970 remained unchanged (Orem, 2002).

Highly regarded globally for its usefulness in all aspects of nursing, Orem's Self-Care Model continues to be the organizing framework of many nurse researchers, educators, scholars, administrators, and providers of patient care (Banfield, 2011; Berbiglia, 2011; Clarke, Allison, Berbiglia, et al., 2009; Horan, Doran, & Timmins, 2004; Orem & Taylor, 2011; Wilson, Mood, Risk, et al., 2003). Nurses who use the Orem model formed the International Orem Society for Nursing Science and Scholarship. This active world organization sponsors conferences and publications on the use and development of the Orem model available on the society website along with a list of schools of nursing that use the Orem model as an organizing framework.

Rogers

Of all the nursing models discussed in this chapter, the work of Martha Rogers perhaps best fits Kuhn's (1970) description of a new paradigm as that which "forces scientists to investigate some part of nature in a detail and depth that would otherwise be unimaginable" (p. 24). With its focus on unitary human beings as the central phenomenon of nursing (Fawcett, 1995), the Science of Unitary Human Beings (Rogers, 1970, 1992) introduces a set of concepts to nursing science that were not suggested by other nursing models. Rejecting the idea of causality, Rogers' work moved beyond the reciprocal interaction worldview of the other nursing models. Rather, Rogers' work has a pandimensional view of people and their world (Rogers, 1992) consistent with the simultaneous action worldview (Fawcett, 1995).

Widely used by nurse researchers, educators, administrators, and clinical practitioners, the Science of Unitary Human Beings has a worldwide impact with nurses who use this truly unique paradigm for their practice. The Society for Rogerian Scholars (SRS) actively encourages the use of the Science of Unitary Human Beings through a program of scholarships, conferences, and publications that provides an avenue for work done in the model to be presented and discussed. The SRS manages a website and a refereed journal, *Visions: The Journal of Rogerian Nursing Science*, in its twentieth year of publication in 2012.

Roy

Beginning work on her model while she was a graduate student in the late 1960s, Sister Callista Roy drew the scientific basis for her Adaptation Model from both systems theory and adaptation-level theory (Roy & Andrews, 1999). Principles from these nonnursing disciplines were reconceptualized for implementation in nursing science (Meleis, 2007). In addition, threads from the work of other nurse scientists, particularly Johnson and Henderson (Meleis, 2007), contributed to what would become a new view of nursing. In a pattern seen in the development of many of the other scientific disciplines (Kuhn, 1970), Roy was able to synthesize contributions from other disciplines as well as works of early nurse scientists into the fabric of her own original thoughts. This resulted in a new paradigm for nursing science: the Roy Adaptation Model.

Formally published in 1970 (Roy, 1970), the Roy Adaptation Model was implemented as the basis of the curriculum at Mount St. Mary's College, where the faculty has continued to work with Roy to develop and publish the elements of the model. The operationalization of the theory in the curriculum at Mount St. Mary's College and the availability of literature and textbooks consistent with the model have resulted in its widespread adoption (Meleis, 2007). In addition, middle-range theory development continues from the model as demonstrated by Dunn's work with chronic pain (Phillips, 2011).

Discussion

The concept of normal science introduced by Kuhn describes the acceptance of a new paradigm for use by a discipline. According to Kuhn (1970), normal science “means research firmly based upon one or more past scientific achievements, achievements that some particular scientific community acknowledges for a time as supplying the foundation for its further practice” (p. 10). The discipline of nursing moved toward normal science with widespread acceptance of the paradigm consisting of four concepts: person, health, environment, and nursing. However, these four concepts by themselves were not adequate for achievement of normal science. In a practice discipline such as nursing, the body of knowledge that is contained in the science must be at a level of abstraction that is suitable for application in practice.

The works of Johnson, King, Levine, Neuman, Orem, Rogers, and Roy, serving as frameworks for practice, education, and research, have provided this level of abstraction and, in doing so have resulted in a body of normal science for the discipline of nursing. Kuhn (1970) points out that “paradigms gain their status because they are more successful than their competitors in solving a few problems that the group as practitioners has come to recognize as acute” (p. 23). Affirmation of the seven models and the theories has developed through the use of them and is evidenced repeatedly in the current nursing literature. Research studies are conducted and reported and results are evidence for nursing education and client care (Barrett, 2002; Bond, et al., 2011; Donohue-Porter, et al., 2011; Im & Chang, 2012; McCrae, 2011). Im and Chang (2012) studied current trends in nursing theories from 2001 to 2010 and found that most of the theory-use-articles were based on four of the seven nursing models: Roy, Orem, Neuman, and Rogers. The theory utilization era is reflected in specific areas such as population-focused public health nursing (Bigbee & Issel, 2012), “people-centered” nursing with the elderly (Dewing, 2004), preadolescent empowerment (Frame, 2003), and curricula content to organize thinking (DeSimone, 2006; Donohue-Porter, et al., 2011).

There are several ways that Kuhn's conception of normal science can be applied. First, it could be proposed that the discipline of nursing has one body of normal science with seven branches—the seven models. Although they are different in language, implementation, and research questions posed, each of the models is based on the four-concept metaparadigm and therefore has some commonalities. The models have their differences and all have contributed to what we

collectively call the *body of nursing knowledge* and, could be considered nursing normal science.

A second possibility for interpretation of Kuhn's definition of normal science with regard to the discipline of nursing is to say that nursing has seven different bodies of normal science. Each of the seven nursing models has attracted a significant group of followers who utilize the models for practice, education, research, and development of nursing knowledge according to the specific views of nursing as evidenced by implementation of the models in health care institutions, schools of nursing, and textbooks. It is also evidenced by the fact that five of the seven models have professional organizations that have as their purpose to support and further the work in the models. In Kuhn's (1970) words, those "whose research is based on shared paradigms are committed to the same rules and standards for scientific practice. That commitment and the apparent consensus it produces are prerequisites for normal science" (p. 11). Thus according to the criteria described by Kuhn for normal science, it is possible to accept the view that nursing does in fact have at least seven bodies of normal science.

The third and last viewpoint regarding the state of normal science within the discipline of nursing is that nursing has two bodies of normal science: one consisting of the knowledge produced from the work of Rogers Science of Unitary Human Beings and the other consisting of knowledge developed from the works of Johnson, King, Levine, Neuman, Orem, and Roy. Evidence for this viewpoint arises from the underlying worldview of the models, with Rogers' model being based on the simultaneous action worldview and the remaining six models based on the reciprocal interaction worldview (Fawcett, 1995, 2005). A comparison of metaparadigm concept definitions from Rogers' model with the other models demonstrates the differences, such as a human being viewed as a unitary irreducible, indivisible whole rather than as parts of a whole. A comparison of the implementation in practice, education, and research yields a similar conclusion. Although each of the six reciprocal interaction models is able to make unique contributions to the body of nursing knowledge, these contributions are similar in nature and thus can be viewed together as a body of normal science, separate and different from the knowledge developed from a simultaneous action view.

To summarize, a comparison of the body of nursing knowledge to the criteria that Kuhn proposes for normal science indicates that the discipline of nursing has, through use of the seven nursing models just examined, achieved the level of normal science. All of the models are accepted by groups of knowledge-building nurse scientists. The models all can and do provide bases for the practice of the discipline of nursing. Finally, all the models are open-ended; that is, they provide a framework for "further articulation and specification under new or more stringent conditions" (Kuhn, 1970, p. 23). Three interpretations of the structure of normal science in nursing have been used to answer the following basic question: "Has nursing achieved the level of normal science?" Each interpretation has led to the following answer: Yes; nursing conceptual models have led to the achievement of normal science in the discipline of nursing.

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Philosophies, Models, and Theories: Critical Thinking Structures

Martha Raile Alligood

It is not simply knowing a lot of things; it is a way of knowing things.
(Levine, 1988)

“Theory development in nursing science is critical for evolution of the discipline” (Clarke & Lowry, 2012, p. 333), and growth of the profession is dependent on nurses knowing and using nursing theoretical works in their practice of nursing. Studies continue to generate evidence of the connections among knowledgeable use of nursing theoretical works, education, and quality nursing practice (Bigbee & Issel, 2012; Erickson, 2007; Fawcett & Garity, 2009; Hatlevik, 2012; Im & Chang, 2012; McCrae, 2011; Sieloff & Bularzik, 2011). This evidence is vital for the practicing nurse.

This chapter sets the stage for the chapters that follow and introduces new understandings as Carper’s (1978) patterns of knowing are proposed as types of nursing theory and evidence for nursing practice (Fawcett, 2012a). These works represent the empirical pattern or the science of nursing understood as a type of theory and the form of evidence necessary for quality nursing practice (Carper, 1978; Fawcett, 2012a). Descriptions of the levels of abstraction of these nursing works from seven nursing models, three philosophies of nursing, and six theories of nursing illustrate their linkages with the practice level in middle-range theory. The theoretical frameworks guide professional practice; organizing the thought processes for decision making and reasoning for quality nursing practice. The content of nurses’ decisions may be unique nursing knowledge, but the modes of making practice decisions are generic processes of logic and critical thinking (Scriven & Paul, 2004). Nursing theoretical works (philosophies, models, theories) are knowledge structures that link logically with inherent critical thinking processes.

A key part of this chapter presents points to be considered when selecting a nursing theoretical work to guide your practice. You may discover that

certain of the works resonate with you more than others. A good fit between the nurse and the theoretical work selected is important and is usually related to mutual values inherent in a theoretical work and the nurse. Chapter 4 presents an insightful discussion of the moral obligations and values inherent in theoretical works. Once a theory is selected it is recommended that you expand your understanding of that theory by reading published materials written by the theorist.

I want to introduce you to the use of the clinical case of Debbie in this text. Debbie has been featured in each application chapter since the first edition of this text in 1997. The case of Debbie was written by Dr. Ken Phillips, author of the Roy chapter. The idea for this feature sprang from a classroom teaching/learning exercise I had used with graduate students. Each student was asked to select a nursing framework and develop a plan of care for the same case (Mrs. Corbett). Their presentations illustrated the similarities and differences in the focus and plan of care when thought and action were guided by a particular nursing framework. This exercise led to important insights and understandings of the frameworks by the students. Therefore, that feature was included in the plans for the first edition of this text. The authors of the chapters in the Application section (Chapters 5 through 20) have developed a plan of care for Debbie, and each author also introduces a case of his or her choice and plan of care for that person. As you read the application chapters, watch for the unique focus of each philosophy, model, and theory noticeable in the care of Debbie. This text focuses on the use of theoretical works in practice. The reader is referred to *Nursing Theorists and Their Work* (Alligood & Tomey, 2010) for analytical critiques of the philosophies, models, and theories.

The Relationship of Philosophies, Models, and Theories

The philosophies, models, and theories of a discipline are theoretical structures that address the central concepts of that discipline. The science of nursing is recognized as a fundamental pattern of knowing for nurses (Carper, 1978). Fawcett (2005) proposes a nursing metaparadigm based on Kuhn's (1970) philosophy of science and paradigm development. The metaparadigm specifies disciplinary boundaries of human beings, environment, health, and nursing as a context to understand the interrelationships among those elements of contemporary nursing science (Fawcett, 2005).

Theoretical knowledge may be differentiated by the way it is named or labeled. A model tends to be named for the person who authors it, for example, the Neuman Systems Model. Grand theories tend to be named for the outcome they propose, for example, the Theory of Optimal Client System Stability, and theories tend to be named for the characteristics their content demarcates as an explanatory shell of the outcomes they propose. An example is Gigliotti's (2003) theory of women's multiple role stress, which she validated as middle range with the age groups of women and forms of stress (Gigliotti, 2011, 2012).

TABLE 3-1 A Structure of Nursing Knowledge Types and an Example of Each Type

| Knowledge Type | Examples of Types of Nursing Knowledge |
|---------------------|---|
| Metaparadigm | Human beings, environment, health, nursing |
| Philosophy | Nightingale's philosophy |
| Conceptual models | Neuman Systems Model |
| Grand theory | Optimal Client System Stability |
| Theory | Flexible line of defense moderates Optimal Client System Stability |
| Middle-range theory | Flexible line of defense moderates stress levels for Optimal Client System Stability in women who are enacting multiple roles (Gigliotti, 2011) |

Knowledge types based on Fawcett, J. (2005). *Contemporary nursing knowledge: Conceptual models and theories* (2nd ed.). Philadelphia: F. A. Davis.

Table 3-1 presents types of nursing knowledge at each level of abstraction and an example of nursing knowledge for each type.

- The metaparadigm is the most abstract set of central concepts for the discipline of nursing (i.e., human being, environment, health, nursing), and these concepts are defined within each of the conceptual models and according to the philosophy of that model.
- Philosophies present the general meaning of nursing and nursing phenomena through reasoning and logical presentation of ideas (Alligood, 2005). Although Nightingale (1946) did not present her philosophy on the relationship of patients and their surroundings as a theory, her philosophy contains implicit theory that guides nursing practice.
- Conceptual models (also called paradigms or frameworks) such as the Neuman Systems Model (Neuman & Fawcett, 2011) are the next less abstract set of concepts in the structure.
- Grand theory (e.g., Neuman's Theory of Optimal Client System Stability) is next as the level of abstraction descends. Theory can be considered grand when it is nearly as abstract as the model itself and when the usefulness of the model depends on the soundness of that theory. Grand theory is especially useful in research and practice because it is more general, and theories specifying the details of practice can be derived from it.
- Theory is the next less abstract level; it is more specific than grand theory but not as specific as middle-range theory (e.g., Optimal Client System Stability in specific settings).
- Finally, as mentioned earlier, middle-range theory is the least abstract set of concepts and the most specific to nursing practice (e.g., promoting Optimal Client System Stability through a stress reduction intervention in the work environment). The understanding of theory terminology is developed over time with knowledge of works at the different levels of abstraction (Fawcett, 2005; Reynolds, 1971).

Philosophies are theoretical works that address one or more of the metaparadigm concepts (person, environment, health, and nursing) in a broad philosophical way. Philosophies address questions such as:

- What is nursing?
- What is the nature of human caring?
- What is the nature of nursing practice?
- What is the social purpose of nursing? (Alligood, 2005).

Therefore, philosophies are broad statements of values and beliefs that propose general ideas about what nursing is, what nursing's concerns are, and how the profession addresses its moral obligation to society. Each philosophy is a unique view of nursing.

Nursing models are frameworks or paradigms of the science of nursing that address the person, environment, health, and nursing metaparadigm. What this means in terms of nursing practice is that the way you think about people and about nursing has a direct effect on your approach with people, what questions you ask, how you process the information that is learned, and what nursing activities are included in your care. Therefore, a model provides a perspective of the person for whom you are caring, specifies the focus for the delivery of care, and structures the reasoning, critical thinking, and decision making in your practice.

Nursing theories derive from models and are guiding structures for reasoning and decision making about the person, the person's health situation, and the care indicated. Theories are composed of sets of concepts, but they are less broad and propose specific outcomes. Theories may have been derived from a philosophy, a nursing model, a more abstract nursing theory, or a model or framework from another discipline. Theories are based on propositions or relationship statements that are consistent with theoretical works from which they are derived, but a theory coming from a nursing model such as Theory of Accelerating Change (based on Rogers' Science of Unitary Human Beings) or Theory of the Person as an Adaptive System (based on Roy's Adaptation Model) is more focused and guides your approach and perspective. When you approach people from the perspective of a certain nursing theory and ask questions, process information, and carry out specific activities, an outcome is anticipated based on the theory. This is true whether the theory is guiding the design and delivery of nursing care or the design and conduct of a research project. Just as theory strengthens nursing practice, theory-based research produces evidence for practice (Fawcett, 2012a,b). Theories have been specified as important forms of evidence. Evidence-based nursing practice is encouraged but is dependent on ways to recognize quality evidence. And the quality of evidence-based practice is dependent on recognition of quality research (Fawcett & Garity, 2009).

Middle-range theory is the least abstract in the structure of knowledge and as the term range suggests middle-range theories are at various levels of abstraction. These theories are at the practice level, and include details of nursing practice. Grand Theories such as Rogers' Theory of Accelerating Change, Roy's Theory of the Person as an Adaptive System, and Neuman's Theory of Optimal Client System Stability are examples of grand theories because they are broad and their level of abstraction is close to the model from which they are derived. When a theory is at

the grand theory level, many middle-range applications of that theory can be developed for practice by specifying factors such as:

- The situation or health condition
- The client population or age group
- The location or area of nursing practice (e.g., home, hospital, community)
- The action of the nurse or nursing intervention

The process of specifying the details in the theory makes it less abstract and less broad; therefore, it applies to specific types of patients, in specific situations, and proposes specific outcomes about the care for the patient. Research reports of studies that test middle-range theories and specify the details yield findings that are evidence for evidence-based practice.

In this theory utilization era the communities of scholars surrounding nursing theoretical works (philosophies, models, and theories) continue to grow and expand globally (Bond, Eshah, Bani-Khaled, et al., 2011; Im & Chang, 2012). Growth in the development and use of middle-range theory in research and practice has exploded in the global nursing literature. Expansion is obvious by publications in scholarly nursing books and journals. A few recent examples are Bultemeier (2012) in Malawi and the long history of Neuman's Systems Model in Holland (Merks, Verberk, Kuiper, et al., 2012). Nursing theory societies have global members who contribute ideas for middle-range theory development, testing, and use in theory-based practice (Biggs, 2008; Bond, et al., 2011; Daiski, 2000; Dobratz, 2008; Dunn, 2005; Fawcett & Garity, 2009; Frey, Sieloff, & Norris, 2002; Gigliotti, 2012; Im & Chang, 2012; Sieloff & Frey, 2007).

Discussion of these types of nursing theoretical works follows, and the application chapters in Part II (Chapters 5 through 20) of this text illustrate nursing practice with each type.

Philosophies

Philosophies provide us with broad general views of nursing that clarify nursing values to answer broad disciplinary questions. Three nursing philosophies are included in this chapter that present different philosophical views of nursing. Examples of these differing views are noted in the works of Nightingale (1946), Watson (1979), and Benner (1984).

Nightingale's Philosophy of Nursing

Nightingale (1946) provides an answer to the question "What is nursing?" in her often-cited work *Notes on Nursing: What It Is and What It Is Not*. In that work Nightingale distinguishes nurses from the household servant of her day, contrasts the differences between nursing and medicine, and specifies the concern of nursing to be involved with health as well as illness. She includes directives for her unique perspective that is focused on the relationship between patients and their surroundings (often referred to as environment). She addresses the categories of pure air, pure water, efficient drainage, cleanliness, and light and provides directives on diet, noise, rest, and the nurse's responsibility for protection and management of the care of the patient. Nightingale's work is very relevant to current nursing practice, as reflected by the nursing literature. For example, Erlen (2007) cites Nightingale in regard to

patient safety and error reduction in care of orthopedic patients. Bolton and Good-enough (2003) recognized Nightingale's work for the nursing contribution to quality improvement, and Jarrin (2012) describes situated caring in nursing and the environment. In Chapter 5, Kim Bolton describes her nursing practice using Nightingale as a guide, illustrates with case applications, and adds an updated bibliography.

Watson's Philosophy of Nursing

Watson (1979, 2011) continues to provide a unique approach to nursing as first proposed in *Nursing: The Philosophy and Science of Caring*. Her work states that nursing is a human science that addresses the nature of human caring. She suggests a return to the earlier values of nursing, which emphasized the caring aspects (Watson, 1988). In this philosophical work she also introduces theoretical propositions for the human-to-human relationships of nursing and specifies 10 carative factors to guide application of her work in nursing practice. Transpersonal caring is the proposed approach to achieve connectedness in which the nurse and the patient change together. Emphasis is on harmony for unity in body, mind, and soul, and illness represents disharmony as the nurse and the patient participate together in their relationship. Watson's work has been used to direct care in various areas of practice and nursing administration to address nurse effectiveness in caring (Per-sky, Nelson, Watson, et al., 2008). Watson (2011) has updated her caring science, its measurement (Nelson & Watson, 2011), and its curriculum approach (Hills & Watson, 2011). In Chapter 6, the authors discuss Watson's work in nursing practice and illustrate with case applications.

Benner's Philosophy of Nursing

Benner (1984) provides yet another philosophical view of nursing with emphasis on the nature of nursing practice, specifically how knowledge of practice is acquired and how it develops over time. In this way her work might be viewed as *personal knowing* using Carper's (1978) patterns. Her interpretive research led to a description of the progression of nurses from novice to expert and an awareness of the importance of caring in nursing. Benner's work has been used to guide the examination of nursing practice innovations and changes. Benner and colleagues (2010) assessed nursing education for quality improvement recommendations. Her work guides patient care (Levy, 2004) and the development of nursing knowledge (Altmann, 2007). In Chapter 7, Benner scholar Karen Brykczynski, reviews Benner's work, illustrates its utilization and application with case presentations, and discusses use of the interpretive approach in her nursing practice.

Nursing Models

Nursing conceptual models (or frameworks) provide comprehensive perspectives for nursing practice. Models are broad conceptual structures that provide holistic views and specific foci of nursing. They are organizing frameworks for a particular perspective of nursing practice, such as adaptation, person-environmental process, interaction, or self-care. This section reviews seven works that have been specified as nursing models by analysis and evaluation (Fawcett, 2005; Fawcett & Garity, 2009).

BOX 3-1**Subsystems of Johnson's Behavioral System Model and Theories****SUBSYSTEMS**

Attachment or affiliative
 Dependency
 Ingestive
 Eliminative
 Sexual
 Aggressive
 Achievement

THEORIES

Theory of the Person as a Behavioral System
 Theory of a Restorative Subsystem (Grubbs, 1974)
 Theory of Sustenal Imperatives (Holaday, et al., 1997)

Johnson's Behavioral System Model

In nursing practice with the Behavioral System Model, the nurse views the person as a system of behaviors (Johnson, 1980). The actions and responses of the person comprise a system of interacting subsystems. Therefore, assessment of the subsystems leads to an understanding of the behavior of the patient. Seven subsystems and three theories of the Johnson Behavioral System Model are presented in Box 3-1.

The Theory of the Person as a Behavioral System is a grand theory implied in the model. Two middle-range theories have been derived from the model: the Theory of Sustenal Imperatives, developed by Holaday, Turner-Henson, and Swan (1997) and based on the work of Holaday (1974) and Grubbs (1974) and the Theory of a Restorative Subsystem (Grubbs, 1974), that proposes an additional subsystem to the seven-subsystem model developed by Johnson (see Box 3-1). Johnson's model was recently applied to adolescent dating relationships for developmental understanding (Draucker, Martsof, & Stephenson, 2012). In Chapter 8, Johnson scholar Bonnie Holaday illustrates the utilization and application of the model and theory in nursing practice (see Box 3-1).

King's Conceptual System

Nurses practicing with King's Conceptual System think in terms of three interacting systems: a personal system, an interpersonal system, and a social system (King, 1971, 1981, 1997). Nursing practice with this system is interactive because the nurse views the patient as a personal system with interpersonal and social systems. King identifies a group of concepts for each of the systems, that, when considered together, specify the processes of that system. The concepts of the three systems and theories derived from that model are presented in Box 3-2.

King (1981) developed the Theory of Goal Attainment from her own Conceptual System. Her theory that perceptual congruence and transactions in the

BOX 3-2**King's Conceptual System and Theories****PERSONAL SYSTEM CONCEPTS**

Perception
Self
Growth and development
Body image
Time and space

INTERPERSON SYSTEM CONCEPTS

Interaction
Communication
Transaction
Stress
Role

SOCIAL SYSTEM CONCEPTS

Power
Authority
Status
Decision making
Role
Organization

THEORIES

Theory of Goal Attainment (King, 1981)
Theory of Departmental Power (Sieloff, 1991, 1995)
Theory of Personal System Empathy (Alligood & May, 2000)
Theory of Empathy, Self-Awareness, and Learning Style (May, 2000)
Theory of Decision-Making in Women Eligible for a Cancer Clinical Trial (Ehrenberger, et al., 2002)
Theory of Nursing Empathy by University of Tennessee–Knoxville Empathy Research Team (Alligood, 2007)

nurse-patient interaction lead to goal attainment has been applied in many different areas of nursing practice (Alligood, 2010; Sieloff & Frey, 2007). Frey and Sieloff (2002) observed middle-range theory development as a major extension of King's work. So they updated their first book (Frey & Sieloff, 1995) in a second book, *Middle Range Theory Development Using King's Conceptual System* (Sieloff & Frey, 2007). King's many contributions to nursing have been noted (Clarke, Killeen, Messmer, et al., 2009). Sieloff and Bularzik (2011) updated the Sieloff-King Instrument for Organizational Assessment of Group Power. The King International Nursing Group (KING) maintains a website and holds annual conferences. In Chapter 9, Mary Gunter, a King scholar, presents King's work and practice applications (see Box 3-2).

BOX 3-3**Levine's Four Conservation Principles and Theories****CONSERVATION PRINCIPLES**

Energy
Structural integrity
Personal integrity
Social integrity

THEORIES

Theory of Conservation
Theory of Therapeutic Intention
Theory of Redundancy
Theory of Health Promotion for Preterm Infants (Mefford, 2004; Mefford & Alligood, 2011a,b)

Levine's Conservation Model

Nursing practice with the conservation model and principles focuses on conserving the patient's energy for health and healing (Levine, 1967, 1991). Four principles that constitute conservation for the whole person and three theories are noted (Box 3-3).

The Theory of Conservation is a grand theory that is implicit from the model and principles. Levine proposed two middle-range theories: the Theory of Redundancy that described the fail-safe systems of the human body and the Theory of Therapeutic Intention. Of these two theories, the Theory of Therapeutic Intention has been used by Schaefer (1991) in nursing practice and found highly relevant based on the connection to intervention. Mefford proposed (2004) and tested the middle-range Theory of Health Promotion for Preterm Infants based on Levine's Conservation Model (Mefford & Alligood, 2011a,b). In Chapter 10, Karen Moore Schaefer illustrates use of Levine's model and application of the conservation principles in nursing practice (see Box 3-3).

Neuman's Systems Model

When practicing nursing with *The Neuman Systems Model* (Neuman, 1982, 1989, 1995, 2002, 2011), the nurse views the client as a system of five variables interacting with the environment while focusing on stressors as they relate to client health. The five variables are physiological, psychological, sociocultural, developmental, and spiritual. These variables interact systematically with the lines of resistance, the normal line of defense, and the flexible line of defense as the client system responds wholistically with intrapersonal, interpersonal, and extrapersonal stressors as the two theories—the Theory of Optimal Client System Stability and the Theory of Prevention as Intervention—propose (Neuman & Fawcett, 2011). The Theory of Optimal Client System Stability is adaptable with changes in clients or other details of the client situation. The Theory of Prevention as Intervention is inherent in the systematic model because interventions are focused on increasing awareness of

BOX 3-4**The Neuman Systems Model and Theories****PATIENT VARIABLES**

Physiological
 Psychological
 Sociocultural
 Developmental
 Spiritual

SYSTEM DEFENSE

Lines of resistance
 Normal line of defense
 Flexible line of defense

THEORIES

Theory of Optimal Client System Stability (Neuman, 2011)
 Theory of Prevention as Intervention (Neuman, 2011)
 Theory of Adolescent Vulnerability (Cazzell, 2008)
 Theory of Moderation of Stress Levels in Women in Multiple Roles (Gigliotti, 2012)
 Theory of Maternal Student Role Stress (Gigliotti, 2011)
 Theory of Infant Exposure to Tobacco Smoke (Stepans & Knight, 2002)
 Theory of Well-Being for Fatigue in Diabetics (Casalenuovo, 2002)

stress and stress reduction for a prevention outcome. Both theories are useful in practice, linking nursing action with outcomes. These broad theories have many applications with age, health status, and stressors specified. Casalenuovo (2002) tested a middle-range theory of well-being in persons with diabetes. Other Neuman scholars continue to use the model in various areas of practice (Bigbee & Issel, 2012; Cazzell, 2008; Gigliotti, 2003; Lowry, Beckman, Gehrling, et al., 2007). In Chapter 11, Kathleen Flaherty demonstrates utilization and application of the Neuman Systems Model in nursing practice (see Box 3-4).

Orem's Conceptual Model

Nursing practice according to Orem's Conceptual Model (Orem, 1971, 1980, 1985, 1991, 1995, 2001) is a deliberate action of the nurse who views patients in terms of their self-care capacity. The concepts of Orem's model of nursing and her theories are presented in Box 3-5.

Orem specified the relationships of her concepts in a set of theories: self-care, self-care deficit, and nursing system. The three theories articulate to form an overall theory called *Self-Care Deficit Theory* (Orem, 2001). The theories specify a system of self-care and therapeutic self-care demand in relation to self-care requisites and nursing agency. The model and system of theories specify nursing action in relation to patient activity whether the patient is capable of self-care or needs compensation of care. Biggs (2008) provided an update on the state of the art and science of

BOX 3-5**Orem's Model and Theories****MAJOR CONCEPTS**

Self-care
 Self-care agency
 Therapeutic self-care demand
 Self-care deficit
 Nursing agency
 Nursing system

PERIPHERAL CONCEPT

Basic conditioning factors

THEORIES

General Theory of Nursing
 Self-Care Deficit Theory or Dependent-Care Deficit
 Theory of Self-Care
 Theory of Nursing Systems

Orem's theory. Seed and Torkelson (2012) applied Orem's model in acute psychiatric nursing and Wilson and Gramling (2009) to burn care. In Chapter 12, Orem scholar Violeta Berbiglia describes Orem's model and its utilization and application in nursing practice (see Box 3-5).

Rogers' Science of Unitary Human Beings

Practice based in the Science of Unitary Human Beings (SUHB) (Rogers, 1970, 1986, 1990, 1992), has a systematic focus of the life patterning of the human being. The four concepts are *openness*, *energy field*, *pattern*, and *pandimensionality*, and three homeodynamic principles—*helicy*, *resonancy*, and *integrality*—describe the relationship of the concepts of the science (Box 3-6).

Rogers' SUHB has supported many theories by Rogers and others. The conceptual system and its theories guide research, education, and practice. The first three theories listed were proposed by Rogers (see Box 3-6). The SUHB was used by other theorists (Parse and Newman) for theory development, as noted in Box 3-6. Theories for testing have been proposed and tested by many Rogerian scholars (Allgood, 2002; Allgood & Fawcett, 2004; Allgood & McGuire, 2000). Bultemeier's (1993) Theory of Perceived Dissonance is an example of a middle-range theory derived from Rogers' Theory of Accelerating Change and tested in women experiencing premenstrual syndrome (PMS). Development of SUHB methodologies and instruments has facilitated the utilization of Rogerian science (Barrett, 2010; Butcher, 2006; Cowling, 2001; Cowling & Swartout, 2011; Fawcett & Allgood, 2001; Green & Greene, 2012). The Society of Rogerian Scholars presents an Annual Fall Rogerian Conference, maintains a website, and publishes *Visions: The Journal of Rogerian*

BOX 3-6**Rogers' Science of Unitary Human Beings and Theories****CONCEPTS**

Openness
 Energy field
 Pattern
 Pandimensionality

PRINCIPLES

Helicy
 Resonancy
 Integrality

THEORIES

Theory of Accelerating Change
 Theory of Paranormal Phenomena
 Theory of Rhythmical Correlates of Change
 Theory of Health as Expanding Consciousness (Newman, 1994)
 Theory of Human Becoming (Parse, 1992)
 Theory of Perceived Dissonance (Bultemeier, 1993)
 Theory of Aging (Alligood & McGuire, 2000)
 Theory of the Art of Nursing (Alligood, 2002)
 Theory of Pattern (Alligood & Fawcett, 2004; Fawcett & Garity, 2009)

Nursing Science. In Chapter 13, Rogerian scholar Kaye Bultemeier discusses the utilization and application of the SUHB in practice.

Roy's Adaptation Model

When nursing practice is based on the adaptation model, the focus is on the person as an adaptive system (Roy, 1980, 1984, 2011; Roy & Andrews, 1999; Roy & Roberts, 1981). Adaptation occurs through cognator and regulator control processes that lead to coping behaviors in the four modes: physiological, self-concept, role function, and interdependence.

Roy has developed a highly abstract Theory of the Person as an Adaptive System, and the four modes are less abstract theories (Box 3-7). In terms of specificity to nursing practice, the Theory of the Person as an Adaptive System is a grand theory and the four theories of the modes are middle-range theories specific to ways of coping.

Phillips (2011) tested Roy's Theory of the Person as an Adaptive System proposing adaptation of persons living with acquired immunodeficiency syndrome (AIDS) and stigma. His work is an example of how middle-range theory derives from grand theory and specifies an outcome (coping in the four modes) in a specific patient population (persons living with AIDS). Dunn (2005) tested a middle-range theory of adaptation to chronic pain. The work continues to be used globally (Debiasi, Reynolds, & Buckner, 2012; Dobratz, 2008; Weiland, 2010). In Chapter

BOX 3-7**Roy's Adaptation Model and Theories****ADAPTATION PROCESSES**

Cognator and regulator

MODES OF COPING

Physiological, self-concept, role function, and interdependence

THEORIES

Theory of the Person as an Adaptive System

Theory of the Physiological Mode

Theory of the Self-Concept Mode

Theory of the Interdependence Mode

Theory of the Role Function Mode

Theory of Adaptation to Chronic Pain (Dunn, 2005)

14, Roy scholar Ken Phillips illustrates the utilization and application of Roy's model and theories in his nursing practice.

Nursing Theories

Nursing theories are theoretical works in the structure of nursing knowledge. They are sets of related concepts that propose a testable outcome (e.g., Neuman's Theory of Optimal Client System Stability, Roy's Theory of the Person as an Adaptive System). Theories are less abstract than models, are more prescriptive, and propose more specific outcomes. Theories are usually named for the outcome they propose or for characteristics of their content, as noted in the examples given previously.

Orlando's Theory of Nursing Process

Orlando's early work (1961) was the Theory of Effective Nursing Practice and later as the Theory of Nursing Process (Orlando, 1990). Her work is specifically about how nurses process observations and respond to patients based on their inferences from the nurse-patient interaction. She differentiates automatic action from deliberate action and specifies the utility of the latter. Therefore, her work is a practice theory specific to the communication process of interaction between the nurse and the patient. Orlando's work has been used as a framework for fall prevention (Abraham, 2011). In Chapter 15, Barbara Ann May discusses the utilization and application of Orlando's framework in nursing practice.

Modeling and Role-Modeling Nursing Theory

Modeling and role-modeling (Erickson, Tomlin, & Swain, 1983) is a theory of nursing that is specific enough to guide nursing practice yet abstract enough for middle-range theories to be derived from it. This theory is derived from developmental theory, from inherent needs and stressors, and from adaptation theory. Nurses and patients are in relationships, and nurses learn from patients about their worlds.

As nurses and patients understand the situation more clearly, resources are identified that move patients toward the goal of self-care action to satisfy their needs. Applications include nursing care in advanced cancer patients (Haylock, 2012) and theory-based practice in a major medical center (Alligood, 2011). In Chapter 16, Margaret Erickson discusses the utilization and application of this theory in nursing practice.

Mercer's Theory of Becoming a Mother

Mercer's (1986, 1995) theory is specific to maternity nursing and the process of becoming a mother for new mothers and mothers-to-be. Mercer's work is a systematic, dynamic developmental approach to the interrelationships among the parents and the infant. She has isolated stages and identified factors that affect the role to assist the nurse in determining where the mothers (or parents) are in the developmental process as they progress toward becoming a mother (or parent). In Chapter 17 Molly Meighan discusses and illustrates utilization and application of Mercer's work in nursing practice.

Leininger's Theory of Culture Care Diversity and Universality

Leininger's (Leininger & McFarland, 2006) work is specific to culture and transcultural nursing. The goal of transcultural nursing is a plan of care based on culturally defined knowledge and use of the plan in care that is culturally congruent. Her theory is broad; it addresses the cultural aspects of all of human life with particular attention to the practices of health and caring. Leininger considers culture of patients and the culture they encounter as they seek health services. The focus is on culture care preservation, accommodations, or repatterning according to patients' needs. Numerous expressions of caring have been identified (McFarland, 2010). In Chapter 18, Marilyn McFarland presents utilization and application of Leininger's theory in nursing practice.

Parse's Theory of Humanbecoming

Parse's theory is derived from Rogers' SUHB and phenomenology and is designated as a human science. Her work has a philosophical perspective specific to the nurse-patient relationship and patients and their health. Parse distinguishes nursing from medicine and makes a contribution to differentiation of the two disciplines. Her work poses nursing as a profession in its own right that focuses on the patient's human becoming and health. She proposes health as a co-creation with the universe for patients as they experience the being and becoming of life.

Parse sets forth the following three principles (Parse, 2012, p. 45):

1. Structuring meaning is the imaging and valuing of languaging.
2. Configuring rhythmical patterns is the revealing-concealing and enabling-limiting of connecting-separating.
3. Co-transcending with possibles is the powering and originating of transforming.

Many practice applications of Parse's theory in the literature are cited in Chapter 19, where Bournes and Mitchell discuss Parse's theory and its application and utilization in nursing practice.

Newman's Theory of Health as Expanding Consciousness

Newman's (1994) work is a theory of health derived from Rogers' SUHB. Newman proposes a life process pattern focus to understand health (and illness) in a pattern of the whole. The nurse interacts with patients viewing them in terms of the pattern of their lives. This pattern is learned in relation to time, space, and movement, which are correlates of consciousness. Nurses relate with patients to discover their perceptions of their health, and this participation facilitates discovery of their inner strengths and new understandings as their consciousness pattern unfolds. Applications of Newman's theory in the literature include maintaining weight loss (Berry, 2004) and living with hepatitis C (MacNeil, 2012). Dyess (2011) developed the concept of faith, and Brown (2011) interpreted grounded theory research. In Chapter 20, Janet Witucki Brown and Allgood present utilization and application of Newman's theory in nursing practice.

Nursing Theory, Critical Thinking, and Best Practices

As the nursing profession developed, the complexity of practice increased and clarified the linkage of critical thinking and professional practice (Daiski, 2000; Turner, 2005). Emphasis on best practices and evidence for practice magnifies the importance of nursing theory for critical thinking in practice decisions (Fawcett & Garity, 2009). Nursing theory structures decision making in practice, joining the knowledge and action of praxis or the art and science of nursing (Kilpatrick, 2008). Theory provides basic nursing information and guides professional nursing action (Bigbee & Issel, 2012). The use of frameworks to guide the beliefs and action of nursing practice in the rapidly changing health care environment is vital to meet the emphasis on evidence and best practices (Fawcett & Garity, 2009). Without structure, best practices are at risk to fall short of quality patient care and hamper the growth of nursing science (Conn, Cooper, Ruppert, et al., 2008; Fawcett & Garity, 2009; Pearson, Wiechula, Court, et al., 2007).

Kuhn (1970) has stated that it is the study of the models or paradigms of a scientific discipline that primarily prepares students for practice as members of a professional community. A paradigm (model or framework) plays a vital role in practice because without a framework, all of the information that the professional encounters seems equally relevant. When students enter a professional discipline, they are introduced to the models and theories as an orientation to that discipline and the approaches used in the practice of that discipline. It is true for psychology, sociology, or the science disciplines and it is true for orientation to the discipline of nursing as well.

Following an introduction and survey of the models, students are ready to identify the model or models for their practice. It is in studying these models and practicing with them that students will "learn their trade" (Kuhn, 1970, p. 43). The National Council for Excellence in Critical Thinking Instruction maintains a definition of critical thinking for higher education that aligns well with the thinking in nursing practice (Scriven & Paul, 2004).

"Critical thinking is the intellectually disciplined process of actively and skillfully conceptualizing, applying, analyzing, synthesizing, and evaluating information

TABLE 3-2 Comparison of the Processes of Critical Thinking and Nursing Thought

| Critical Thinking Process | Nursing Thought Process |
|-------------------------------------|---|
| 1. Purpose, goal, or end in view | Person's health outcome |
| 2. Question at issue or problem | Person's health at risk |
| 3. Point of view/frame of reference | Person viewed (w)holistically |
| 4. Empirical dimensions | Person, environment, health, and nursing |
| 5. Conceptual dimensions | What is the client view in the conceptual lens? |
| 6. Assumptions | What are the assumptions of the selected model? |
| 7. Implications | What does the view with this model imply? |
| 8. Inferences | What reasoned hunches are inferred? |

gathered from, or generated by, observation, experience, reflection, reasoning, and communication, as a guide to belief and action” (Paul & Nosich, 1991, p. 4).

The fact that nursing is a practice profession carried out for a specific purpose, according to the laws governing it in each state, makes nursing practice a licensed purposeful activity. Nurses are obliged to answer a social mandate and use reasoning to meet the criterion required for critical or higher-order thinking. Nursing theoretical works guide the reasoning of critical thinking (Bond, et al., 2011). A comparison of the eight elements of thought in critical thinking and nursing thought with nursing models in Table 3-2 illustrates this premise.

In this era of theory utilization, the discipline of nursing continues to develop evidence of the vital contribution of nursing practice to patient outcomes (Daiski, 2000; Fairman, 2008). The process and content of nursing are intertwined in a unique way in theory-guided critical thinking that leads to quality practice. Nursing process expands to a complex consideration of the philosophical, conceptual, and theoretical perspectives of patients and their worlds, for unique approaches to nursing practice.

One can see how development of the professional level of nursing came to emphasize outcomes and best practices. Processes beg the question “Process for what?” Theory-based practice answers that question: the framework specifies the content and the process guiding the thought and action to best practices. Very early, Mayberry (1991) recognized the value of nursing frameworks for nursing practice, saying “Theories and models reveal the relationship of one part of nursing to another. They provide a systematic approach for thinking about nursing matters, for observing the nursing situation, and for interpreting what is seen in the practice setting” (p. 47). Kerlinger (1979) said, “The most important influence on practice is theory” (p. 296) and Levine (1995) noted the rhetoric of theory illuminates care with a perspective of the person, nursing action, and expected outcome. The type of high-level thinking needed to practice in health care systems today requires that nurses structure their thinking process. Nursing philosophies, models, and theories provide such structure.

Selecting a Framework for Nursing Practice

This chapter has presented content that is useful when selecting a model or theory for practice. However, in addition to the values of philosophies, models, and theories and an understanding of how they relate to the thought and action of nursing practice for best practices, an additional factor is offered—a guide to use when selecting a theory for your nursing practice.

The “fit” between the values inherent in the framework and your personal values as a nurse is vital to professional theory-based practice. Therefore, recognizing your personal values and those within the framework assists you to select a model best suited to your practice. The process of selecting a model or theory requires thoughtful consideration and the actual experience of use in practice because the model or theory is a tool for reasoning and decision making in practice.

You may find that writing a brief philosophy of nursing helps clarify your beliefs and values. This exercise can be done using the headings of *person*, *environment*, *health*, and *nursing* or other concepts that come to mind when you consider nursing and why you chose the nursing profession. The thought process of writing a philosophy compels you to recognize beliefs and values you hold true. Once your beliefs are clarified, surveying the definitions of person, environment, health, and nursing in the nursing theoretical works leads you to particular theoretical works to consider. Reviewing the assumptions of the philosophy, model, or theory in comparison with statements in your philosophy helps you identify an association between a theoretical work and your values and beliefs. This process may be undertaken by considering whether the concepts in the theoretical work you have selected focus on ideas similar to the values expressed in your philosophy about the patient, environment, health, and nursing. Certain framework ideas may resonate with your ideas. Chapter 4 may be helpful in this process as Pam Grace discusses values in nursing works.

The survey and evaluation of various frameworks lead to the next step: exploring particular philosophies, models, or theories in more depth. The process in this step is a bit like “trying them on.” You should consider the frameworks that you have identified as similar to your values and beliefs and make trial applications in your area of nursing practice. As you compare two or three frameworks on client focus, nursing action, and proposed outcome, you will find that a more in-depth understanding of the frameworks emerges. That is, your use of the framework in nursing practice expands your understanding of the framework and your practice. Reviewing the nursing literature written by authors who have used the framework in various areas of nursing practice will increase your understanding and highlights the flexibility of the model as you see its application and utilization in various practice areas. Finally, select a nursing theoretical framework and develop its use for your practice. After you have practiced with the philosophy, model, or theory, it becomes more natural and you can tailor it to your personal art of nursing or style of practice. The guidelines in Box 3-8 may be useful as you identify a framework for theory-based nursing practice. Remember, the first step toward theory-guided practice is the decision to do so, which is a truth discovered many years ago (Mathwig, 1975). Developing a basis of understanding for professional nursing is where you start to achieve best practices and outcomes.

BOX 3-8**Guidelines for Selecting a Framework for Nursing Practice**

1. Consider values and beliefs personally held about nursing.
2. Develop a philosophy statement about persons, environment, health, and nursing.
3. Survey meaning of person, environment, health, and nursing in nursing frameworks.
4. Identify two or three frameworks that resonate best with your values and definitions.
5. Review the assumptions of the frameworks you have selected.
6. Apply the frameworks in your nursing practice (try them in actual practice situations).
7. Compare the frameworks with attention to client focus, nursing action, and client outcome.
8. Review nursing literature written by persons who use the frameworks in their practice.
9. Select a framework and begin to develop its use in your nursing practice.

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Philosophies, Models, and Theories: Moral Obligations

Pamela J. Grace

The end or purpose of nursing is the well-being of other people...it is a moral end. That is, it involves the seeking of a good, and it involves relationships with other human beings. The science learned and the technical skills developed are designed and shaped by this moral end.
(Curtin & Flaherty, 1982, p. 86)

This chapter explores the moral obligations that are inherent in nursing's theoretical works. An underlying assumption of this chapter is that nursing is a moral undertaking. This assumption is defensible because of the nursing profession's implicit and explicit promises to provide a vital service to society—services that propose to address, via the endeavors of its scholars and practitioners, certain needs associated with human functioning. A recent work has identified from several decades of nursing literature a consistent focus of, and for, nursing work. This central unifying focus is articulated as “facilitating humanization, meaning, choice, quality of life, and healing in living and dying” (Willis, Grace, & Roy, 2008, p. E28). This focus is inherent in almost all (if not all) nursing's theoretical works. Nursing furthers a *good* for individuals and for society. However, the idea that nursing is engaged in providing for a *good* makes nursing actions susceptible to moral criticism. We can say that actions are good or bad, praiseworthy or blameworthy, to the degree that they are aimed at advancing nursing's purposes in regard to human functioning and flourishing or the relief of suffering. As a point of clarity the terms *ethical* and *moral* are used interchangeably in this chapter. Although in some settings a distinction is made between the terms *good nursing actions*, *ethical nursing actions*, and *moral nursing actions*, these terms are synonymous. They are representative of actions that are required of the nurse.

It follows then that there is a disciplinary responsibility for ongoing theorizing about the nature of nursing, the boundaries of practice, and the knowledge necessary for practice. This is because nursing does not take place in a static world.

Knowledge about humans and their needs evolves in response to environmental and social changes, and these changes tend to be interrelated with scientific knowledge developments as well as sociopolitical movements. Thus a discipline such as nursing needs knowledge that continues to be effective in its provision of services and is continually and responsively evolving. The theoretical works of nursing must be able to account for and remain relevant to contemporary conditions of nursing practice. They provide a basis for understanding why nursing as a profession is necessary, what needs it serves, and what the essential nature of the profession entails. They also direct knowledge development and are influenced by knowledge developed in other fields. Since the publication of an article by Carper (1978) that was based on her dissertation work, it has become generally accepted that there are various types of knowledge used in nursing practice.

Nursing Ways of Knowing

Carper (1978) identified four patterns of knowledge used by nurses as a result of her review and synthesis. The four types of knowledge were empirical knowledge (the science), esthetic knowledge (the art), personal knowing (an ability to understand one's relationship to another for whom one has assumed certain responsibilities, as in the nurse-patient relationship), and ethical knowing (understanding what constitutes good actions). These forms of knowing are interrelated and only distinguishable for the purposes of discussion. Take the following relatively simple example as an admittedly rough illustration. A patient suffers a gastrointestinal hemorrhage secondary to a duodenal ulcer. It is severe but not immediately life-threatening. *Empirical knowledge* gives us an understanding of the pathophysiology and what is necessary to restore homeostasis. In this case, a blood transfusion is needed. However, from previous theorizing we understand that human beings are complex individuals who differ in their needs and our job, in part, is to understand what those individual needs are. *Personal knowledge* is that knowledge of self that the nurse uses to form a therapeutic relationship with the patient and that permits the discovery of contextual details that are important to understanding "who" this particular person is (given the limits of any emergency situation). In this case, our patient has a fear of needles and is afraid of dying. *Esthetic knowing* involves creativity in tailoring interventions that are appropriate and effective for this patient's needs. *Ethical knowledge*, in turn, is about conceptualizing what good actions are for **this** patient and determining how to achieve them, even when obstacles exist. The four types of knowledge are interrelated and all are essential for optimal nursing care.

Jacobs-Kramer and Chinn (1988) subsequently expanded on this model of nursing knowledge and White (2009, 1995) provided a critique of the work both of Carper and of Jacobs-Kramer and Chinn. She recognized the absence of sociopolitical knowing, which "represents a fifth pattern of knowing essential to an understanding of all the others" (p. 403) and consequently to appropriate (or optimally beneficial) actions. Sociopolitical knowing, labeled *emancipatory* by Chinn and Kramer (2008), permits us to see that the roots of many ethical problems are buried within the contexts in which nursing care is provided or in the environments of our

patients. It facilitates a broader understanding of our professional responsibilities as continuing beyond resolution of the immediate situation. In accord with White's critique this chapter takes ethical knowledge in nursing as a broad concept. Ethical knowing in nursing must inevitably encompass the evaluation and critique of environments of practice that obstruct good nursing care as this is conceptualized by nursing philosophers and theorizers. That is, ethical knowing at the theory development level inevitably requires an understanding of the discipline's obligations to the broader society given the nurse theorist's—albeit tentative—answers to the following question: What is nursing and what does it do?

Ethical Knowing: Broadening the Scope

Flaming (2004) has argued that, insofar as theories assert what nursing is (ontology), they might be said to represent ethical imperatives. For example, it is generally agreed that one role of nursing is to promote health (however, this is ultimately defined by the nursing philosopher/theorist). Given this claim, then, we ought to be able to promote health by identifying, developing or acquiring, and using the necessary knowledge and skills. Further, when nursing actions to facilitate health are obstructed by environmental conditions, there are ethical obligations to address such obstacles. Barriers to good actions are most effectively addressed when individual professionals are not working alone. Obstructions often require educated, concerted, and coordinated efforts to tear them down. Such efforts depend on both the ability to identify the source of barriers and an understanding that an obligation exists to develop strategies that address the barriers. Theorizing and knowledge development necessarily incorporate the recognition that there are professional responsibilities for optimal practice (Chinn & Kramer, 2010).

Of course, there may be many reasons why a particular theoretical work is inadequate to direct ethical (good) practice, including that it is in an early stage of development. The assumptions of the work may be at too high a level of abstraction and development of propositions or principles may be too immature for decision making in a variety of settings or for particular situations, or important aspects of the theory have not been tested for soundness. With this proviso in mind, it can nevertheless be asserted that theory used as a guide for practice beyond determining what is generally "good" practice should also be able to assist the individual nurse in deciding appropriate courses of action in a variety of diverse situations. In addition, it should give explicit or implicit directions for the nurse when obstacles to good practice arise (Kenney, 1999).

In this way a particular theoretical work assists the individual nurse with clinical reasoning, judgment, and ensuing action (clinical decision making) as well as with ethical reasoning, judgment, and ensuing action (ethical decision making). In this sense, clinical and moral reasoning in nursing are intimately related if not synonymous because the best clinical action or actions are those that are ethically warranted. However, further ethical reasoning may be needed to determine the best courses of action when the "good" clinical action is blocked by environmental conditions of varying sorts (e.g., institutional restrictions, health care delivery system problems, interpersonal conflicts).

The Moral Endeavor

As noted, an examination of nursing viewed as a moral endeavor is appropriately addressed via the explications of nursing's theorists and scholars. This is so because theorizing in nursing is aimed at the following two main ends:

1. To describe and explain nursing
2. To provide a structure or framework that facilitates practice, research, and practitioner education

Within each of the theoretical works are moral implications and imperatives for the student, practitioner, researcher, or educator. Additionally, implications exist for the profession as a whole related to structuring environments in a way that enable theory-derived practice as described later.

The moral concerns of nursing as a practice profession are derived primarily from the works of these original thinkers, who realistically can be considered nursing's philosophers. Whereas general philosophy engages in the search for knowledge or wisdom about humans and the world in which they find themselves, nursing philosophy has a more particular focus. Nursing philosophies attempt to answer the question "What is nursing?" as well as the following related significant question: "Why is nursing important to human beings?" It is the task of other parts of this book to look at practice directed by various philosophical and theoretical frameworks; the purpose of this book's companion text—Alligood and Marriner Tomey (2010)—is to delineate more clearly the formulations of nursing's theorists and the distinctions among them. This chapter draws on such literature in an effort to clarify the moral responsibilities and obligations that accompany philosophically founded practice.

As noted, the question of whether there is or can be a central unifying focus for nursing given differences in philosophical beliefs and conceptual approaches of nursing's scholars was revisited recently (Willis, et al., 2008). A synthesis of historical and contemporary theoretical works points to a central unifying focus. Embedded in most if not all of nursing's theoretical works is the idea that nursing practice involves "facilitating humanization, meaning, choice, quality of life, and healing in living and dying" (p. e28). Thus regardless of differing methods and approaches to knowledge development, implicit in almost all of nursing's theoretical works is this underlying focus that in turn can, arguably, serve as a touchstone for the ethical appraisal of nursing actions.

Guided Practice

It has been noted that nurses who believe they are not practicing according to theory are in fact using some sort of internalized guide. That is, individual nurses are using a personal philosophy or theory that directs their practice. Such frameworks also have inherent moral components. The tenets or assumptions of a personal or nonnursing framework used for nursing practice require examination for congruency with nursing's purpose. Critics have rightly questioned the capacity of such personal frameworks to adequately accomplish nursing's purposes. Moreover, insights from moral and cognitive psychology research reveal that actions, even the reasons given for actions, can be inconsistent depending on whether one is reacting "in-the-moment" or

purposefully deliberating (Doris & Moral Psychology Research Group, 2010; Egleman, 2011). It is unlikely that individual nurses have engaged in the sort of rigorous investigation and analysis undertaken by nursing theorists in formulating their views; therefore, the capacity of such practice to be consistent is questionable. Thus the following discussion is appropriate for nurses who are openly using the ideas of a theorist to guide practice and to those who are not—or at least are not at present.

The bases for nursing practice have been explicated in one or more of the following forms: philosophies, conceptual models, and/or theories. For simplicity and from this point forward in the chapter, when it is necessary to refer simultaneously to the terms *philosophies*, *models*, and *theories*, they will be grouped under the term *theoretical works*. An elucidation of the distinctions and relationships among these terms is discussed in the writings of Fawcett (2005), Higgins and Moore (2000), and Alligood and Marriner Tomey (2010). Discussions regarding the validity of these distinctions have appeared in the nursing theory literature; however, it is generally understood that where distinctions are made, the conceptual progression of the theoretical works is from more abstract to less abstract. Philosophies are more abstract than conceptual models, which in turn are more abstract than theories. It should also be understood that each of the theorists developed their conceptual model and theory or theories from a foundational philosophy or from a synthesis of one or more philosophies.

Professional Goals

The use of philosophies, models, and theories as guides for nursing practice and the reverse influence of practice experiences on theory development are factors critical to the development of nursing's knowledge base and thus to the maturation and evolution of the discipline. However, as noted, it is the discipline's explicit aim of contributing both to the health of individuals and to the overall health of society that makes nursing itself a moral endeavor. The discipline's broad goal of promoting health includes restoring health, preventing illness, and relieving suffering (International Council of Nurses [ICN], 2006). Health is a human good in that it is necessary for optimal functioning. It is a state of being that is generally (if not universally) valued by individuals and societies. This objective of the profession—to further overall health or well-being—constitutes nursing's promise to society. The objective, along with guidelines for the ethical conduct of practicing nurses, is publicly articulated in codes of practice such as the American Nurses Association's (ANA) *Code of Ethics for Nurses with Interpretive Statements* (ANA, 2001; Fowler, 2010), the ICN's (2006) *Code of Ethics for Nurses*, and a variety of codes that have been developed in other countries, and thus more specifically address the cultural norms of that country. Codes of ethics, as noted elsewhere, might be conceived as the tentative end results of an evolving profession's political process (Grace, 1998, 2001). This is because codes of ethics are formulated as a result of a given profession's intradisciplinary conversations over time; they publicly articulate the purpose and the manner in which its services will be furnished to society. Therefore, the formulation of codes of ethics for a discipline is influenced by both scholars and practitioners of nursing and, more indirectly, by society.

Codes of ethics are subject to change over time and in response to societal needs (Grace & Gaylord, 1999). For this reason they are somewhat reflective of what society expects of the profession in question, although this influence is indirect. The public is generally not well informed about any given discipline's code of ethics, which is predicated on disciplinary goals and focus, or about the implications of these codes for practitioners. Viens (1989) presents a good historical account of the development of the ANA code over the past century. The ANA periodically updates its code. The latest revision was published in 2001. An opportunity for input from the wider nursing community was provided during this process. Changes to this latest document include the idea that the nurse has responsibility for his or her personal integrity. Provision 5 states, "The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence and to continue personal and professional growth" (ANA, 2001, p. 18). At first glance this seems a strange addition. However, a deeper look at the explanatory statements for this provision reveals the idea that personal empowerment is at issue. This involves both knowledge of self as an integrated being (Fowler, 2010), the strength to maintain integrity even in difficult situations, and the acquisition of knowledge necessary for competent practice. These qualities are seen as imperative in furthering nursing's purposes especially in times of economic turmoil and chaotic environments. The relatively recently described concept of moral distress has been ascribed to the shaken sense of personal integrity that occurs when one has acted against one's personal or professional values (Corley, 2002; Corley, Minick, Elswick, et al., 2005; Hamric, 2012; Jameton, 1984). Moral distress is a cause of harm to nurses but ultimately to patients. Nurses may leave the profession as a result of unresolved moral distress or distance themselves from the patients for whom they provide nursing care (Huffman & Rittenmeyer, 2012). Because moral distress results from a sense of powerlessness to act differently, one antidote to moral distress is taking action to resolve the problem. Although the ANA code provides guidelines for U.S. nurses, its pertinence to global nursing remains unclear even in the latest iteration. The ICN's (2006) *Code of Ethics for Nurses* speaks more explicitly to the conduct of nurses practicing in a wide variety of countries.

Nurse philosophers/theorists, along with other influences, affect both the development and revisions of the *Code of Ethics for Nurses with Interpretive Statements* (ANA, 2001) and the conceptions of what constitutes ethical practice. Whereas the *codes of ethics* give broad guidelines related to the conduct of nurses, theoretical works might be expected to give more specific direction. The moral implications of practicing according to a given theorist's works involve all of the following: individual, group, community, societal, and perhaps—although more debatably—global considerations. Therefore, the writings of nursing's theorists, the profession's codes of ethics, and the recognition of central unifying foci (Fawcett, 2000, 2005; Willis, et al., 2008) for the discipline each prove useful in clarifying the moral responsibilities of practice, including knowledge development needed for practice.

Health as a Metaparadigm Concept

Nursing's metaparadigm also proves important to the present discussion because the metaparadigm concepts are those "that identify the phenomena of central interest

to the discipline” (Fawcett, 2000, p. 4). They specify or identify the scope of concern for the profession. References to four concepts—(1) health, (2) person, (3) environment, and (4) nursing (viewed as a verb or action rather than as the discipline)—are explicitly or implicitly present in the writings of almost all of nursing’s philosophers and/or theorists. One of the metaparadigm concepts, health, is (although perhaps arguably) a designator for nursing’s main purpose with regard to the population of concern. How health is viewed and addressed depends, of course, on the particular theorist’s definition, which will stem from a philosophy regarding the nature of human beings and of the world in which they find themselves or of which they are parts. Because the metaparadigm concepts are at the highest level of abstraction, they do not guide action for the practitioner; rather, they clarify the boundaries of the action and subject matter of a discipline (Fawcett, 2005). In addition, as noted, the metaparadigm concepts delineate the scope of nursing’s foci of concern.

It is from the description or definition of health, along with those of environment, person, and nursing as given by the nursing scholars, that direction is provided for the practitioner. It remains to be seen whether the recently proposed central unifying focus (Willis, et al., 2008) will withstand criticism. As the proposal is considered, its facets could contribute to the refining of the goals of knowledge development and practice. The characteristics of the metaparadigm concepts may be explicit in the scholar’s writings, or they may be implicit. Thus actions taken by a nurse to further health may also vary in accordance with the philosophy, model, or theory used to guide practice, depending on a nurse’s personal philosophy or belief system. It becomes important, then, for nurses to understand not only the philosophical and theoretical implications but also the moral implications of practicing according to a certain perspective. Understanding is required because nursing actions that stem from a certain viewpoint may be inadequate for this purpose for a variety of reasons, although they are directed at fostering health.

Moral Implications of Philosophically or Theoretically Guided Practice

A grasp of the implications of certain viewpoints gives nurses the capacity for adjusting practice in such a way as to most consistently address health for the individual, group, or society. The nurse has three main responsibilities if the ramifications of a given perspective seem dissonant with any, or any combination, of the following:

- The context or situation
- The nurse’s philosophy
- The patient’s philosophy or beliefs

First, it is necessary to check that the framework is consistent and well developed. Second, the nurse must understand whether it is being utilized as intended. An inadequate grasp of both the framework and its implications for practice has the potential for poor or inconsistent practice. Third, it is important to investigate whether another framework is a better fit for the setting, the patient’s situation and/or beliefs about health, or the practitioner’s beliefs. Logically, then, it follows that practicing according to a well-established theoretical framework generally results in more consistent and better care than does practice without such guides, even in those cases in which there

is some disagreement about the underlying philosophical assumptions. If a nurse chooses to avoid the use of any of the discipline's theoretical structures in favor of a personal one, that nurse should be capable both of articulating what that theoretical structure of choice is and of justifying its use. One way to do this is by demonstrating that it leads to consistent practice and that it is capable of furthering the profession's purpose. Thus the practices of such nurses are also subject to moral critique.

There are a variety of reasons a nurse who purports to be grounding practice in a given philosophical and/or theoretical point of view might be faced with or, worse, be ignorant of resulting problems. The following section provides a brief discussion of possible issues for nurses and for those receiving (or not receiving, as the case may be) care. The major questions that present themselves are important for theorists, practitioners, educators, and researchers, as well as for students of nursing. They concern, among other things, the moral responsibilities or, more strongly, obligations attendant on theory-based practice. This list is not intended to be exhaustive but rather to clarify some of the moral problems associated with directed practice.

Major Questions for Theory-Based Practice

In Chapter 3 the idea of theoretical frameworks as critical thinking structures was introduced. There it was noted that the first obligation of any nurse in selecting a framework for practice is reflection. The nurse reflects on the congruence of a personal philosophy of nursing with the underlying philosophical assumptions of the theorist. The next consideration entails an exploration of the specific responsibilities and/or obligations of a nurse practicing according to a particular theoretical or philosophical perspective. For example, nurses must ask themselves the following questions:

- Are my beliefs and values about the nature of human beings and nursing's role congruent with those underlying the theorist's assumptions?
- What are my responsibilities to be faithful to the original intent of the theorist?
- What is the fit between the context of my practice and the framework I wish to use?
- To what am I committed by using this perspective?
- What further obligations exist when I find myself unable to practice according to the spirit of my chosen framework?
- Are there further obligations explicit or implicit in the guiding framework or philosophy when obstacles to practice present themselves?

These questions have serious implications for nursing's purpose of addressing health in whatever manner it is conceptualized by the philosopher or by the theorist. Thus they all represent crucial moral considerations for a nursing student, practitioner, researcher, or educator because health itself is defined differently in the various theoretical works.

Philosophical Fit

A fundamental concern of nurses, in this process, is to ensure that their personal philosophies about the nature of human beings are congruent with the underlying

philosophy of the theory. This is necessary because a philosophy, as Salsberry (1994) has pointed out, “relates nursing to a particular world view” (p. 13). A philosophy highlights those values that provide direction for practice and therefore for the practitioner (Salsberry, 1994). The following example illustrates this point: A nurse’s beliefs about human nature are congruent with those of Roy (2009) where human beings are understood to be “adaptive system(s)” and are “described as a whole comprised of parts” that “function(s) as a unity for some purpose” (p. 29) and nursing work is “to promote adaptation for individuals and groups in (the) four adaptive modes” (p. 29). However, if the nurse uses Rogers’ ideas to guide practice there is likely to be some dissonance. Rogers’ fundamental philosophical beliefs about the nature of human beings differ from those of Roy. She postulated persons as irreducible wholes in which cause and effect are not separable and man and environment are also not separable but instead “energy fields” that interact with each other (Rogers, 1987). Nursing actions for Roy are aimed at specific identifiable problems or areas where adaptation is seen to be necessary. However, good nursing actions for Rogers require an understanding of what constitutes “quality of life from the person’s perspective” (p. 136). Thus the possibility of incoherence in practice exists. Practice incoherence not only interferes with the logical reasoning of the nurse but also has implications for how health is understood and consequently what is needed to optimize health for the practice population. That is, patient goals outweigh nursing goals.

The questions one asks of Roy’s patients are framed in terms of the person viewed as a complex whole: “In a nursing situation, the primary concern is a certain type of behavior, behavior that requires further adaptive responses as a result of environmental changes straining the coping processes of the human adaptive system” (Roy, 2009, p. 59). The nurse’s concern is to assess the person in terms of the person’s adaptation to circumstances “internal or external” (p. 59) that threaten integrity (Roy, 2009). Therapeutic nursing actions and the effects of these upon the individual are thus aimed at assisting adaptation. A nurse whose philosophical beliefs are more consistent with Rogers’ view of persons in their life process as irreducible wholes that cannot be understood in terms of their parts will experience dissonance in trying to practice according to Roy’s framework. According to Roy’s view, nurses should attempt to identify problems in each adaptive mode (physiological, interdependence, self-concept, and role function) and subsequently design interventions to facilitate adaptation where necessary. In the case study presented in Chapter 14, Kenneth Phillips (2010) illustrates the care of Debbie using Roy’s model and theories as the framework for practice.

Debbie is a woman with multiple physical and psychosocial issues. Her present admission is for a radical hysterectomy and bilateral salpingo-oophorectomy for stage II squamous cell cancer. Phillips carefully works through the assessment, nursing diagnoses, and interventions, using Roy’s framework as a guide. What emerges is a comprehensive plan to address stimuli that are causing problems for Debbie. The plan is compartmentalized by the “modes” to ensure that all aspects of Debbie’s adaptation needs are addressed.

Rogers’ conceptual model, on the other hand, provides a basis for further theory development based on abstract assumptions about the nature of humans as

unitary human beings viewed as dynamic, evolving energy fields (Gunther, 2010). Rogers' (1987) model views the nurse the same as the patient, as an irreducible whole and "integral with the universe" (p. 269). Life is evolutionary, developing to greater levels of complexity. The implications of Rogers' view for practice with Debbie, for example, is to get a sense of the pattern of Debbie's life rather than to break it down into component parts. See Chapter 13 for Bultemeier's applications of Rogers' model.

These two examples (Roy and Rogers) illustrate how the views of individual theorists differ and why it is important for a nurse to understand the fundamental beliefs of the theorist's work. To label this as a moral problem for a nurse might seem extreme. However, if the aim of nursing action is health, both the definition of health and the approach to furthering it are dependent on a particular philosophy and/or models and theories developed from it. To engage in therapeutic action stemming from one viewpoint while subscribing personally to another is likely to prove problematic in furthering nursing's purpose. This discussion highlights the importance of nurses having an in-depth awareness of their guiding frameworks. They should be capable both of explicating it and of comparing it with other theoretical works.

Commitment of the Framework

The pertinent parts of a given theoretical work may not be well understood by the practitioner who is using it. In such cases, practice is subject to inconsistency, as was noted earlier. It is understood that some inconsistency in practice will always exist because practice is necessarily contextual and thus affects practitioners no less than patients. However, nurses can nevertheless be held accountable for inadequate understanding of the framework they are utilizing. Accountability is a hallmark of professionals. Society has expectations of professionals, but if professionals are unable to at least make progress toward meeting these expectations, the very idea of professions becomes questionable. Newton (1988) has asserted that the professional "comprehends both the person ultimately served and the knowledge essential to the service in his perception of his obligations" (p. 49). This proposition has societal implications for several reasons. The discipline is both present- and future-oriented. It has strategies for addressing immediate problems and is concerned with predicting future areas of need. The person in question might be a potential rather than an actual patient. That is, a person may not yet be susceptible to formal identification because he or she is serving as a placeholder for one who has future nursing needs.

The knowledge that the professional possesses in Newton's assertion varies. This draws attention to the idea that frameworks not only guide practice but also guide knowledge development and knowledge acquisition for practitioners. Thus the use of theoretical works has moral implications not just for practice itself but also for the education of practitioners and for research, and perhaps on occasion for policy. This idea is explored later.

Newton's conceptualizations concerning professional activity are reflected in tenets of the ANA's (2001) *Code of Ethics for Nurses with Interpretive Statements*. Practice inadequacy that results from misinterpretation, misrepresentation, or

uninformed adaptation of any elements of the theoretical works or an inadequate grasp of the prescriptions of one's personal framework is implicitly proscribed by the ANA's Code. Provision 4 asserts that "the nurse is responsible and accountable for individual nursing practice..." (p. 16) and provision 5 includes the imperative to "maintain competence" for practice (ANA, 2001, p. 18). These are statements about what constitutes ethical practice. Many of the theoretical frameworks contain inherent guidelines, although these may be subtle regarding what constitutes competence (a minimum criterion for ethical action) under the particular perspective. Although it is true that novice nurses might not have achieved competence in all of the skills needed for their particular work setting, they are nevertheless responsible for understanding the limits of their knowledge. This ensures competence in the actions that they do undertake or that they receive supervision from someone who is competent.

Nightingale's (1946) ideas about nursing, presented in Chapter 5 by Kim Bolton, are viewed as a philosophy and serve as an example of a philosophy with unmistakably moral foundations. Nightingale's work stemmed from a desire to serve humankind. She encouraged nurses to attend to the environment of the patient, who could be sick or well. Manipulation of a patient's environment was necessary to "put the patient in the best condition for nature to act upon him" (Nightingale, 1946, p. 74). Observation, experience, and reflection were required to both learn the laws of health and apply them in practice (Nightingale, 1946). Furthermore, Nightingale's philosophy, evident both in her life work and in her writings, placed expectations on nurses to tackle the social forces that got in the way of "putting the patient in the best condition for nature to act upon him" (Nightingale, 1946, p. 74).

A professional nurse practicing according to Nightingale's philosophy such as Bolton describes in Chapter 5, is committed both to gathering and analyzing data about a given patient's environment and, more broadly, to assessing the environment for its effect or potential effect on individuals. Thus a nurse whose focus of action is so narrow that only the immediate situation is handled would fail to practice well. For example, a nurse who sees her role only as educating her patients about the relationship between smoking and their pulmonary disease but argues that she does not have time to address the broader social context in which the person has become addicted is ethically culpable from Nightingale's perspective. We may reaffirm here that a firm grasp of the implications of a given framework is a moral responsibility or moral obligation of the nurse.

Nightingale-style education of nurses would also necessarily include strategies that enable one to address both the immediate situation and any wider environmental problems implicated. Political activity might well be within a nurse's domain of practice activity (Ballou, 2000; Mechanic & Reinhard, 2002; Spenceley, Reutter, & Allen, 2006; Woods, 2012). The idea that nursing education includes the development of skills necessary for immediate practice and for political activity on behalf of actual or possible patients constitutes a moral obligation of nursing educators with regard to teaching theory-based practice that is based on Nightingale's perspective. Researchers, no less than educators, are subject to moral critique based on the questions they ask, the information they seek to uncover, and the methods they use. Moral critique, as noted throughout this chapter, is warranted because

nursing as a discipline makes promises to society about the services it can provide. The discipline and its members are accountable for that service.

Commitment to the Theorist's Intent

Nurses who are very conversant with the intent of a given model or theory and who find the philosophical underpinnings congruent with their own views may nevertheless wish to do the following:

- Derive a middle-range theory that is more specific to a certain aspect of care or particular population (as described in Chapter 3).
- Take the theory further.
- Test it via research questions.
- Apply it in practice situations.

Once again, self-reflection is required to determine whether beliefs about persons, health, and environment are indeed pertinent to the particular situation.

It is also important to reflect collaboratively with others who have expertise in both the area of concern and the theory to be used. One source for theoretical questions is the theorist himself or herself, when this is possible. Contemporaneously, a growing number of scholars, including doctoral students, have extended the work of various theorists. Some examples of these can be found in the later chapters of this text, in which a variety of clinical experts provide descriptions of their applications of specific theoretical works in practice. In addition, various communities of scholars have been formed for the express purposes of studying and/or furthering the works of a particular theorist. This self-reflection and reflection on the proposed project are moral responsibilities for the reasons given previously and because theory development and testing provide important contributions toward knowledge development for the profession and ultimately for the benefit of the population of concern.

Fit Between the Framework and Practice Context

Fit is an important consideration for theory-based practice. Professional nursing practice makes demands on a nurse to use knowledge and reasoning both in the choice of a guiding framework and in practice that stems from a framework. Although it is true that most of the theories will provide for consistent patient care, the setting and the nurse's personal value system may suggest a particular framework as best suiting both requirements. In deciding which theoretical work is a good fit for an individual's personal practice, the clinician should clearly understand the inherent moral implications of practicing according to this particular theorist's conceptions and in this particular setting. The majority of nursing's philosophers derived their frameworks as a result of engagement with specific populations. For example, Newman's (1986) emphasis on grasping human patterns might be difficult (although not necessarily impossible) to accomplish in an ambulatory surgery center because of time constraints. It is thus a responsibility of nurses to examine a variety of theories with which they have philosophical congruence to discover those that are best able to further nursing's goals in the specific setting.

There may be occasions when a nurse is faced with working on a patient care unit or in a setting where practice is structured by a particular framework with

which he or she either is not familiar or does not like. In the former case, one should familiarize oneself with the theoretical work to comprehend both how it structures care for these patients and what are the moral imperatives of the framework. Take, for example, a neurological unit that has adopted Orem's (2001) framework as a guide for practice. Nurses on this floor are committed to assisting patients to regain self-care agency, when this is possible. Assisting patients with a variety of neurological impairments to meet therapeutic self-care demands (Orem, 2001) often requires more time and patience of a nurse than does the giving of total care for the patient. However, according to Orem's framework, it is a moral imperative that we take the longer route when this is what will best serve a patient. Obstacles to facilitating self-care, such as inadequate staffing or lack of appropriate supportive equipment, present an Orem nurse with further obligations to address these shortcomings. Such shortcomings may require a nurse to serve on policymaking committees or to become more politically aware and active. At the very least, the nurse's understanding of what sort of environment is conducive to good practice on this perspective should be used to inform/persuade those who have the power to initiate change.

Even if a nurse has an aversion to a given framework, it may still be true, as argued earlier, that the resulting care will be better than unstructured care. Nevertheless, if a nurse believes another framework will better address the needs of a particular patient population, then that nurse has further options. For example, some institutions, settings, or patient care units have adopted a nursing framework in an effort to ensure consistency in practice. This may pose a challenge for the nurse who has a personal philosophy that is incommensurable with the prevailing perspective. What are the nurse's responsibilities in this regard? This is a difficult question. First, and before employment, the nurse should try to ascertain what the philosophy of the institution is and whether the values are congruent with his or her personal views regarding nursing care. It is understood, however, that there may be occasions when employment choices are limited. In such instances, a nurse is faced with a difficult balancing decision. Second, a nurse can investigate whether the framework is actually being used correctly. Theoretical works, as previously argued, generally have the capacity to structure good nursing care. Third, a nurse can present a reasoned case for a change of framework or for the freedom to choose from a variety of frameworks.

If, however, there are serious concerns about whether the model being used to direct unit care has suffered distortion in institutional hands and/or is being used to serve institutional rather than patient needs, this abuse needs to be addressed. For example, a professional nurse recently reported being asked by her employing institution (where Benner's [1984] work is used [see Chapter 7 in this text]) to provide an exemplar that demonstrates her practice expertise. When she replied that she was not sure she could do this, she was asked by a superior, "You can embellish a story, can't you?" The institution was apparently collecting these exemplars as part of accreditation documentation. In such cases, it is a moral responsibility of the nurse to address this inaccurate and thus unethical use of nursing theory.

A singular nurse may feel inadequate to the task of influencing change, or may be endangered by speaking out. In such cases, collaborating with others or gaining

supervisory assistance is required, or guidance may be sought from a professional group or organization. It is, however, a moral responsibility of the nurse to take appropriate steps toward addressing those problems that constitute either injustice or distortion of purpose and that ultimately find expression in the quality of patient care and the facilitation of health. An important justification for this assertion is that persons with health needs are in an especially vulnerable position. For the most part they lack the knowledge, skills, and/or capacity to meet these needs themselves. They are, in a sense, forced to trust that nurses (and other health care providers as well as the system) can help them and will keep their interests as a priority.

Finally, there may be obligations to discover whether a patient's beliefs and goals are congruent with the approach to care suggested by the particular framework the nurse is using. For example, a patient may believe that one accepts one's fate and that effects have causes that are beyond our control. This is a deterministic view. A patient with such beliefs might find a philosophical framework geared to assisting individuals to discover meaning in illness problematic, whereas a philosophical framework that attempts to alleviate suffering, address stressors, or help adaptation might be more appropriate. Thus among other obligations, it is also important to discover a given patient's view of health.

Inherent Moral Implications of Theoretical Works: Some Examples

Examples of the moral implications of several theoretical works have already been given throughout this part of the book. Some further examples are offered here to assist in addressing the questions posed earlier in the chapter. A crucial aspect of theory-guided practice for the nursing student, practitioner, researcher, or educator to consider, as noted throughout this chapter, involves understanding the commitments of the particular framework.

The pivotal hypothesis of Parse's (1992) Theory of Humanbecoming is that "humans participate with the universe in the co-creation of health" (p. 37). In Parse's (1987) view, persons are free-willed and capable of making meaning from life. Health is defined as "lived value priorities" that cannot be judged as "good, bad, more, or less" (p. 159). Health is an existential concept related to personal evolution as persons select or create meaning from their interactions with the world in which they find themselves. Nursing is concerned with the patient's (or group's) process by "illuminating meaning, synchronizing rhythms, and mobilizing transcendence" (Parse, 1987, p. 167). The nurse is interactive with the patient. This interaction facilitates the patient's grasp of meaning in the situation or phenomenon. It is the patient, in this perspective, who decides the value of a given experience. A nurse practicing from Parse's framework is committed to this approach. He or she must guard against practicing from personal value priorities when these are at odds with the patient's priorities. For example, it may be that a nurse's beliefs include the idea that it is a patient's duty to hang on to life as long as possible. Perhaps the clinician's belief is that life is sacred and that this means one should never give up. However, if the patient is in the process of discovering that he or she is ready to stop life-sustaining treatment, then the nurse must continue to facilitate the patient's development of meaning rather than his or her own development, as this is a commitment of Parse's work.

To understand Parse's theory is to grasp this fact. Practice will be erratic if the nurse uses Parse's theory for only part of his or her relationship with the patient. The nurse is morally committed to continue practice because this is what will best serve the patient's health as Parse conceptualizes it. Gail Mitchell describes practice according to Parse's theory in Chapter 19. Parse (1987) notes that her theory requires "special education" (p. 166). This education is to assist the clinician in suspending personal judgments about patient situations. Parse (1992) argues that "[i]t is essential to go with the person where the person is, rather than attempting to judge, change, or control the person" (p. 40).

The nurse's obligations are perhaps less clear when obstacles to practice occur. Extrapolating from theory, one could surmise that nurses have obligations to politically address obstructive environments. This is what is meant by professional advocacy, and for many nurses this involves widening their perspective on the true scope of accountability (Grace, 2001).

The responsibilities of a nurse practicing according to Orlando's Theory of the Deliberative Nursing Process can be contrasted with those of a nurse practicing according to Parse's theory. Orlando's background includes experience with psychiatric nursing and education (Fawcett, 2005). An important aspect of this theory involves interpersonal processes occurring between nurse and patient that, optimally, result in improvement in the patient's behavior. This improvement is accomplished as a result of "finding out (what are) and (thus) meeting the patient's immediate needs for help" (Orlando, 1990, p. viii). Both the cognitive processes and the personal and professional knowledge base of the nurse are engaged to perceive, interpret, and react to patients' needs. These needs become discernible in the course of the nurse-patient interaction.

The implication is that the nurse, rather than the patient, recognizes and interprets, from the interaction, the need for help that exists and grasps what strategies are most likely to meet the need. If the need is not met, as is evidenced by unchanged or worsened patient behavior, the process is repeated. Further efforts on the part of a nurse are made to correct misunderstanding or misinterpretation of the problem by validating these with the patient.

Thus the nurse individualizes care to a patient situation and needs. This is a moral responsibility attendant upon using Orlando's theory. The development of a trusting relationship is also important because trust is more likely to facilitate revelation of a patient's needs. A patient's unique needs may commit a nurse to enlisting other appropriate services when a particular need is beyond that nurse's capacity to address it. When the patient's needs cannot be met because of institutional constraints, the nurse is obliged to undertake further action.

This can be considered a political obligation that is inherent in this particular theoretical work (as well as in many of the other frameworks). For example, perhaps it becomes clear that it would be in the patient's interest to have her hospital stay extended another day to meet her psychological support needs, but pressure is being placed to send her home. Thus there are responsibilities that take a nurse out of the demands of the immediate nurse-patient relationship to meet a patient's actual needs.

It is not as clear how this theory affects the obligations of the nurse in terms of addressing the needs of those people who are unable, for a variety of reasons, to

access the health care system and thus gain assistance from Orlando's theory. It is reasonable to assert that those nurses who choose to structure practice by Orlando's theory do have commitments to political or policy activities on behalf of those who could be assisted by a deliberative nursing process. Barbara May presents her nursing practice using Orlando's theory in Chapter 15.

Theory-Based Practice: Nursing's Commitments

It can be noted that subsequent to the work of self-reflection and theory selection, further moral commitments are inherent in theoretical frameworks for the nursing student and practicing nurse. These commitments also extend to nurse educators and researchers. For example, as discussed earlier and later in this text, responsibilities to address obstacles to structuring care according to a given framework are implicit in theoretical works. The moral commitment for nurse educators who are charged with teaching nursing philosophies, models, and theories is to elucidate by discussion and by other means the inherent moral responsibilities of theory usage. The responsibilities of educators (in their position as educators rather than as practitioners, which many also are) with regard to theoretical works are thus somewhat more general. They include highlighting not just the importance of theory use but also moral commitments inherent in particular theories. In addition, educators are accountable for elucidating theory implications for policy formulation and for the profession's political efforts on behalf of patients.

Political Implications

In summary, a given framework will generally direct professionals when obstacles to providing service in the envisioned manner arise. For example, if the number of nurses assigned to a patient care unit is insufficient to provide even the minimal interventions implied by a particular framework, it becomes obvious that health issues cannot be addressed adequately and that further responsibilities exist. When such barriers exist, the practitioner should be able to articulate what further obligations accrue when using a particular theoretical work. Possible barriers include time constraints, conflicts of interest, access-to-care problems, economic concerns, and a host of other problems associated with profit-driven and other forms of health care delivery.

Health care provision in the United States and elsewhere is continually evolving—and not necessarily in a positive manner. That is, it is not evolving in a manner designed to actually facilitate health as it is envisioned either by nursing or by any other interested or susceptible parties. Because many of nursing's theoretical works were conceptualized in an earlier era, in which more time was available for hands-on nursing care, those nurses using theory are increasingly faced with time constraints and other barriers to their ability to accomplish goals. This does not mean that theoretical frameworks are obsolete; rather, it implies that individuals and society are not getting their health needs met. Thus the important question for nursing to consider is the following: "What are our individual and collective obligations when circumstances are such that nursing cannot be practiced in the manner envisioned by its theorists?" The answer to this question should be implicit in any conceptualization regarding the advancement of health. It is pointless to urge actions facilitative of health for individuals (from any perspective of what this might look like) if conditions are such that what

is postulated as necessary cannot possibly be accomplished. Thus theoretical works should be able to assist the profession in demonstrating the importance of nursing to the health of persons in society by illuminating the nature and location of problems.

Theories should help the nursing profession avoid the philosophical problem of “ought implies can,” which recognizes the futility of obliging persons to actions they cannot possibly complete. Newton’s (1988) view of professional obligation may be helpful here. She notes the following:

The professional must respond...if practices in his field are inadequate at any stage of the rendering of the service; if the client the ultimate consumer is unhappy; if he is happy but unknowing, badly served by shabby products or service; or if he is happy and well served but the state of the art is not adequate to his real needs (p. 49).

Newton’s conclusion, although not written specifically about health professions, is pertinent to theory-based nursing and highlights some of the obligations that are attendant upon providing societally based service. Her conclusions support statements in the ANA’s *Code for Nurses with Interpretive Statements* (2001) and in the ANA’s *Social Policy Statement* (2003), as well as in the ICN’s (2006) *Code for Nurses: Ethical Concepts Applied to Nursing*.

Conclusion

Professional nursing practice that is guided by any or all of the elements of philosophies, models, and/or theories carries with it a number of moral responsibilities and obligations. These responsibilities have moral force because the nursing discipline professes to be capable of furthering health for its population of concern. It is to this purpose and for this end that nursing endeavors to increase its knowledge base. The development of this knowledge base is dependent in part on theory-based practice and research and in part on theory informed by practice and research. Thus members of the profession are obliged to examine the bases for their practice and the potential of these bases for accomplishing nursing’s—and thus society’s—goals.

CRITICAL THINKING EXERCISES

1. What are possible immediate, intermediate and/or long-term implications of permitting a patient’s philosophy to guide the choice of an appropriate model or theory to guide his or her care?
2. What creative strategies could be used to deal with conflict between personal philosophy and the philosophical assumptions underlying a setting-imposed framework?
3. What are the moral implications of a clash between a nurse’s personal philosophy and a patient’s personal philosophy?
4. What avenues are open to a nurse attempting to address broader societal obstacles to providing theory-guided care?
5. Examine the ANA’s *Social Policy Statement* (2003) and identify the moral obligation nurses have to be aware of the framework that is guiding their practice, research, or teaching.

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PART II

Application

Utilization of nursing theoretical works illustrates their explicit focus and applicability as frameworks for evidence-based nursing practice and quality care.

Philosophies

- Nightingale application focuses on patients and their environmental surroundings
- Watson application uses caritas processes to guide caring nursing actions
- Benner application provides care in a healing nurse and patient relationship

Models

- Johnson application bases nursing care on a systematic view of patient behavior
- King application uses a conceptual system and theory for goal attainment
- Levine application relates conservation principles to adaptive health promotion
- Neuman application is nursing from a systematic view of strengths and stressors
- Orem application of self-care deficit theory identifies self-care agency and needs
- Rogers application is quality care from human/environmental field patterning
- Roy application uses environmental assessment and adaptive modes to plan care

Theories

- Orlando applies a deliberate interactive approach to meeting patient needs.
- Modeling and role-modeling applies the patient worldview to design care.
- Mercer applies stages of maternal role identity to the process of becoming a mother.
- Leininger applies culture-specific care to round out total patient care planning.
- Parse applies humanbecoming presence for quality nursing and health care.
- Newman applies health as expanding consciousness and pattern recognition to care.

Nightingale's Philosophy in Nursing Practice

Kim Bolton

I use the word nursing for want of a better. It has been limited to signify little more than the administration of medicine and application of poultices. It ought to signify the proper use of fresh air, light, warmth, cleanliness, quiet, and the proper selection and administration of diet—all at the least expense of vital power to the patient.
(Nightingale, 1969, p. 8)

History and Background

Nightingale was born in 1820 in Florence, Italy. Her parents were very wealthy and often traveled abroad. Nightingale was beautiful and was expected to behave like every other Victorian lady, filling her time before marriage with music, reading, embroidery, and learning how to be the perfect hostess (Brown, 1988).

Nightingale had other ideas. She had felt different from those around her even at a young age, and by the time she was 17, believed she was called by God into His service (Woodham-Smith, 1951). She had great compassion and sympathy for people of all types, and as she grew older, she believed she had been called to help mankind. She desired to help the truly poor but suffered in silence for years because it was improper for someone of her upbringing to involve herself with actual physical work (Brown, 1988).

At the age of 24, Nightingale decided she needed to help the suffering masses and wished to work in a hospital. This was met with opposition from her family, and they fought about it for years before finally allowing her to go to Kaiserswerth, Germany, to learn nursing from the Institution of Deaconesses (Brown, 1988; Woodham-Smith, 1951). She studied there for 3 months and then returned to the service of her family. It was another 2 years before she was allowed to practice nursing (Brown, 1988; Woodham-Smith, 1951).

She developed what we have come to refer to as her *nursing theory* after her travel to Scutari to care for wounded soldiers during the Crimean War. Her writings, which included philosophy and directives, were developed from a need to define nursing and reform hospital environments rather than for the purpose of providing nursing new knowledge. Nightingale worked endlessly during her lifetime to introduce many types of reform, in areas as diverse as the British military and the environment of England (Brown, 1988; Woodham-Smith, 1951). Because of her work in nursing and nursing education, she is known as the *founder of modern nursing* (Dennis & Prescott, 1985; Henry, Woods, & Nagelkerk, 1990). She started a school of nursing at St. Thomas Hospital in England and wrote many manuscripts about hospital reform and nursing care (Brown, 1988; Woodham-Smith, 1951). Nightingale (1969) clarified that “nursing knowledge is distinct from medical knowledge” (p. 3).

Overview of Nightingale's Environmental Philosophy

Nightingale's philosophy is environmentally oriented. This is evidenced by her many writings and her book *Notes on Nursing: What It Is and What It Is Not* (Nightingale, 1969). She believed that the environment of the patient should be altered to allow nature to act on the patient (McKenna, 1997; Nightingale, 1969). Her work focuses mostly on the patient and the environment but also includes the nurse and health. For instance, it was the nurse's duty to alter the patient's environment so that nature could act on the patient and repair health. The components of Nightingale's philosophy, which is now recognized as theory in this theory era, are the following:

- *Environment*: Environment can be defined as anything that can be manipulated to place a patient in the best possible condition for nature to act (Selanders, 1998). This theory has both physical and psychological components. The physical components of the environment refer to ventilation, warmth, light, nutrition, medicine, stimulation, room temperature, and activity (Lobo, 2011; Nightingale, 1969; Reed & Zurakowski, 1996; Selanders, 1998). The psychological components include avoiding chattering hopes and advices and providing variety (Lobo, 2011; Nightingale, 1969).
- *Person*: Although most of Nightingale's writings refer to the person as the one who is receiving care, she did believe that the person is a dynamic and complex being. Reed and Zurakowski (1996) state, “Nightingale envisioned the person as comprising physical, intellectual, emotional, social, and spiritual components” (p. 33).
- *Health*: Nightingale (1954b) wrote, “Health is not only to be well, but to be able to use well every power we have” (p. 357). From this statement we can infer that she believed in prevention and health promotion in addition to nursing patients from illness to health.
- *Nursing*: Nightingale believed nursing to be a spiritual calling. Nurses were to assist nature that was healing the patient (Chinn & Kramer, 2011; Nightingale, 1969; Reed & Zurakowski, 1996; Selanders, 1998). She defined different types of nursing as *nursing proper* (nursing the sick), *general nursing* (health promotion), and *midwifery nursing*

(Reed & Zurakowski, 1996; Selanders, 1998). Nightingale saw nursing as the “science of environmental management” (Whall, 1996, p. 23).

Nurses were to use common sense, observation, and ingenuity to allow nature to effectively repair the patient (Pfetscher, 2010).

Although the model seems linear, it has been observed that the nurse initiates mutuality of care and outcome between the nurse and the patient (Selanders, 1998). Nightingale assumed that the patient wanted to be healthy and would cooperate with and assist the nurse to allow nature to help the patient (Pfetscher, 2010). Using Nightingale’s philosophy in practice today fits well with the use of the nursing process. The nurse assesses the patient situation, identifies a need, implements a plan of care, reevaluates the situation, and finally changes the plan to better serve the patient. This is done as often as necessary until the main goal of nursing (improved health state) is accomplished. At each phase of the process, documentation occurs to allow other caregivers to follow the plan of care (Selanders, 1998).

Critical Thinking Using Nightingale’s Theoretical Philosophy

The term *critical thinking* was not in use in Nightingale’s day; however, she expected nurses to use their powers of observation in caring for patients. In her book *Notes on Nursing: What It Is and What It Is Not* (1969), she developed a whole section on observation of the sick. She wanted her nurses “to be clear thinkers and independent in their judgments” (Reed & Zurakowski, 1996, p. 47). She advocated for nurses to have educational backgrounds and knowledge that were different from those of physicians (Nightingale, 1969; Reed & Zurakowski, 1996; Selanders, 1998). She believed in and rallied for nursing education to be a combination of clinical experience and classroom learning. Nightingale states, “Neither can [nursing] be taught by lectures or by books, though these are valuable accessories, if used as such; otherwise what is in the book stays in the book” (Nightingale, 1954b, p. 355).

Using critical thinking for the application of Nightingale’s environmental theory requires use of her 13 canons (Selanders, 1998) and the nursing process. Table 5-1 illustrates the interaction of the nurse and the patient with the use of Nightingale’s environmental theory.

Although the 13 canons are central to Nightingale’s theory, they are not all-inclusive. She believed that the person was a holistic individual and thus had a spiritual dimension. She believed nursing was a spiritual calling, and with that belief she assumed that nurses could help those clients who were in spiritual distress (Nightingale, 1954a, 1969). This is an assumption because of the time period in which Nightingale lived; it was expected that Christians would help other Christians. She identified nursing of the sick (nursing proper) and nursing of the well (nursing general) (Nightingale, 1969). She believed the two to be almost identical, with the outcome being the major difference.

Because Nightingale believed in nursing well persons—or health promotion—it is logical that she assumed her nurses would complete some health teaching as they were caring for the sick or for those who were already well. The use of Nightingale’s theory, the 13 canons, as well as health promotion and spiritual distress is illustrated in the following two case applications.

TABLE 5-1 Critical Thinking with Nightingale's Theory

| Nightingale's Canons (Nightingale, 1969; Selanders, 1998) | Nursing Process and Thought |
|--|---|
| Ventilation and warmth | Assess the client's body temperature, room temperature, and room for fresh air (or adequate ventilation) and foul odors. Develop a plan to keep the room airy and free of odor while maintaining the client's body temperature. |
| Light | Assess the room for adequate light. Sunlight works best. Develop and implement adequate light in the client's room without placing the client in direct light. |
| Cleanliness of rooms and walls | Assess the room for dampness, darkness, and dust or mildew. Keep the room free from dust, dirt, mildew, and dampness. |
| Health of houses | Assess the surrounding environment for pure air, pure water, drainage, cleanliness, and light. Examples include removing garbage or garments from the area, removing any standing water (or ensuring that water drains away from the area), and ensuring that air and water are clean and free from odor and that there is plenty of light. |
| Noise | Assess the noise level in the client's room and surrounding area. Attempt to keep noise level to a minimum, and refrain from whispering outside the door. |
| Bed and bedding | Assess the bed and bedding for dampness, wrinkles, and soiling, and check the bed for height. Keep the bed dry, wrinkle-free, and at the lowest height to ensure the client's comfort. |
| Personal cleanliness | Attempt to keep the client dry and clean at all times. Frequent assessment of the client's skin is needed to maintain adequate skin moisture. |
| Variety | Attempt to stimulate variety in the room and with the client. This is accomplished with cards, flowers, pictures, books, or puzzles. Encourage friends and relatives to engage the client in some sort of stimulating conversation. |
| Chattering hopes and advices | Avoid talking without reason or giving advice that is without fact. Continue to talk to the client as a person, and continue to stimulate the client's mind. Avoid personal talk. |
| Taking food | Assess the diet of the client. Take note of the amount of food and drink ingested by the client at every meal or snack. |
| What food | Continue with the assessment of the diet to include type of food and drink the client likes or dislikes. Attempt to ensure that the client always has some food or drink available that he or she enjoys. |
| Petty management | Petty management ensures continuity of care. Documentation of the plan of care and all evaluation will ensure others give the same care to the client in your absence. |
| Observation of the sick | Observe everything about your client. Record all observations. Observations should be factual and not merely opinions. Continue to observe the client's surrounding environment, and make alterations in the plan of care when needed. |

CASE HISTORY OF DEBBIE

Debbie is a 29-year-old woman who was recently admitted to the oncology nursing unit for evaluation after sensing pelvic “fullness” and noticing a watery, foul-smelling vaginal discharge. A Papanicolaou smear revealed class V cervical cancer. She was found to have a stage II squamous cell carcinoma of the cervix and underwent a radical hysterectomy with bilateral salpingo-oophorectomy.

Her past health history revealed that physical examinations had been infrequent. She also reported that she had not performed breast self-examination. She is 5 feet, 4 inches tall and weighs 89 pounds. Her usual weight is approximately 110 pounds. She has smoked approximately two packs of cigarettes a day for the past 16 years. She is gravida 2, para 2. Her first pregnancy was at age 16, and her second was at age 18. Since that time she has taken oral contraceptives on a regular basis.

Debbie completed the eighth grade. She is married and lives with her husband and her two children in her mother’s home, which she describes as less than sanitary. Her husband is unemployed. She describes him as emotionally distant and abusive at times.

She has done well following surgery except for being unable to completely empty her urinary bladder. She is having continued postoperative pain and nausea. It will be necessary for her to perform intermittent self-catheterization at home. Her medications are (1) an antibiotic, (2) an analgesic as needed for pain, and (3) an antiemetic as needed for nausea. In addition, she will be receiving radiation therapy on an outpatient basis.

Debbie is extremely tearful. She expresses great concern over her future and the future of her two children. She believes that this illness is a punishment for her past life.

Nursing Care of Debbie with Nightingale’s Theory

In Nightingale’s environmental theory, Debbie is the person seeking care. She needs nature’s reparative process. The nurse’s goal is to assist nature in that process. The nursing process and Nightingale’s theory are used together to provide care for Debbie. Her care begins with a review of the environment.

Physical Environment

Assessment

Debbie speaks of her living area as being less than sanitary. To start the nursing care of Debbie, a visit to her home environment is necessary. Assess the environment for pure air and water, light, drainage, and cleanliness. The air that Debbie breathes should be clean and free from odors. The house should have an adequate heat and air system; the filters should be free of dirt; and the system should be able to maintain the house at a comfortable temperature. Garbage should be disposed of away from the house to stop odors from polluting the air or water. The water should be evaluated for cleanliness. It may be a good idea to enlist the help of the local water company to ensure that the water is not contaminated from outside pollutants. Assess the cleanliness

of the house for waste or other contaminants, such as dirt, rodents, insects, mildew, and mold. Assess the environment for artificial and natural lighting. The light fixtures should be in working order, and there should be windows that allow natural light to filter in during the daytime. Assess the area around the house for adequate drainage. Water should not be under the house or in areas standing around the house.

Plan

Enlist the aid of the local water and electric companies in the assessment of the heat and air system, the water system, and the drainage of water and wastes at Debbie's house. Develop a plan to correct any deficiencies that may be found. Educate Debbie and her family about the importance of cleanliness inside the house and of the benefits of both natural and artificial lighting. Check into financial assistance from county and state resources.

Psychological Environment

Assessment

Debbie has several psychological concerns. She is worried about her family and her own health. She believes this illness is a form of punishment for her past life. She complains of continued pain and nausea. She describes her husband as emotionally distant and sometimes abusive. She admits to not having regular physical examinations and to not performing breast self-examinations.

Plan

Continue to talk to Debbie in an attempt to gather more information about her fears and concerns. Listen to her concerns, and offer factual information to help alleviate her fears. Nightingale (1969) believed that talking would be helpful to the client if it was sincere and did not involve giving an opinion. Investigate the possibility of arranging for psychological help from both a psychologist and a member of the clergy. Teach Debbie preventive health maintenance measures for herself and her family. Educate Debbie about self-catheterization and personal cleanliness. People usually feel better if their physical appearance improves. Discuss with Debbie the benefits of an exercise program that could be performed at least three times per week. Help Debbie discover other means of pain management, such as meditation, imagery, and relaxation techniques. Encourage Debbie to speak to her physician about the inadequate pain relief with her current pain medicine. Encourage her to speak freely about all of her concerns and feelings, and be sure to include her family in these discussions. Encourage her family to provide Debbie with variety in her daily routine and around the house. This could include activities such as games, watching TV together, coloring with her kids, going on walks, or engaging in any other family activities.

Nutrition

Assessment

Debbie states she still suffers from nausea and that she has lost 21 pounds. Assess nausea in relation to timing, quality, quantity, interference with nutrition, and alleviating and aggravating symptoms. Assess her diet with a 3-day diet recall. Determine her food likes and dislikes.

Start Debbie on a well-balanced diet that includes her food preferences, and educate her on the importance of following this diet. Work mealtimes around the periods of nausea to facilitate eating, or, if necessary, allow for frequent, small meals. Allow for snacks to help decrease the periods of nausea. Discuss with Debbie her medications, particularly the one for nausea, to be sure she takes it correctly and is aware of its possible side effects. Remind her that she should not operate machinery while she is under the influence of the medication. Educate Debbie in other techniques designed to relieve nausea, such as relaxation or imagery.

The remaining canons of Nightingale's theory deal with nursing management and observation. Debbie's plan of care needs to be documented so that the plan continues even in the absence of the nurse. In Debbie's case, she will be at home and undergoing outpatient therapy. Debbie and her entire family need to be aware of the nursing plan and require education to enable them to assist the nurse with the plan. Other caregivers will need access to her plan when the nurse is unavailable, and documentation is the best point of reference. Accurate documentation ensures that everyone who may have contact with Debbie will be aware of her nursing care plan and will be able to assist her as well as the nurse and nature.

Observation is essential both to the nursing process and to Nightingale's environmental theory. Nightingale (1954a) states, "The trained power of attending to one's own impressions made by one's own senses, so that these should tell the nurse how the patient is, is the *sine qua non* of being a nurse at all" (pp. 320-321). Observation is used to provide essential information about the client's progress with the plan of care and whether the plan needs modification. Debbie's family should be taught observation techniques that would assist the nurse in modifying the plan. Nightingale (1954a) believed, "Observation may always be improved with training—will seldom be present without training; for otherwise the nurse does not know what to look for" (p. 321).

A second example of the utilization of Nightingale's theory is illustrated in the case study of Michelle, a 25-year-old who is seeing her practitioner for preconceptual counseling. This case illustrates how sick nursing and health nursing are essentially congruent except for their differing outcomes.

CASE HISTORY OF MICHELLE

Michelle, a 25-year-old white female, visits her nurse practitioner for preconceptual counseling. She states that she and her husband have been married for 4 years and have decided to begin their family. She desires to be as healthy as she can be before becoming pregnant. Her medical history and family history are unremarkable. She denies smoking and states she may have a drink about once a month. She is currently employed as a computer programmer for a large computer company. She works 40 hours a week and has the weekends off. She and her husband enjoy each other's company and spend their free time outdoors as much as possible. She has been taking oral contraceptives for 6 years.

Nursing Care of Michelle with Nightingale's Theory

Preconceptual counseling is increasing among married couples when they have decided to begin raising a family. The main goal of preconceptual counseling is to place the intended mother in the best health possible before she conceives. The nurse practitioner, to achieve this goal, must complete a thorough assessment into the client's lifestyle and environment. Nightingale's environmental theory can be a very useful tool in this endeavor.

Physical Environment

Assessment and Plan

The home, workplace, and community environment should be assessed according to the 13 canons. The main areas of assessment include ventilation and warming, noise, light, and health of houses (Nightingale, 1969). Health of houses includes pure air, water, drainage, cleanliness, light, and bed and bedding. Assess both the home and the workplace with the items included under "Health of houses" (see Table 5-1). Assess the community and neighborhood with all of the canons regarding physical environment.

Home and Workplace Assessment

1. *Light.* Assess for adequate windows and working light fixtures.
2. *Pure air.* Assess for ventilation, offensive odors, drafts, and a working heat and air unit.
3. *Pure water.* Assess for a working water system that is free from contamination.
4. *Drainage.* Assess the area for drainage of rainwater away from the house.
5. *Cleanliness.* Assess the home for the means to keep the house clean and for freedom from mold, mildew, excessive dust, offensive odors, and pet droppings.
6. *Bed and bedding.* Assess the beds for quality and comfort. Assess the bedding for cleanliness and a working washing machine (for home assessment only).
7. *Noise.* Assess the area for loud, offensive, and unnecessary noise.

Home and Workplace Plan

1. *Light.* Enlist the help of Michelle and the electric company in assessment of the light fixtures. Suggest replacing incandescent light fixtures with fluorescent lighting, since the latter lighting is better and less expensive. Ensure that the windows are in working condition and that there are at least two windows in every room. Educate Michelle about the benefit of light to one's health, and suggest keeping blinds or curtains open during the daytime hours.
2. *Air.* Enlist the help of Michelle and the electric company in assessment of the heat and air unit for working order and efficiency. The unit should be able to maintain the area at a comfortable temperature. Check the windows and doors for drafts, and ensure that the windows can be opened to allow natural air into the area. Educate Michelle about changing or cleaning the air filters in the heat and air unit about once a month and about the benefits of opening the windows occasionally to allow outside air into the area. The open windows will allow for cross-ventilation and will freshen the air of the house or workplace.

3. *Pure Water.* Enlist the help of Michelle and the water company to assess the plumbing for working order and freedom from contamination. Have the water checked for levels of lead and other metals that could contaminate it. Discuss the possibility of a water filtering or purification system in the house or workplace. Educate Michelle about the benefit of pure water for drinking and eating. Advise Michelle to keep garbage and other refuse away from the water supply or any parts of the water system.
4. *Drainage.* Enlist the help of the water company to assess for adequate drainage. Educate Michelle about removing hazards that allow standing water to remain too close to the house or the workplace.
5. *Cleanliness.* Talk with Michelle about using environmentally safe cleaning products that kill most common germs. Educate Michelle about mold and mildew and the potential problems both could cause with air and water contamination. Ask Michelle to constantly observe the environment for hazards to the health of her family and herself.
6. *Bed and bedding.* Educate Michelle about cleaning, vacuuming, and airing the bedding. Discuss ways to evaluate the bed for adequate performance and to maintain the bed in proper working order, such as turning and/or replacing the mattress.
7. *Noise.* Discuss with Michelle the types of noises in both the home and the workplace. Discuss ways to decrease the level of the noise, such as placing bushes in front of the home or using earplugs for work.

Community and neighborhood assessment. Assess the community and neighborhood for offensive odors, garbage and refuse, adequate water and electricity, and areas for outside activities.

Community and neighborhood plan. The community water and electric companies should conform to guidelines for operation and maintenance of their systems. The community or neighborhood should be free from garbage or other refuse. If the community or neighborhood is close to a dump or a landfill, assess the area for offensive odors. If there is an area for outside activities, assess for maintenance of equipment and cleanliness of the area. Any assessed deficiencies can be addressed by meeting with community leaders to discuss the deficiencies and any proposed solutions.

Psychological Environment

Assessment and Plan

1. *Variety.* Assess the activities of Michelle and her husband. Develop an exercise plan for her that includes a variety of activities. Exercise leads to a healthy lifestyle and will help Michelle with the weight gain of pregnancy. Educate her that exercise should be performed at least three times per week for at least 30 minutes at a time. Encourage Michelle and her husband to continue to perform their current activities and to attempt to enjoy a variety of activities. Explain to Michelle that she can also alter her work environment with fresh flowers or new pictures.
2. *Chattering hopes and advices.* Refrain from giving Michelle your opinion. Provide factual information about health, exercise, and other topics of importance when talking with her. Praise all activities that increase her health. Allow Michelle to speak to you freely and express all of her desires and concerns.
3. *Personal cleanliness (health).* Encourage Michelle to continue with her routine medical checkups. Encourage 8 hours of sleep per night. Discuss the timing of

the pregnancy, and instruct her to discontinue oral contraceptives for 3 months before attempting pregnancy.

Taking Food and What Food: Nutrition

Assessment and Plan

1. Assess the nutritional status of Michelle by asking for a 3-day diet recall. Ask her for her food likes and dislikes and for her drink preferences. Ask whether she takes over-the-counter dietary or herbal supplements.
2. Educate Michelle about maintaining a well-balanced diet. Encourage her to consume foods from the groups in the food pyramid. She needs two to three servings from the milk group (e.g., milk, yogurt, cheese) and six to eight glasses of water per day. She should also increase her intake of folic acid by taking prenatal vitamins once a day.
3. Educate Michelle about the hazards of alcohol consumption during pregnancy, and advise her to avoid the use of tobacco and drugs.

Observation

The observation of Michelle will consist of keeping routine visits in place until pregnancy is achieved. Educate Michelle and her husband about what to report to you during this period before her pregnancy. Encourage her to call you whenever she needs to talk or to ask questions. If needed, return appointments can be scheduled every 3 months to allow the nurse practitioner to reevaluate Michelle and the plan.

Conclusion

Nightingale's environmental theory arose out of a need to reform nursing and the environment of England in the late 1800s. Her theory is simple and easy to apply to nursing practice because it contains many of the same elements that nursing students learn during their education. Use of Nightingale's theory will help the nurse have a beginning focal point and allows the nurse to view the client as an individual who interacts with and lives in an environment that may or may not be conducive to optimal health.

CRITICAL THINKING EXERCISES

1. Consider three patients you cared for recently. Reflect on the environment of each patient using Nightingale's theory as a guide. What aspects of the patient's environment did you not consider with the framework you used to guide your practice at that time? What aspects of care does this environmental assessment lead you to consider?
2. Walk across your campus and complete an environmental assessment of what you observe using Nightingale's canons. Compile a list of potential problems and how to correct them.
3. Complete an environmental assessment of your community and identify the governmental authority to whom you would report for improvement of each problem. Contact the public health department and report the observed community problem.
4. Use Nightingale's canons to conduct an assessment of your living area. Develop a health promotion plan for change in at least one area based on the assessment.

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Watson's Philosophy and Science of Caring in Nursing Practice

*D. Elizabeth Jesse and Martha Raile Alligood**

Caring in nursing conveys physical acts, but embraces the mindbodyspirit as it reclaims the embodied spirit as its focus of attention. It suggests a methodology through both art and aesthetics, of being as well as knowing and doing. It concerns itself with the art of being human. It calls forth from the practitioner an authentic presencing of being in the caring moment; carrying an intentional caring-healing consciousness. . . . Nursing becomes a metaphor for the sacred feminine archetypal energy, now critical to the healing needed in modern Western nursing and medicine.

(Watson, 1999, pp. 10-11)

History and Background

Watson's (1979, 2008) scholarship of caring philosophy and science in nursing began as a textbook for an integrated nursing curriculum at the University of Colorado. Beginning with the question of the relationship between human caring and nursing, this initial work laid the foundation for what was to become *The Theory of Human Caring: Retrospective and Prospective* (Watson, 1997); *Nursing: Human Science and Human Care* (Watson, 1988a), *Caring Science as Sacred Science* (2005), *Nursing: The Philosophy and Science of Caring* (2008), and her latest book, *Human Caring Science: A Theory of Nursing* (2011). Watson defines caring as the ethical and moral ideal of nursing with interpersonal and humanistic qualities. It is a complex concept involving development of a range of knowledge, skills, and expertise that encompass holism, empathy, communication, clinical competence, technical proficiency, and interpersonal skills (Watson, Jackson, & Borbasi, 2005). She defines caring science as "an evolving philosophical-ethical-epistemic field of study, grounded in the discipline of nursing and informed by related fields" (Watson, 2008, p. 18). Watson desired to bring meaning and focus to nursing as

*This revision includes text by Mary-Jean McGraw, chapter author for the second edition.

an emerging discipline and a distinct health profession with unique values, knowledge, practices, ethics, and mission (Watson et al., 2005). Her early writing (1979) identified 10 carative factors that served as the foundation and framework for the science and practice of nursing (Table 6-1). The original carative factors grounded in philosophy, science, art, and caring evolved into the theory of human caring (Watson, 1985, 1988a, 1995, 1997). In later works, Watson (1999, 2005, 2008, 2011) revised the original carative factors with the emerging concepts of “clinical caritas” and “carative processes.” These processes, also included in Table 6-1, emphasize the sacred and spiritual dimension of caring. “Caritas” means to cherish, appreciate, and give special attention (Watson, 1999, 2005) and is related to “carative,” a deeper and expanded dimension of nursing that joins caring with love. Caritas is differentiated from “amore” that “tends to be a love in which self-interest is involved” (Watson, 2008, p. 253).

Watson describes the core of nursing as those aspects of nursing that potentiate therapeutic healing processes and relationships, transcending time and “trim” of nursing, such as procedures, tasks, treatments, and technology. Watson calls caring “the ethical principle or standard by which curing interventions are measured” (1988b, p. 2). Within this caring ontology, technical interventions commonly aimed at cure are reframed as sacred acts conducted with a caring consciousness and completed in a way that honors the person as an embodied spirit. Watson differentiates “care” from “cure” but describes them as compatible and complementary aspects of nursing (Watson et al., 2005).

Watson (2005, 2008) draws on the works of other theorists and proposes linkages among Caring Theory (CT), the Science of Unitary Human Beings (SUHB) (Rogers, 1970, 1992, 1994; Watson & Smith, 2002), and Health as Expanding Consciousness (Newman, 1994), integrating Rogers’ principle of resonancy with caring consciousness. Caring science is noted as an interdisciplinary or transdisciplinary field of study (Watson, 2002a,b, 2005, 2008, 2011).

Although Watson’s work does not deny the importance of empirical factors and the physical world of nursing practice, she embraces concepts of mind, consciousness, soul, the sacred, the ancient, the contemporary Yin emergence, holism, energy fields, waves, energy exchange, quantum, holography, transcendence, time and space, healing artistry, evolution, and the transpersonal. Watson’s language also includes more elemental grounds of being: beauty, truth, goodness, harmony, openings, possibility, beyond, deep understanding, oneness, coming together, nurturance, honoring, authenticity, wide awakesness, human sensitivity, suffering, pain, hope, joy, spiritual, the divine, grace, the mystical, dream work, passion, poetry, metaphor, nature, I-thou, awe, dignity, reverence, ritual, light, the sacred feminine, wonder, compassion, love, blessings, peace. It is here that practicing nurses find the CT’s truest resonance and hope. Despite some challenges Watson is an eternal optimist (Watson, 1999, 2005) who writes about the personal as well as the sacred.

Watson’s book, *Caring Science as Sacred Science* (2005), tells how her professional and personal journeys converge as she describes her healing after traumatic events in her life. Watson (2005, 2008) refers to Nightingale’s work and spiritual “calling” to practice, a pivotal experience that gave strength to her conviction

Text continued on p. 102

TABLE 6-1 Carative Factors and Caritas Processes in Watson's Philosophy and Science of Caring in Nursing Practice

| Watson's 10 Carative Factors* | Watson's Caritas Processes* | Patient's Subjective World† | Nurse's Reflection‡ |
|---|---|---|--|
| 1. The formation of a humanistic-altruistic system of values | 1. Practice of loving-kindness and equanimity with context of caring-consciousness | <ul style="list-style-type: none"> • Perception/response to caring intent • Choices of how to be in relation | <p>Who is this person? Am I open to participate in his or her personal story? How am I being called to care? How should I be in this situation?</p> |
| 2. The instillation of faith/hope | 2. Being authentically present and enabling and sustaining the deep belief system and subjective life world of self and the one-being-cared-for | <ul style="list-style-type: none"> • Conceptions of reality through storytelling • Belief system as support • Sources of faith/hope | <p>What does this relationship mean to this patient? What health event brings this person to this health facility? What information do I need to nurse this person? Can I imagine what this experience is like? Can I encourage this person to find faith/hope?</p> |
| 3. The cultivation of sensitivity to one's self and to others | 3. Cultivation of one's own spiritual practices and transpersonal self, going beyond ego self; being sensitive to self and others | <ul style="list-style-type: none"> • Aspects of soul care as part of lifestyle • Responses to one-giving-care | <p>How am I attending to this person's spiritual needs and soul care? Does the experience of others nurture my compassionate self? Can I find new ways of caring?</p> |
| 4. The development of a helping-trusting relationship | 4. Developing and sustaining a helping-trusting, authentic caring relationship | <ul style="list-style-type: none"> • Degree of trust (openness) • Signs of vulnerability in relation • Signs of invitation to relate • Willingness to disclose deep meanings • Past experiences in caring relation • Responses to nurse as subject/presence • Validation of concerns, needs, priorities • Translation of concerns to goals for care | <p>How can I enter this person's private space? Can I establish a caring dialogue to help this person find meaning in this experience? What specific forms of caring will best acknowledge, affirm, and sustain this person? What strategies can I use to help this person translate his or her concerns to me and use them as goals for his or her recovery and self-healing?</p> |

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|---|---|--|---|
| 5. The promotion and acceptance of the expression of positive and negative feelings | 5. Being present to and supportive of the expression of positive and negative feelings as a connection with deeper spirit of self and the one-being-cared-for | <ul style="list-style-type: none"> • Comfort level with self-disclosure • Expression of feelings about experiences • Search for interpretation and meaning • Disclosure of deep search • Relation of behavior and expressions to cultural mores • Openness to others' interpretations • Clarity of current health situation and its meaning for his or her life/choices | <p>How can I enable this person to express his or her concerns? How must this person be feeling? How does this person show his or her pain? What are the mores about pain in his or her culture? What are the subtle patterns that surface in this person's story? Can I use this to help him or her understand the deep meanings of his or her health event/moment? Am I meeting my obligation to reveal my understandings to the one-being-cared-for with a healing intent?</p> |
| 6. The systematic use of the scientific problem-solving method for decision making | 6. Creative use of self and all ways of knowing as part of the caring process and engagement in artistry of caring-healing practices | <ul style="list-style-type: none"> • Disclosure of uniqueness as person • Perceptions of pattern of experiences/responses to health situation • Perceptions of life pattern and role changes and consequences • Definition of helpful care • Responses to art/act and other caregivers • Openness to nontraditional, creative interventions and care | <p>What is the uniqueness of this person and this situation? How has this event affected his or her usual life patterns and roles? How can I contextualize the theory of care for this person and situation? How does this situation compare with my previous experience? What are the significant issues to attend to? How can I help this person? Which healing arts are appropriate?</p> |

Continued

TABLE 6-1 Carative Factors and Caritas Processes in Watson's Philosophy and Science of Caring in Nursing Practice—cont'd

| Watson's 10 Carative Factors* | Watson's Caritas Processes* | Patient's Subjective World† | Nurse's Reflections† |
|--|---|--|---|
| 7. The promotion of interpersonal teaching-learning | 7. Engaging in genuine teaching-learning experience that attends to unity of being and meaning and attempts to stay within other's frame of reference | <ul style="list-style-type: none"> • Definition of health, healing, wholeness • Understanding of experiences, self-care needs, and limitations • Awareness of personal resources, strengths for healing • Identification of habitual ways of responding • Sense of freedom and commitment to action • Preferred ways of knowing • Past experiences with learning and health • Openness to self-discovery, participative learning, accessing external resources • Goals for recovery/healing | <p>Is this person able to understand what he or she is experiencing?</p> <p>Is he or she aware of his or her choices and their consequences?</p> <p>How does this person view the future?</p> <p>How can this person's concerns be translated into goals for recovery?</p> <p>What are his or her preferred ways of knowing?</p> <p>How can I share knowledge in a way that can assist with self-care and healing?</p> |
| 8. The provision for a supportive, protective, and corrective mental, physical, sociocultural, and spiritual environment | 8. Creating healing environment at all levels (physical, as well as nonphysical) whereby wholeness, beauty, comfort, dignity, and peace are potentiated | <ul style="list-style-type: none"> • Role of emotion/senses in healing • Definition of space that is healing • Stressors in environment • Responses to stress and preferred methods of stress management • Use of healing arts in lifestyle • Sense of self-worth, dignity, peace • Responses to beauty, sources of color, movement, texture, and form | <p>What is important to this person to make his or her stay comfortable?</p> <p>What meanings do the surroundings, sounds, and smells have for this person?</p> <p>How can the healing art be incorporated into this space?</p> <p>How can I use assertiveness and political action to create a healing environment for this person?</p> <p>How can I creatively deal with institutional imperfections, manage constraints, contingencies, and dilemmas with wisdom, while maintaining the goal of healing and wholeness?</p> |

| | | | |
|--|--|---|--|
| 9. Assistance with the gratification of human needs | 9. Assisting with basic needs, with an intentional caring consciousness; administering human care essentials, which potentiate alignment of mindbodyspirit, wholeness, and unity of being in all aspects of care; attending to both embodied spirit and evolving emergence | <ul style="list-style-type: none"> • Perception of self as embodied spirit • Relationship of self to physical body • Willingness to assume central role in healing • Priorities for needs/goals for care • Sense of personal wholeness/fragmentation • Personal supports and involvement in care • Preferred timeline for healing • Feedback on responses to care | <p>Am I process-focused or outcome-focused? Can I let go of the need to fix situations? What supports does this person have in his or her life? How involved are they in his or her care? Which caring/healing modalities are appropriate for his or her care? Am I honoring this person as an embodied spirit in my actions? What is the desirable practice here that will honor caring as moral ideal?</p> |
| 10. The allowance of existential-phenomenological forces | 10. Opening and attending to spiritual-mysterious and existential dimensions of one's own life-death; soul care for self and the one-being-cared-for | <ul style="list-style-type: none"> • Openness to deeper self-exploration and soul care • Personal definition of spiritual needs/soul care and relation to healing • Key existential life issues in the moment/experience • Role of dream work, deep imagination, intuitions, myth, etc. in search of meaning • View of future, purpose in life • Critical life decision areas | <p>How does this person view the future for himself or herself and others? How can I enable this person to find meaning in this experience and make good decisions about his or her life and/or death? What are the life lessons in this situation for the patient and myself? What soul care is useful for this patient?</p> |

*From Watson, J. (1979). *Nursing: The philosophy and science of caring*. Boston: Little, Brown. (Reprinted 1985, Boulder: University Press of Colorado); Watson, J. (2008). *Nursing: The philosophy and science of caring*. Boulder, CO: University Press of Colorado.

†From Watson, J. (1998). A meta-reflection on reflective practice and caring theory. In C. Johns & D. Fleschwater (Eds.), *Transforming nursing through reflective practice* (pp. 214-220). London: Blackwell Science; Watson, J. (1999). *Postmodern nursing and beyond*. Edinburgh: Churchill Livingstone/Saunders.

that she was destined for an unconventional life (Watson, 1999, 2005). Watson (2002b) writes:

For Nightingale, nursing was a spiritual practice, and spirituality was considered intrinsic to human nature and a potent resource for healing; she was clear about nursing being a calling; she articulated nursing's healing role, working in harmony with nature. In this heritage, nursing and its focus on caring and healing in harmony with nature and environmental conditions, was a form of values-guided, artful practice, attending to basic human essentials, grace and beauty (p. 4).

Nightingale (cited in Watson, 2008, p. 252) stated that health "is not only to be well, but to be able to use every power we have to use." Watson's writings encourage similar exploration with questions such as the following:

- What calls me to care?
- What is the root of my caring response?
- How will I respond?
- Why do I fail to respond?
- When is it hard to care?

Watson views nursing as "both a human science and an art." Her description of her science places her work firmly in human science by disclosing the symbolic, conceptual, and linguistic world while practicing within a material, concrete, sensual world (Watson, 1988a; Wilber, 1999). She champions a broad definition of nursing science with its own concepts, relationships, and methodology, a science with vistas and opportunities to understand nursing from a view of caring human experience (Watson, 1990). According to Watson (1989):

this science with a view...leans toward employing qualitative theories and research methods, such as existential-phenomenology, literary introspection, case studies, philosophical-historical work, hermeneutics, art criticism, and other approaches that allow a close and systematic observation of one's own experience and that seek to disclose and elucidate the lived world of health-illness-healing experience and the phenomena of human caring (p. 221).

This interpretation of science does not negate the significant contributions of objective medical and nursing science but does include subjective experience and values, meaning, quality, and soul-to-human phenomena allowing an integral view of the whole. In *Postmodern Nursing and Beyond* (1999), Watson clearly proposed four aspects of caring: (1) as moral ideal, (2) as intentionality, (3) as ontological competencies, and (4) as healing art and healing space in the theory of transpersonal caring-healing.

Overview of Watson's Philosophy of Human Caring

Watson describes her work as a framework, theory, model, worldview, or a paradigm that is transdisciplinary. She expands the original 10 carative factors to a science, philosophy, and ethic of human caring useful for all health professionals and healing practitioners, particularly those practicing mind-body medicine (Watson, 2005, 2008). Watson's paradigm of caring in the human health experience is recognized

within the discipline (Newman, Sime, & Corcoran-Perry, 1991; Watson, 2005, 2008, 2011). Educators will find *Creating a Caring Science Curriculum* (Hills & Watson, 2011) useful, and *Measuring Caring: International Research on Caritas as Healing* (Nelson & Watson, 2011) is particularly useful to those researching caritas as healing. Watson's (2011) latest update on nursing practice with this theoretical approach is *Human Caring Science: A Theory of Nursing* (Watson, 2011). Although there are various caring theories, Watson maintains that caring is central to the professional discipline of nursing (Newman et al., 1991; Watson, 1990; Watson & Smith, 2002); and that her book *Nursing: The Philosophy and Science of Caring* “could equally be titled *Caring: The Philosophy and Science of Nursing*” (Watson, 2008, p. 15). The nursing metaparadigm concepts (human being, health, nursing, and environment) from the perspective of Watson's theory follow.

Human Beings (Personhood)

Person is viewed holistically wherein the body, mind, and soul are interrelated, each part a reflection of the whole, yet the whole is greater than and different from the sum of parts (Watson, 1979, 1989). The person is a living, growing gestalt that possesses three spheres of being—body, mind, and soul—influenced by the concept of self. The mind and emotions are the starting point and the access to the subjective world. The self, the seat of identity, is the subjective center that lives within the whole of body, thoughts, sensations, desires, memories, and life history. She gives honor to deep meanings and feelings about life, living, the natural inner processes, personal autonomy, and freedom to make choices shaped by subjective intent (Watson, 1985, 1999). Watson says, “The person is neither simply an organism, nor simply spiritual. A person is embodied in experience in nature and in the physical world and a person can also transcend the physical world by controlling it, subduing it, changing it, or living in harmony with it” (1989, p. 225).

Watson's notions of personhood and life are based on the concept of human beings as *embodied spirit*. Within this transpersonal framework, the body is a living spirit that manifests one's being-in-the-world and one's way of standing and reflects how one holds oneself with respect to one's relation to self and one's consciousness or unconsciousness (Watson, 1999). This view holds respect and awe for the concept of the *human soul* (also called *spirit*, *geist*, or *higher sense of self*) transcending the physical, mental, and emotional existence of person. The soul and spirit are those aspects of consciousness that are not confined by space and time or linearity. By emphasizing the spiritual dimension of life, Watson speculates on the human capacity to co-exist with past, present, and future in the moment. She respects the dignity, reverence, chaos, mystery, and wonder of life because of the continuous yet unknown journey the soul takes through the infinite and eternal. Watson (1999) views the soul as “the essence of the person, which possesses a greater sense of self-awareness, a higher (ascent) degree of consciousness, an inner strength, and a power that can expand human capacities and allow a person to transcend his or her usual self” (p. 224). The soul fully participates in healing. As nurses and future nurses, we continue to explore the spiritual, nonphysical, inner, and extrasensory (beyond the five senses) realms to learn of the dynamic and creative energy currents of the soul's existence and to learn of the inner healing journey toward wholeness (Watson, 1999).

“Human life is defined as *being-in-the-world*, which is continuous in time and space” (Watson, 1989, p. 224). The locus of human existence is experience, broadly defined as sensorimotor experience, mental/emotional experience, and spiritual experience. Experience is translated through multiple layers of awareness. Consciousness has the capacity to construct and create. The world as experienced is not merely reflected and interpreted by consciousness; it is *co-created*. Collective and individual worldviews are dynamic and co-created.

Nursing (Transpersonal Caring-Healing)

Watson (1999) describes nursing as *transpersonal* that “conveys a human-to-human connection in which both persons are influenced through the relationship and *being-together in the moment*. This human connection...has a spiritual dimension...that can tap into healing” (p. 290). She continues, “*transpersonal* includes the unique individuality of each human, while extending beyond ego-self” (p. 290). The goal of nursing in the caring-healing process is to help persons gain a higher degree of harmony within the mindbodyspirit, which generates self-knowledge, self-reverence, self-healing, and self-care processes allowing for diverse possibility. Watson suggests the greater the “degree of genuineness and sincerity” (Watson, 1985, p. 69) of the nurse within the context of the caring act, the greater the efficacy of caring. The nurse pursues this goal and testable proposition by integrating *caritas* processes and human care processes with intention, transpersonal caring, and relationship, responding to the subjective world of persons such that individuals find meaning in their existence by exploring the disharmony, suffering, and turmoil within the lived experience. This exploration promotes self-knowledge, self-control, self-love, choice based on subjective intent, and self-determination. Watson emphasizes the nursing act of helping persons while preserving the dignity and worth of the patient or client regardless of his or her situation (Watson, 1979, 1985, 1999, 2005, 2008, 2011).

Caring science allows nurses to approach the sacred in caring-healing work (Watson, 2005, 2008). In caring sciences, compassionate human service and caring are motivated by love. The general goal is biophysical-mental-spiritual evolution for self and others as well as discovery of inner power and self-control through caring. Shifting the focus from illness, diagnosis, and treatment to human caring, healing, and promoting spiritual health potentiates health, healing, and transcendence (Watson, 1999). Watson describes *nurse* as noun and verb. The noun nurse represents the discipline of nursing. The verb nurse is engaged in the caring-healing praxis, demonstrating ontological and epistemological competencies and redefining technological competencies as sacred acts manifest with an intentional caring-healing consciousness. She states, “Therefore, it is important to find ways to cultivate a consciousness of *Caritas*: loving-kindness and equanimity if one is to authentically practice within this paradigm” (Watson, 2008, p. 56). Equanimity means knowing one has a balanced spirit and ability to be in the present moment (2008). *Healing*, redefined, relates directly to the individual’s evolving personhood. Transpersonal caring-healing is a moral ideal and ontology. Informed moral passion and caring ontology are nursing’s substance (Watson, 1990). As the essence of nursing, “caring is the most central and unifying focus for nursing practice” (Watson, 1988a, p. 33). Caring, as a moral ideal, encourages the nurse to attempt to hold the conscious intent

to preserve wholeness, to potentiate healing, and to preserve dignity, integrity, and life-generating processes (Watson, 1999).

In Watson's theory, a single caring moment becomes a moment of possibility (Watson, 1989). She explains that:

Transpersonal describes an intersubjective, human-to-human relationship that encompasses two unique individuals, both the nurse and the patient, in a given moment. Simultaneously the relationship transcends the two subjectivities, connecting to other higher dimensions of being and a higher/deeper consciousness that accesses the universal field and planes of inner wisdom: the human spirit realm (p. 115).

Coming together in the moment provides an opportunity—an *actual occasion*—for human caring to occur. Human caring is actualized in the moment based on the actions and choices made by both the one-caring and the one-being-cared-for. The nurse and patient both determine the relationship and the use of that moment in time and space. In the moment, how the nurse chooses to be and to act will have significant effect on the opportunities of the moment and the eventual outcomes. The goal in the relationship is the protection, enhancement, and preservation of the dignity, humanity, wholeness, and inner harmony of the patient or client. This outcome for the patient is achieved through heightened self-knowledge, self-control, self-care, caring, and self-healing. The nurse influences these outcomes by intentional use of caring consciousness in the moment and by holding intentionality toward wholeness as a moral ideal. Caring-healing consciousness is an intentionality of love and wholeness that is a source and form of life energy, life spirit, and vital energy that can be communicated by the one-caring to the one-being-cared-for, which potentiates healing (Watson, 1999). She challenges educators to model transpersonal caring by encouraging self-affirmation and self-discovery in students, using teaching moments as “caring occasions” in a values-based moral curriculum (Bevis & Watson, 2000). Watson (2008) describes “Caritas educators of nurses and health care professionals...face a double challenge in establishing, promoting, and maintaining the human-to-human dialogue and caring relationships as the epicenter of the curriculum and teaching” (p. 261). Yet competencies of being, such as these, are essential for teaching transpersonal caring-healing.

The healing arts activate specific responses to promote wellness and centering, act as modes of expression and meditation, comment on healing and illness experiences, and provide psychoarchitecture for healing spaces. Watson integrates and embraces visual art and poetry to illustrate and enhance her concepts. Examples are her use of Sylvia Plath's poem “Tulips” to illustrate the importance of not separating science and human values and use of a painting to the necessity for adequate ventilation for mine workers in the workplace.

Advanced caring-healing arts, or modalities, are integral to transpersonal practice. These modalities are also extensions of the carative factors of Watson's earlier work (1985) and the art of transpersonal caring that included “movement, touch, sounds, words, color, and forms” (pp. 66-68). These advanced caring-healing modalities include the intentional conscious use of imagery and auditory, visual, olfactory, tactile, gustatory, mental-cognitive, kinesthetic, and caring consciousness, which includes psychological and therapeutic presence modalities (Watson, 1999, 2008).

By exploring the integration of such therapies as music, visualization, breath work, aromatherapy, therapeutic touch, massage, caring touch, reflexology, dream work, humor, play, journaling, poetry, art making, meditation, transpersonal teaching, dance, yoga, movement, authentic presencing, and centering into caring practice as options for patient healing, the nurse acknowledges the emerging consciousness paradigm. Within this transpersonal philosophy and theory, different caring-healing modalities may be operating as sources of the patient's healing at different levels across the spectrum of consciousness. The advanced healing arts Watson outlines as the *carative factors/carative processes* (see Table 6-1) does not preclude other practices including emotional, expressive, and relational work; comfort measures; and teaching-learning (Watson, 1979, 1985, 1988a, 2008, 2010). According to Watson (1999), "To be implemented into care, they require of the nurse's intention, caring values, knowledge, a will, a relationship, actions, and commitment" (p. 227).

Intentionality is the projection of awareness or consciousness with some purpose and efficacy toward some object or outcome. The conscious use of intention mobilizes internal and external resources to meet the intended purpose (Watson, 1999). Watson (1999) has said, "If our conscious intentionality is to hold thoughts that are caring, open, loving, kind, and receptive, in contrast to an intentionality to control, manipulate and have power over, the consequences will be significant for our actions" (p. 121).

Health

Health is redefined in this philosophy as unity and harmony within the body, mind, and soul and harmony between self and others and between self and nature and openness to increased possibility. Watson (1989, 1999, 2008, 2011) defined health as a subjective experience and a process of adapting, coping, and growing throughout life that is associated with the degree of congruence between self as perceived and self as experienced. Thus nursing focuses on the individual's view of health or illness. Health focuses on physical, social, esthetic, and moral realms and is viewed as consciousness and a human-environmental energy field. Health reflects a person's basic striving to actualize and develop the spiritual essence of self (Watson, 1988a). It is a search to connect with deeper meanings and truths and "embrace the near and far in the instant and to seize the tangible, manifestly real, and the divine" (Watson, 1999, p. 80). Watson views health and illness functioning simultaneously as a way to stabilize and balance one's life (Watson, 1979). Illness is subjective turmoil or disharmony within a person's inner self or soul at some level or disharmony within the spheres of mind, body, and soul. Illness connotes a felt incongruence within the person such as incongruence between the self as perceived and the self as experienced (Watson, 1985, 1988a), yet it is also an "invitation to understand, to gain new meaning for one's life pattern, to see health and illness as evolving consciousness and opportunist for healing" (Watson, 2008, p. 228). Illness may lead to disease but not on a continuum. Rather, she suggests that health, illness, and disease may exist simultaneously (Watson, 2008).

Within the transpersonal caring relationship and the caring moment, there is healing potential. Nurses work with people during times of despair, vulnerability, and death. Watson and Smith (2002) acknowledge that caring knowledge transcends all health disciplines but point out that the "nursing disciplinary focus on the relationship of caring to health and healing differentiates it from other disciplines..." (p. 456).

Environment (Healing Space)

In the 10 carative factors and in clinical caritas, Watson (1999, 2008) addresses the nurse's role in the environment based on Nightingale's tradition of the significance of the environment for healing: "attending to supportive, protective, and/or corrective mental, physical, societal, and spiritual environments" (Watson, 1979, p. 10) and recently as "creating a healing environment at all levels" (Watson, 2008, p. 129). Watson (1999, 2005, 2008) has broadened her focus from the immediate physical environment to a nonphysical energetic environment, vibrational field integral with the person (Quinn, 1992; Watson, 1999, 2005, 2008, 2011). The nurse becomes the environment in which "sacred space" is created. She describes how the "nurse is not only in the environment, able to make significant changes in the ways of being/doing; knowing in the physical environment, but that the nurse IS the environment" (Watson, 2008, p. 26). This environment promotes the intentional healing role of architecture (or surroundings) alongside conscious, intentional, caring, healing modalities. Conscious attention to healing spaces shifts the health care facility from being simply a place for bodies to be treated to a place in which there is conscious promotion of mindbodyspirit wholeness, attention to the relationship between stress and illness, recognition of hospital stress factors, and acknowledgment of the key role that emotions and the senses play in healing. Through the intentional introduction of quiet, art, favorite music and colors, pleasant smells, beautiful views of nature, mythology, and the patient's favorite rituals and symbols of expressions of humanity and culture, healing spaces can assist in transcending illness, pain, and suffering.

Watson describes a caring/love that radiates in concentric circles from self, to others, the community and planet, and the universe, "nurses with informed Caritas Consciousness could literally transform entire systems, contributing to worldwide changes through their own practices of being, thus 'seeing' and doing things differently..." (Watson, 2008, p. 59). Yet, she recognizes how environmental challenges to concepts of caring—including a diminishing workforce, admission of more acutely ill patients with complex needs, cultural differences, economic factors, as well as organizational, social, and health care policies—influence the amount and quality of time a nurse can spend with clients/patients (Watson, 1999, 2005, 2008, 2011).

Critical Thinking in Nursing Practice with Watson's Philosophy and Theory

Engaging in Watson's philosophy and caring theory involves subjectivity and reflection. She suggests that you:

- Experience the transpersonal body in centering and meditation practices.
- Experience your own caring through the use of art or healing therapies on yourself.
- Experiment with the conscious use of caring consciousness in patient relations.
- Compare your experience with the theory.

Watson's theory involves healing *through* being, knowing, doing, and seeing that moves the personal *through* the professional (Watson, 1998). She emphasizes that the nurse's subjectivity and ontological competencies are critical to caring and healing. Using caring philosophy and science as a lens for reflective caring practice brings wholeness to disharmony and makes sense of the broader landscape uniting the marshes of messy "practice" and the lofty mountains of "abstract thought" (Watson, 1998, p. 215). In an integrated knowledge-in-action approach, much of what is called *knowing* may be spontaneous and tacit, given the murky nature of clinical situations, the embedded assumptions that often direct decisions, the unique subjectivity of both the nurse and the patient, and the hectic uncontrollable variables.

In coming to know the patient during a caring moment, the nurse always begins first in relation with self and other. In the first instance, during the caring moment, reflection begins with a genuine need to know the other with compassionate concern. Reflection is lived out both inside the caring moment as *reflection-in-action*, and retrospectively as *reflection-on-action*. Reflection assists the nurse to question what calls him or her to care, his or her responses to that call, the patient's response to the nurse's caring-consciousness and caring actions, the healing space that is being created, and, most significantly, the meaning of the situation for the patient. Watson's carative factors and caritas (2005, 2008) address the patient's and the nurse's subjective worlds (see Table 6-1). The nurse's subjectivity always has the intent to heal and acts both as a way of creating compassionate understanding through common human bonding with the patient and as a way of learning from each other because of each person's unique history. When patients/clients tell their stories, in whatever form (physical symptoms, oral communications, behavior, presence, or spiritual connection), it becomes a way for them to find their voices and own their lived experience, yet create some distance from the experience for introspection and meaning. The day-to-day concerns and personal worlds of the nurse and patient can become instructive for locating and understanding a deeper, more universal, more complex pattern of life. In this way, each of these revised carative factors contributes to their relationship and the meaning transpersonal caring has for the patient and the nurse.

With *retrospective reflection-on-action*, deeper personal meaning develops as the nurse reflects on his or her lived experiences, which accumulate and obtain interpretive significance as they are remembered. Retrospective contemplation involves integrating nursing experiences—physical, mental, and spiritual—into personal history, which then becomes the basis for future caring relations. Reflection starts from a place of unique experience where uncomfortable feelings and thoughts surface in relation to existing understanding. Reflection on a caring philosophy such as Watson's may require a quiet, relaxed time during which you withdraw from patient care issues and allow thoughts at a much deeper transpersonal level. As you return to conscious awareness, the evolved meaning of the experience may be felt, with a sense of intuitive understanding and spiritual insight. These retrospective reflections are often life-affirming and restore purpose and meaning to human relationships in nursing. Two case applications follow to illustrate nursing practice with Watson's philosophy of caring.

CASE HISTORY OF DEBBIE

Debbie is a 29-year-old woman who was recently admitted to the oncology nursing unit for evaluation after sensing pelvic “fullness” and noticing a watery, foul-smelling vaginal discharge. A Papanicolaou smear revealed class V cervical cancer. She was found to have a stage II squamous cell carcinoma of the cervix and underwent a radical hysterectomy with bilateral salpingo-oophorectomy.

Her past health history revealed that physical examinations had been infrequent. She also reported that she had not performed breast self-examination. She is 5 feet, 4 inches tall and weighs 89 pounds. Her usual weight is about 110 pounds. She has smoked approximately two packs of cigarettes a day for the past 16 years. She is gravida 2, para 2. Her first pregnancy was at age 16, and her second was at age 18. Since that time, she has taken oral contraceptives on a regular basis.

Debbie completed the eighth grade. She is married and lives with her husband and her 11-year-old and 13-year-old son and daughter in her mother's home, which she describes as less than sanitary. Her husband is unemployed. She describes him as emotionally distant and abusive at times.

She has done well following surgery except for being unable to completely empty her urinary bladder. She is having continued postoperative pain and nausea. It will be necessary for her to perform intermittent self-catheterization at home. Her medications are (1) an antibiotic, (2) an analgesic as needed for pain, and (3) an antiemetic as needed for nausea. In addition, she will be receiving radiation therapy on an outpatient basis.

Debbie is extremely tearful. She expresses great concern over her future and the future of her two children. She believes that this illness is a punishment for her past life.

Nursing Care of Debbie with Watson's Theory: A Transpersonal Caring Occasion with Debbie

I practice in Watson's theory by cultivating and activating intentional caring practice. I honor nursing as a biopsychosocial-spiritual practice and work to cultivate discernment in my daily life and work. I awaken and do centering exercises, sitting silently for a few moments to receive the day and cultivate loving-kindness and equanimity for *caritas* consciousness. I incorporate self-care by walking and stretching, by having a massage at least once a month, and by including time and attention to family and friends. This allows for my own sense of connect- edness and self-healing of the mind, body, and spirit, which is especially important because my practice on an oncology unit is very intense with many patients who are terminally ill.

I know very little about Debbie other than the brief report: “29-year-old married woman gravida 2 para 2 with stage V cervical cancer. Postoperative day 2 from radical hysterectomy, complains of postoperative pain and urinary retention,

nausea, poor appetite at 89 pounds (a 21-pound loss), and a heavy smoker. She has limited social support, two children, and outpatient radiation scheduled after discharge.” This report tells me little about how she is coping and feeling. I found myself wincing when several of the nurses described her husband as abusive and her kids as sweet and very young to be motherless. My immediate thoughts are of the tragedy of her situation. I ask my co-workers about their interactions with her husband, if Debbie has given permission for him to visit, and if security has been alerted; then I inquire if the social worker was contacted or if the family was aware of our services. No referral was considered and there was no note in the chart about the husband’s visitation. As we discuss Debbie further, I hear my co-workers’ concerns of little time to address Debbie’s social issues. I find out Debbie has gained 2 pounds in 3 days and knows little about self-catheterization. I empathize with what Debbie must be experiencing right now, how alone she must feel, and how scared her children and other family members may be. I wonder about her history of abuse and weight loss, when she discovered she had cancer, and what social support she may have. Even for brief moments, I use every opportunity to bring authentic, intentional caring presence into conversation with my colleagues and Debbie, using caring occasions to energetically repattern the environmental field with an awareness of the clinical *caritas* guiding my practice. As I knock and then enter her room, I remember the first three “*caritas*” processes: (1) practice loving-kindness and equanimity within a context of caring consciousness; (2) be authentically present, and enable and sustain my belief system and subjective life world of self and the person being cared for; and (3) cultivate one’s own spiritual practices and transpersonal self, going beyond ego self. *Caritas* potentiates my attentiveness, listening, comforting, and patience. Incorporating these attributes into daily practice has played a major role in my practice as an oncology nurse to address the patient’s many physical, psychosocial, and spiritual needs.

As I go to Debbie’s room, I greet her and then wash my hands. I use this 30-second opportunity to be still, to consciously take a deep breath, and to center myself in the caring moment, remembering that intention, actions, words, behaviors, cognition, body language, feelings, intuition, thought, and senses present themselves simultaneously. My energy field contributes to the transpersonal caring connection. As Watson suggests, I am awake with the intention of creating a deeper level of interaction by “being-the-*caritas*-field” (Watson, 2008, p. 48). I hold an awareness of my emotions so my judgment is not clouded as I care for Debbie. I am hopeful I will know what to offer her, not knowing her or even knowing what I will find as I meet her. I have no expectations, keeping myself open to receive each patient/client as a unique person, yet I have learned it is necessary to set flexible boundaries to avoid burnout; this is a professional nurse caring occasion rather than a personal caring relationship. I have confidence that the right words will somehow find their way to me. I know I can be present for her on several levels and be authentic if I stay true to who I am. As I turn toward her bed, I hear low, muffled sobs. As I quietly pull the curtain back and move into her space, I make an effort to “see” who the spirit-filled person is and hold caring thoughts as intent, as I relate with Debbie the person. Her fear and stress are evident and dominate over her frail physical presence.

She has her face turned away, but I can see enough to immediately sense her anguish and despair. She is only a few years younger than I am yet she seems much older. Her face is drawn and pale; her thin hand is at her mouth; and she holds a soggy tissue to her lips. I sense her vulnerability as she attempts self-control. A part of me just wants to immediately touch her, even though I hardly know her. This frail young woman, lying in a fetal position with the sheet pulled up to her shoulders, meets my concerned gaze with reddened eyes and a sob. I gently touch her free hand, which is damp, cool, and bruised from a previous venipuncture. She does not withdraw from my touch but keeps her eyes on my face. I can feel myself consciously center, steady, and open. In a quiet, gentle voice I ask if I can be of any help. I reach for a fresh tissue, and I offer it to her but keep my eyes on hers. She looks briefly away and then returns my gaze. She apologizes for crying and says she hopes she is not disturbing the other patient in the room. I feel this is a releasing of disharmony and blocked energy that may interfere with her natural healing processes. I tell her it is okay for her to focus on herself and her own healing. I smile gently, trying unobtrusively to show her that feelings are okay and that she can trust me. No words pass between us. She turns to lift herself up in the bed. I extend an arm to help her gain her balance. She grimaces as she frees the covers from her back and uses my arms for leverage as she tries to find a more comfortable position. She is obviously in discomfort.

I ask to see her dressing, carefully pull back the covers, and see that everything appears to be intact and dry. I ask her about the level and type of pain she is experiencing (using a pain scale) and when she last had some pain medication, as I continue watching her face. She says it feels like a sharp pain and an 8 on a scale of 1 to 10. She is unsure about the time she received her last pain medication. She looks over at the untouched breakfast tray and responds, "Sometime during the night, I guess. Perhaps it would calm me down some if I had another shot now. I just feel so teary and weak. This just isn't me. I need to pull myself together for my kids. I am all they've got, yet I might not be here long." Falling apart and pulling together, she seems to be feeling some dissonance between how she sees herself "before" and how she is "now." Her hope seems anchored firmly in her relationship with her children.

She glances down to the only personal thing in her hospital room—a small, framed photo of a healthier-looking Debbie smiling, her arms wrapped protectively around her two young children. She touches the photo from a happier time, as if to touch the young boy and girl there, a precious touchstone, and then lies back in bed with a sigh. She says, "I just don't know what my children will do without me." I hear fear and grief around the edges of her voice. What could—what should—I say? I give her some space and remain silent. She goes on, "Maybe all of this is a punishment for what I have done in the past, but they shouldn't be punished too. My husband isn't working right now, and he seems so removed from everything that is happening and is easily frustrated." I reflect on what she has said as she continues to share more. Her husband, who lives with friends right now, is looking for work and going to a court-ordered anger management class, and lately he has been treating her and the children well. She has support from her mother and a church family, although right now she says, "My faith is being tested."

I ask if she would like to speak with a social worker or a minister before discharge, and she agrees. I find out the foods that appeal to her and discover her tastes and a favorite soup. She agrees to see a nutritionist, a member of our oncology team. I quietly excuse myself, telling her I will be right back with some pain medication. I ask her if she will be okay alone for a few moments. She turns with a faint smile and responds, "Yes, and thank you." I look back as I return the curtain to its place of privacy. Outside the room, I look down at my watch and am shocked to find only 10 minutes have passed. As I move quickly to get the medication for her pain, I sort through what has just happened to find a pattern in the words and gestures, in the look of a face, the untouched tray, the family, the pain, the dressing, the information from report. How can I be of help to Debbie? Where is the place of healing for her? Who will be there for her? Where is the harmony in it all? I know I cannot fix it for her, but maybe I can help her find her own sources for healing and resources for her family. I sense strength there beneath the surface and her appetite is returning. She certainly has a strong motive to heal and more resources than I had anticipated. I admire and am touched by the obvious love she has for her children, her determination to parent them well and to be there for them, and her willingness to receive support. I sense there are many complex issues here for Debbie, not the least of which must be her very own mortality and her relationship with her husband. How does she feel about what she is facing? What meaning does it have for her? Where does she get her own inner strength? What will the role of her husband be with her and their children? Who will care for her?

When I return in a few minutes, her hand is pressed slightly on her abdomen. She thanks me for the medication, and her shaky smile makes me think she may be connecting with me as well. I let her know there are techniques to help her relax and potentiate the effect of the narcotic to relieve her pain. We review how to use breathing and visualization to decrease pain. I straighten her room, bring fresh water, and, with her permission, remove the wilted flowers. I ask if there is anything she needs. At the same time I am mindful of a healing environment by paying attention to environmental factors such as light, sound, air quality, and space; promoting positive nutrition and lifestyle change; or using touch, imagery, music, humor, or meditation.

I leave, telling her I will check in with her later in the morning. Perhaps we can continue to get to know each other later. I want to hear more of her story, and we will talk more about her self-catheterization, smoking, aftercare, and her children. I am grateful that I can write referrals to our nutritionist, the social worker with experience in grief counseling, and the minister, all members of our oncology team who will help Debbie with many issues before she is discharged. I breathe deeply and briefly talk with a co-worker before moving on to meet Zeke, a 30-year-old patient with colon cancer.

In her reflection-on-action in the hall, the nurse concedes to the need for active engagement in critical thought, in pattern seeking, priority setting, and mutual planning with Debbie to identify healing modalities that would best suit her needs. She resists labeling and categorizing and she seeks instead Debbie's own meaning related to care. She approaches her care in an open-ended way, recognizing the limits of human control in a universe with its own grander purposes. We see evidence

of reframing and consideration of the larger consciousness. She is able to use her own subjectivity and history-in-care as foreground for this relationship with Debbie. She envisions possibilities in the relationship of herself and Debbie, consciousness to consciousness, so that a new field of choices and advanced human capacity can be realized. She considers how their relationship evolved and stores that in memory for future caring opportunities.

CASE HISTORY OF MARIA

Maria is a 20-year-old, gravida 4, para 3, at 22 weeks' gestation. She is a partnered, Hispanic female, returning for her third prenatal visit. Her medical history is unremarkable; she had no hospitalizations other than childbirth and no known maternal or paternal genetic diseases. Her first two pregnancies in Mexico were normal vaginal deliveries without problems. Maria completed ninth grade in Mexico, and she stays home caring for her 5-, 7-, and 9-year-old daughters. She and Daniel moved to the area for factory work, so they have little social support from family and friends and Maria stays home caring for her three children. Maria speaks no English. She denies smoking or use of drugs and alcohol. Maria revealed at her initial visit that she had not established any friends since moving here a year ago and her boyfriend works long hours and provides little to no emotional support. She has been feeling alone and depressed. She has no close friends in the United States, nor does she have a group of casual friends or a church home since transportation is difficult.

Nurse-Midwifery Care of Maria with Watson's Approach

Today I am the nurse-midwife caring for Maria. I read Maria's medical history before going into the examination room. Fortunately, I know much more about Maria, the person, since I cared for her during her initial examination and her second prenatal visit. I incorporate Watson's theory in my caring-healing practice as a nurse-midwife. I use every opportunity to bring authentic, intentional caring presence into conversation with my colleagues and clients, to incorporate "clinical caritas"—caring occasions to energetically repattern the environmental field with awareness of the carative factors and caritas that guide me in my practice. I have learned from my experience and from workshops that friendliness, caring, sitting at the level of the patient/client with good eye contact using open body language, and a gentle touch are all received positively from those of Latino culture. This understanding helps me overcome cultural beliefs that might pose barriers to transpersonal caring. I know that family is very important to her, but her mother and sisters are in Mexico and her partner works 10-hour days. Therefore, having continuity is an aspect of her care and because that is not always possible, I thought to myself that we were fortunate that I was Maria's nurse-midwife again today.

It seems that we bonded quickly right after our first visit, because, although limited, I was able to speak with her in Spanish. Although some say caring takes “too much time,” I have found that focusing on patients’ priorities helps them participate actively in their prenatal care and that seems to help them achieve healthier birth outcomes. I use our time together to ask about her physical health, her feelings, and priorities for her care. This helps me know her as a person rather than just another patient in the prenatal clinic. Upholding Watson’s caring theory provides the framework for me to practice the art of caring, to provide compassion to ease patients’ and family’s fears, and to promote their healing and dignity; it also contributes to my own actualization.

“Maria, please tell me more about how you feel.” She shares her story through Kathy, an interpreter, since she speaks no English and my Spanish is limited. She feels exhaustion, tiredness, and little energy, yet she is sleeping well and I know her hemoglobin level is normal. Maria expresses stress and feeling “overloaded” and reports feeling sad and crying a lot. She tells me she prays to the Virgin of Guadalupe that her baby will be healthy and she prays when she feels bad. I listen attentively and notice that she is wearing a necklace with a symbol of the Virgin of Guadalupe. I comment that this seems to be a source of strength for her, and she agrees (an example of esthetic knowing). Finally, I let her know we will talk more about her concerns after her examination.

When she is sitting on the examination table, I make eye contact as I gently touch her shoulder. After I measure her fundal height, my hands feel the baby’s position and we talk about her baby as I gently perform the examination. I invite her daughters to feel the baby as it moves and to listen to the baby brother or sister; the fetal heart rate of 150 beats per minute is heard with Doppler and Maria smiles as we listen. She plans to breastfeed this baby as she did with her daughters. When asked about her daily nutrition, Maria admits skipping meals and not having much of an appetite, yet her hemoglobin level is normal. We talk about ways to make meals more appetizing and eating small meals more frequently. She agrees to meet Jane from the Women, Infants, and Children (WIC) program after our examination is completed. I think about Maria reaching some harmony (mindbodyspirit) in her life again and promoting hope when her situation feels overwhelming. How can I use my heart-centered awareness, consciousness, presence, voice, touch, face, and hands to create patterns and enhance the healing of the whole person? In this holistic perspective, each dimension is a reflection of the whole, yet the whole is greater than the sum of parts.

While her daughters are coloring in the coloring books that the clinic has available, I have centered time to talk with Maria through the interpreter. I ask about her living experiences and present interpretations that she can reject, consider, or accept. I ask open-ended questions to explore her feelings and to examine for signs of depression. Maria tells me about her feelings of great sadness and feelings of depression. She feels very alone without her family and friends from Mexico. Knowing that she feels depressed, it is my moral obligation to provide resources for her to enhance and preserve her “human dignity, wholeness, and integrity” (Watson, 2005).

I tell her after our visit (routine prenatal visits usually last 15 to 20 minutes) that I would like her to meet Dana, our maternity care coordinator who is fluent

in Spanish and provides case management, home visits, and support to Spanish-speaking women. Dana will follow her more closely for depressive symptoms and stress in pregnancy.

“Being-in-the-world” entails that I cannot consider Maria without her context or environment of which I am a part (family, culture, community, nurses, health care team, society). Therefore, in my inquiry, I ask about her family, friends, and resources within her community. Watson’s theory, which recognizes the whole in the parts, supports a focus on the wholeness of a community, aggregate, or population, while still attending to the individuals and families within it. Watson emphasizes seeking to strengthen the client’s resources and capacities as well as mutually planning and evaluating health actions.

Based on the importance of social support during prenatal care, I discuss ways that Maria might build a support network to help during her pregnancy. I ask her to identify people she might rely on for practical help and who might be available during some of the intense emotions of childbirth. She describes a past friendship with Danielle, but she is unsure about reestablishing contact since she had no daytime transportation. We discussed creative solutions so she could overcome the transportation difficulties.

I ask open-ended questions to offer the option for Maria to talk about spirituality as a resource during her pregnancy and birth. For example, I ask her to tell me more about the Virgin of Guadalupe to help us care for her during her pregnancy and birth. Maria’s description of what is important to her is helpful. Addressing spiritual beliefs helps me determine if the patient and the patient’s family have needs or wishes about the prenatal care or birth. Faith-hope extends beyond an understanding of the integration of mindbodyspirit and involves fostering faith and hope in her, based on her beliefs rather than mine. It is not didactic giving of information, but exploration of the meaning of the situation for Maria. Treating Maria with patience, kindness, and encouragement helps her appreciate herself.

Dana, the maternity care coordinator, made a home visit and determined that Maria was experiencing situational stress that contributed to her depressed mood; however, she was not diagnosed with major depression. Maria kept her prenatal appointments with the midwives and worked with the maternity care coordinator to create a plan to decrease stress in her life. She reestablished a friendship with Jeanette, who agreed to care for Maria’s children when she was in labor, and her partner planned to be there with her too. At 39 weeks’ gestation, Maria delivered a 7-pound, 4-ounce daughter, Lilia, with an Apgar score of 8 and 9; she was diagnosed with a kidney problem soon after birth and was transported to the level III regional hospital for further tests and evaluation. She was discharged in good health, and the pediatrician expects a good outcome. Maria continues to breastfeed her and is bonding well. Because of Maria’s psychosocial history the postpartum nurses were alerted about her risks. They provided Maria and her family members with information and a brochure on signs and symptoms of postpartum depression that also included information on community support groups. Maria agreed to call us if she experienced symptoms of postpartum depression any time before her 6-week visit. At her 6-week visit, I reevaluated Maria for signs and symptoms of depression. At this time, Maria is adapting well to parenthood, she is socializing

more, she is looking forward to her role as a new mom, and her sister-in-law, her friend Jeanette, and her family recently moved closer to Maria to provide support. I hold her baby, and we laugh, and we put her baby's picture on the bulletin board. As she leaves, I gently hold her hand as I make eye contact, letting her know we have a continued relationship and she is welcome back. At the end of the day I offer gratitude for all.

CRITICAL THINKING EXERCISES

1. Reflect on the caring moments with Debbie and Maria using Watson's 10 carative factors/caritas and describe caring in each of the cases.
2. Describe a patient situation where you found it difficult to care. Consider what aspects of the situation were difficult for you. How would you modify your being, knowing, and doing if you confront this situation again? Why is your care different?
3. Observe a place in a hospital and assess the environment as a healing space. How would you evaluate this space in terms of its potential to heal? How might you use creativity, psycho-architecture, and artistry to enhance this healing space? Who might you ask about a needed change? Can you think of a co-worker who would join you and support your efforts?
4. Does art work express your experience of caring? Reflect on your process of performing the art of nursing in your practice and review it in relation to Watson's factors in Table 6.1.
5. You are managing care of a woman in your practice that is described as "difficult". Consider your capacity to engage with similar patients in the past and describe your approach.

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Benner's Philosophy in Nursing Practice

Karen A. Brykczynski

A caring, involved stance is the prerequisite for expert, creative problem solving. This is because the most difficult problems to solve require perceptual ability as well as conceptual reasoning, and perception requires engagement and attentiveness.

(Benner, 1984, p. 214)

History and Background

More than 30 years ago, Benner began what she describes as an articulation project of the knowledge embedded in nursing practice (Benner, 1999). Her initial thrust toward further understanding of the theory/practice gap in nursing (Benner, 1974; Benner & Benner, 1979) became transformed while conducting the Achieving Methods of Intra-professional Consensus, Assessment and Evaluation (AMICAE) project, which provided the data for the widely acclaimed book *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*, abbreviated *FNE* in this chapter (Benner, 1984). Profound exemplars of nursing practices were uncovered from observations and interviews with clinical nurses during this project that demonstrated that clinical nursing practice was more complex than theories of nursing could describe, explain, or predict. This constituted a paradigm shift in nursing by demonstrating that knowledge can be developed in practice, not just applied, and signifying that practice is a way of knowing in its own right.

Two direct outcomes of the AMICAE research project were (1) validation and interpretation of the Dreyfus model of skill acquisition for nurses and (2) description of the domains and competencies of nursing practice. Benner's ongoing research studies have continued the development of these two components that have been applied extensively in clinical practice development models (CPDMs) for nursing staff in hospitals around the world (Alberti, 1991; Balasco & Black, 1988;

Bryczynski, 1998; Dolan, 1984; Gaston, 1989; Gordon, 1986; Hamric, Whitworth, & Greenfield, 1993; Huntsman, Lederer, & Peterman, 1984; Nuccio, Lingen, Burke, et al., 1996; Silver, 1986). These findings have also been used for preceptorship programs (Neveryeld, 1990), symposia on nursing excellence (Ullery, 1984), and competency validation in maternal and child community health nursing (Patterson, Leff, Luce, et al., 2004).

The books *FNE* (Benner, 1984), *Expertise in Clinical Nursing Practice* (Benner, Tanner, & Chesla, 1996, 2009), and *Clinical Wisdom and Interventions in Critical Care* (Benner, Hooper-Kyriakidis, & Stannard, 1999, 2011) report studies of skill development in nursing and research-based interpretations of the nature of clinical nursing knowledge. The ongoing development of interpretive phenomenology as a narrative qualitative research method is described and illustrated in each of Benner's knowledge development publications. The growing body of research that this work has generated is highlighted in the books *Interpretive Phenomenology: Embodiment, Caring, and Ethics in Health and Illness* (Benner, 1994b) and *Interpretive Phenomenology in Health Care Research* (Chan, Bryczynski, Malone, et al., 2010). Interpretive phenomenology is both a philosophy and a qualitative research methodology. In these books, Benner and colleagues delineate the historical background, philosophical foundations, and methodological processes of interpretive phenomenological research and examine caring practices and aspects of the moral dimensions of caring for and living with both health and illness.

Benner's thesis (1984) that caring is central to human expertise, to curing, and to healing was extended in *The Primacy of Caring: Stress and Coping in Health and Illness* (Benner & Wrubel, 1989). The meaning of caring in this work is that persons, events, projects, and things matter to people. This work examines the relationships between caring, stress and coping, and health. It claims that caring is primary for the following reasons (Benner & Wrubel, 1989):

- What matters to people influences not only what counts as stressful but also what options are available for coping.
- It enables a person to notice salient aspects of a particular situation, to discern problems, and to recognize potential solutions.
- It sets up possibilities for giving and receiving help.

This book articulates the nursing perspective of approaching persons in their lived experiences of stress and coping with health and illness. It is based on "the notion of the good inherent in the practice and the knowledge embedded in the expert practice of nursing" (Benner & Wrubel, 1989, p. xi). The primacy of caring has been used as a framework for nursing curricula in several schools of nursing including the University of Toronto in Ontario and McMurray College in Illinois (P. Benner, personal communication, January 12, 2000).

Benner's work is research based and derived from actual practice situations. Darbyshire (1994) stated that her "work is among the most sustained, thoughtful, deliberative, challenging, empowering, influential, empirical [in true sense of being based on data] and research-based bodies of nursing scholarship that has been produced in the last 20 years" (p. 760). Benner's work has been developed and applied in general staff nursing, critical care nursing, community health nursing, advanced practice nursing, and nursing education.

Benner's research offers a radically different perspective from the cognitive rationalist quantitative paradigm prevalent during the 1970s and 1980s (Chinn, 1985; Webster, Jacox, & Baldwin, 1981). Her research constitutes an interpretive turn—a move away from epistemological, linear, analytical, and quantitative methods toward a new direction of ontological, hermeneutic, holistic, and qualitative approaches. Benner (1992) has stated that “the platonic quest to get to the general so that we can get beyond the vagaries of experience was a misguided turn.... We can redeem the turn if we subject our theories to our unedited, concrete, moral experience and acknowledge that skillful ethical comportment calls us not to be beyond experience but tempered and taught by it” (p. 19).

Overview of Benner's Philosophy

Nursing is a caring practice guided by the moral art and ethics of care and responsibility that unfolds in relationships between nurses and patients (Benner & Wrubel, 1989). The original domains and competencies of nursing practice (Benner, 1984) were identified and described inductively from clinical situation interviews and observations of novice and expert staff nurses in actual practice. This interpretive phenomenological study used a situational approach to the study of the knowledge and meanings embedded in the everyday practice of nurses. “The strength of this method lies in identifying competencies from actual practice situations rather than having experts generate competencies from models or hypothetical situations” (Benner, 1984, p. 44). A holistic perspective such as this provides details of the situational contexts that guide interpretation. Thirty-one interpretively defined competencies were identified and described from the narrative data. These competencies were grouped according to similarities of function, intent, and meaning to form seven domains of nursing practice (Box 7-1).

The *helping role* domain includes competencies related to establishing a healing relationship, providing comfort measures, and inviting active patient participation and control in care. Timing, readying patients for learning, motivating change, assisting with lifestyle alterations, and negotiating agreement on

BOX 7-1

Benner's Domains of Nursing Practice

- The helping role
- The teaching-coaching function
- The diagnostic and patient-monitoring function
- Effective management of rapidly changing situations
- Administering and monitoring therapeutic interventions and regimens
- Monitoring and ensuring the quality of health care practices
- Organizational and work-role competencies

From Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Menlo Park, CA: Addison-Wesley, with permission from Pearson Education.

goals are competencies in the *teaching-coaching function* domain. The *diagnostic and patient-monitoring function* domain refers to competencies in ongoing assessment and anticipation of outcomes. Competencies in the *effective management of rapidly changing situations* domain include the ability to contingently match demands with resources and to assess and manage care during crisis situations. The domain *administering and monitoring therapeutic interventions and regimens* incorporates competencies related to preventing complications during drug therapy, wound management, and hospitalization. *Monitoring and ensuring the quality of health care practices* domain includes competencies concerned with maintenance of safety, continuous quality improvement, collaboration and consultation with physicians, self-evaluation, and management of technology. The *organizational and work-role competencies* domain refers to competencies in priority setting, team building, coordinating, and providing for continuity of care.

The domains and competencies of nursing practice are nonlinear, with no precise beginning or endpoint. Instead, the nurse enters the hermeneutic circle of caring for the patient by way of whichever competency is needed at the time. One competency in one domain may be more prominent at a particular point in time, but all seven domains and numerous competencies (some not yet identified) will perhaps overlap and come into play at various times in the transitional (ongoing) process of caring for a patient.

The domains and competencies of nursing practice (Benner, 1984) were initially presented as an open-ended interpretive framework for enhancing understanding of the knowledge embedded in nursing practice. The expectation was that they be interpreted in the context of the situations from which they arise along with articulation of ideas of the good or ends of nursing practice. Narrative text must accompany the identification and description of domains and competencies. They are not mutually exclusive, jointly exhaustive categories that can be abstracted from their narrative sources. Because of the socially embedded, relational, and dialogical nature of clinical knowledge, the domains and competencies need to be adapted for each institution. This is achieved through study of clinical practice at each specific locale by systematically collecting 50 to 100 clinical narratives that are then interpreted to identify strengths, challenges, or silences in that practice community. A CPDM can then be designed specifically for the particular setting (Benner & Benner, 1999).

Benner's work focuses on developing understanding of perceptual acuity, clinical judgment, skilled know-how, ethical comportment, and ongoing experiential learning. Benner's proposal (1994b) that narrative data be interpreted as text rather than being coded with formal criteria is useful for understanding her work, specifically with regard to expertise, practical knowledge, and intuition. When these terms are considered as formal, explicit criteria (Cash, 1995; Edwards, 2001; English, 1993; Gobet & Chassy, 2008), erroneous interpretations of conservatism, traditionalism, or mysticism may arise. Therefore, each term is discussed in detail in the following sections.

The Dreyfus (Dreyfus & Dreyfus, 1986) model of skill acquisition maintains that expert practice is holistic and situational. Qualitative distinctions between

the levels of competence, from the novice to expert skill acquisition model (Benner, et al., 1996), reflect “the situational and relational nature of common-sense understanding and developing expert practice” (Darbyshire, 1994, p. 757). According to this model, which Benner (1984) validated for nursing, expert practice develops over time through committed, involved transactions with persons in situations.

Clinical nursing expertise is embodied—that is, the body takes over the skill. Embodied expertise means that as human beings, we know things with our feelings and bodily senses (sight, sound, touch, smell, intuition), rather than just our rational minds. According to Brykczynski (1998):

To say that expertise is embodied is to say that, through experience, skilled performance is transformed from the halting, stepwise performance of the beginner—whose whole being is focused on and absorbed in the skilled practice at hand—to the smooth, intuitive performance of the expert. The expert performs so deftly and effortlessly that the rational mind, feelings, and perceptions are available to notice the patient and others in the situation and to perceive salient aspects of the situational context (p. 352).

Because expertise in this model is situational rather than defined as a trait or talent, one is not expert in all situations. When a novel situation arises or the usually expert nurse incorrectly grasps a situation, his or her performance in that particular situation relates more to competent or proficient levels. This experience then becomes part of the nurse’s repertoire of background experiences. In future encounters this nurse will approach a similar situation more expertly. This variable nature of expertise is very troublesome for those seeking abstract, objective, mutually exclusive, jointly exhaustive categories. However, it is quite compatible with the holistic, interpretive phenomenological approach. Experts functioning according to this perspective maintain a flexible and proactive stance with regard to possibly forming an incorrect grasp of the particular situation. For example, the intensive care unit (ICU) nurse described in *FNE* (Benner, 1984) who negotiated for more time for a patient to relax and stop resisting ventilator assistance before administration of additional sedation based her actions on the premise of a concern that she might be wrong. This model of expertise is open to possibilities in the particular situation, which fosters innovative interventions that maximize patient, staff, and other resources and supports to achieve an optimal outcome.

Next, an understanding of distinctions between practical and theoretical knowledge is essential for grasping this perspective (Kuhn, 1970; Polanyi, 1958). Embodied knowledge is the kind of global integration of knowledge that develops when theoretical concepts and practical know-how are refined through experience in actual situations (Benner, 1984). The more tacit knowledge of experienced clinicians is uniquely human. It is the kind of knowledge that computers do not have (Dreyfus, 1992). It requires a living person, actively involved in a situation with the complexity of background and context. The following distinction between human and computer capabilities clarifies aspects of the theory-practice gap so widely discussed in practice disciplines:

All of knowledge is not necessarily explicit. We have embodied ways of knowing that show up in our skills, our perceptions, our sensory knowledge, our ways of organizing the perceptual field. These bodily perceptual skills, instead of being primitive and lower on the hierarchy, are essential to expert human problem-solving which relies on recognition of the whole (*Benner, 1985b, p. 2*).

Theoretical knowledge may be acquired as an abstraction through reading, observing, or discussing, whereas the development of practical knowledge requires experience in an actual situation because it is contextual and transactional. Clinical nursing requires both types of knowledge. Table 7-1 provides definitions and examples of aspects of practical knowledge based on Benner (1984).

The examples of aspects of practical knowledge described in Table 7-1 are self-explanatory. However, maxims require explanation. The maxim “When you hear hoofbeats in Kansas, think horses, not zebras” reminds clinicians that for most common conditions time-consuming, extensive searches for rare conditions are usually not warranted. The maxim “Follow the body’s lead” relates to the perceptual acuity developed by nurses to intuitively sense the meaning of a patient’s bodily responses. It appears, for example, in situations in which patients are being assessed for readiness to be weaned from ventilator assistance and when nurses evaluate comfortable positions preferred by a particular infant.

In the interpretive phenomenological perspective, the body is indispensable for intelligent behavior rather than interfering with thinking and reasoning. According to Dreyfus (1992), the following three areas underlie all intelligent behavior:

1. The role of the body in organizing and unifying our experience of objects
2. The role of the situation in providing a background against which behavior can be orderly without being rule-like
3. The role of human purposes and needs in organizing the situation so that objects are recognized as relevant and accessible

Finally, intuition, rather than mystical, is defined as immediate situation recognition (Dreyfus & Dreyfus, 1986). This definition is based on Merleau-Ponty’s (1962) ideas that “the body allows for attunement, fuzzy recognition of problems, and for moving in skillful, agentic, embodied ways” (*Benner, 1995, p. 31*). Intuition functions on a background understanding of prior similar and dissimilar situations and depends on the performer’s capacity to be confident in and trust his or her perceptual awareness. This ability is similar to the ability to recognize family resemblances in faces of relatives whose objective features may be quite different. Benner (1996) argues that “[c]linical reasoning is necessarily reasoning in transition, and the intuitive powers of understanding and recognition only set up the condition of possibility for confirmatory testing or a rapid response to a rapidly changing clinical situation” (p. 673).

Interfacing with Practice

Practice and theory are seen as interrelated and interdependent. An ongoing dialogue between practice and theory creates new possibilities (*Benner & Wrubel, 1989*). In Benner’s work, practice is viewed as a way of knowing in its own right

TABLE 7-1 Aspects of Practical Knowledge

| Aspect | Definition | Examples |
|-------------------------------------|---|--|
| Qualitative distinctions | Perceptual, recognitional clinical judgment that refers to accurate detection of subtle alterations that cannot be quantified and that are often context dependent | Discrete alterations in skin color Significance of changes in mood Different manifestations of anxiety |
| Maxims | Cryptic statements that guide action and require deep situational understanding to make sense | When you hear hoofbeats in Kansas, think horses, not zebras. Follow the body's lead. |
| Assumptions, expectations, and sets | Knowledge from past experience that helps orient and provide a frame of reference for anticipatory guidance along the typical trajectory Assumptions are beliefs that something is true; expectations are outcomes that can be reasonably anticipated following a certain scenario; sets are inclinations or tendencies to respond to anticipated situations | Assumptions include the ability to maintain and communicate hope in situations based on possibilities learned from previous similar situations. It is expected that an obese person with essential hypertension who loses weight and engages in aerobic exercise 3 times a week will experience a decrease in blood pressure. A set can be illustrated by thinking about the difference in the way a nurse would approach a woman in labor for whom everything seemed to be going normally and the way a nurse would approach the woman if there was a known fetal demise. |
| Common meanings | Shared, taken for granted, background knowledge of a cultural group that is transmitted in implicit ways | It is often better to know even bad news than not to know. The need to advocate for the vulnerable and voiceless |
| Paradigm cases | Clinical experiences that stand out in one's memory as having made a significant impact on the nurse's future practice and profoundly alter perceptions and future understanding | The first patient a nurse worked with who stops smoking The first patient with a breast lump who a nurse refers for evaluation |
| Exemplars | Robust clinical examples that convey more than one intent, meaning, or outcome and can be readily translated to other clinical situations that may be quite different An exemplar might constitute a paradigm case for a nurse depending on its impact on personal knowledge and future practice | Helping a patient/family to experience a peaceful death Teaching/coaching a patient/family to live with a chronic illness |
| Unplanned practices | Knowledge that develops as the practice of nursing expands into new areas | Experience gained with available alternative therapies and patient responses to them |

Developed from Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Menlo Park, CA: Addison-Wesley.

(Benner, 1999). As noted earlier, Benner's approach to articulating nursing practice is inductive, developmental, and interpretive. She locates it in "the feminist tradition of consciousness raising that seeks to name silences and to bring into public discourse poorly articulated areas of knowledge, skill, and self-interpretations in clinical nursing practice" (Benner, 1996, p. 670).

Articulation is defined as "describing, illustrating, and giving language to taken-for-granted areas of practical wisdom, skilled know-how, and notions of good practice" (Benner, Hooper-Kyriakidis, & Stannard, 1999, p. 5). Since the publication of *FNE* in 1984, which involved staff nurses from various clinical areas, Benner and colleagues have focused on articulating skill acquisition processes and competencies of nurses in acute and critical care areas (Benner, et al., 1996, 2009; Benner, et al., 1999, 2011). Domains and competencies have also been useful for articulation of knowledge embedded in advanced nursing practice (Brykczynski, 1999; Fenton, 1985; Fenton & Brykczynski, 1993; Lindeke, Canedy, & Kay, 1997; Martin, 1996).

Selected studies illustrate applications of Benner's work and continued articulation of the competencies of advanced nursing practice. Fenton's (1985) study indicated that the original domains were present in the practice of clinical nurse specialists (CNSs). She identified additional competencies for three of Benner's original domains and described one additional domain, *the consulting role of the nurse* (Figure 7-1). Fenton described the competency *making the bureaucracy respond* in her study of CNSs. This involved knowing how and when to work around bureaucratic roadblocks in the system so patients and families could receive needed care.

Brykczynski (1985) developed an additional domain from her study of outpatient nurse practitioner (NP) practice. The new domain consolidated two of Benner's domains that were typical of inpatient nursing practice—*diagnostic and patient monitoring function* and *administering and monitoring therapeutic interventions and regimens* (see Figure 7-1)—and replaced it with *management of patient health/illness status in ambulatory care settings*. The remaining five of Benner's seven domains were interpreted as valid for the practice of the NPs studied. The cumulative nature of qualitative research is demonstrated by Brykczynski's (1985) identification of *managing the system* as a competency in her NP study. Further interpretation revealed that this competency was identical to *making the bureaucracy respond* described by Fenton with CNSs. This competency involves negotiating and interpreting policies and procedures for patients so that they can fit into the system and get what they need. It demands flexibility in the nurse's stance toward the system and requires not getting caught up in unproductive interpersonal conflicts; instead, the nurse uses knowledge of the bureaucracy and interpersonal communication skills to provide care for patient needs.

Later Fenton and Brykczynski compared the findings of their studies to discover commonalties and distinctions between the practice of NPs and CNSs. The comparative analysis indicated "a shared core of advanced practice competencies as well as distinct differences between the practice roles" (Fenton & Brykczynski, 1993, p. 313). As noted, *making the bureaucracy respond* was shared by both groups; however, the organizational and work-role competencies were more prominent in

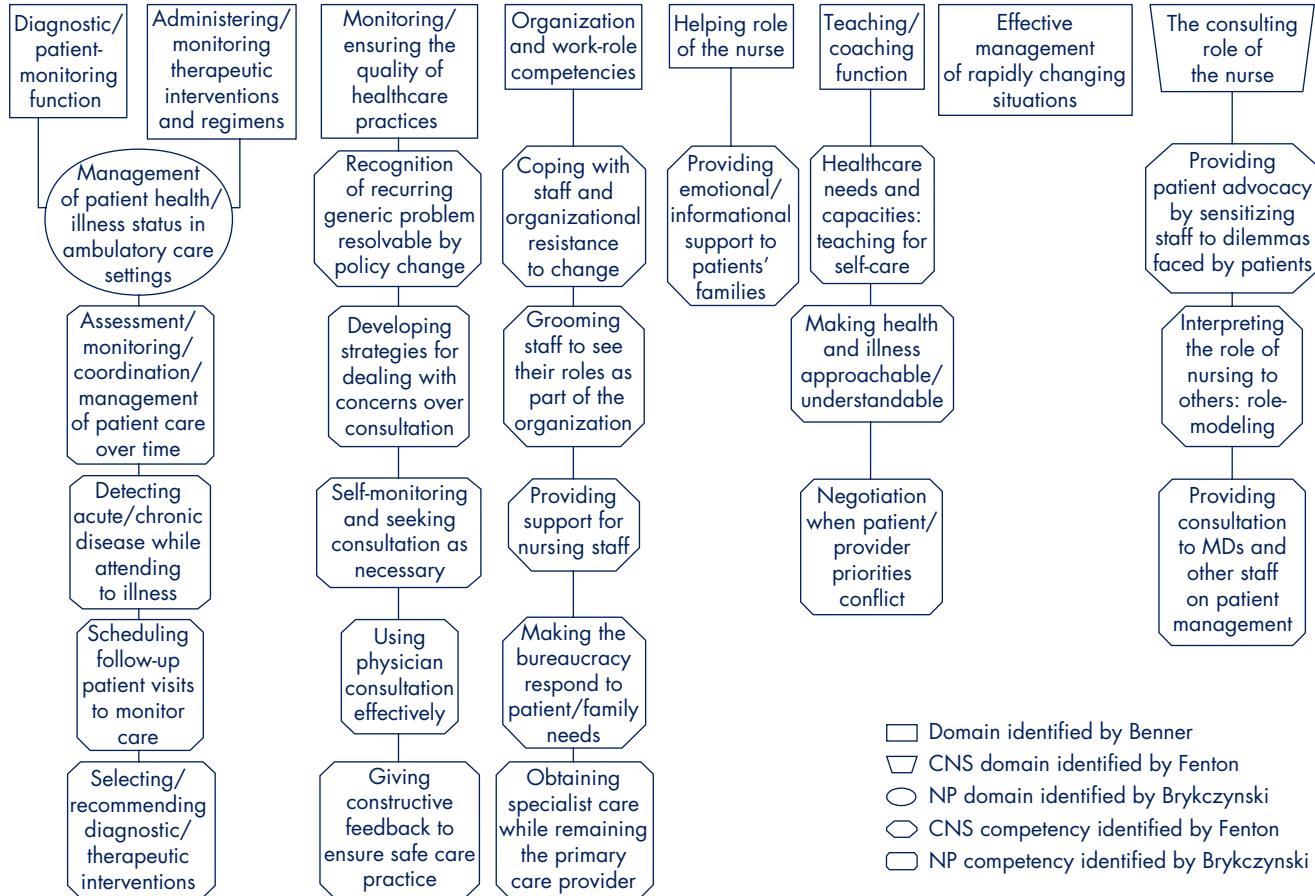


FIGURE 7-1

Expert practice domains of the clinical nurse specialist and the nurse practitioner. (From Fenton, M. V., & Brykczynski, K. A. [1993]. Qualitative distinctions and similarities in the practice of clinical nurse specialists and nurse practitioners. *Journal of Professional Nursing*, 9[6], 317.)

the practice of the CNSs. NPs practiced more as direct providers of care, whereas CNSs functioned more as facilitators of care. The new domain, *the consulting role of the nurse*, was evidenced in the practice of both CNSs and NPs. Competencies in this domain represent the initial articulation of skills and knowledge specific for advanced nursing practice.

Lindeke, Canedy, and Kay (1997) followed this work with a study of similarities and differences between CNS and NP roles among CNSs who completed a post-master's NP program. They found that although practice domains were similar, there was distinct expression of the domains in each advanced practice nurse (APN) role. The post-master's participants stated that they "experienced significant role change in the transition from CNS to NP roles" (Lindeke, et al., 1997, p. 287); important advanced practice role findings for curriculum planning.

Critical Thinking in Nursing Practice with Benner's Approach

Benner addresses critical thinking in a developmental and interpretive way. Whereas formal definitions of critical thinking tend to signify abstract, rational calculation with analysis and weighing of options to arrive at decisions, Benner specifies that a thinking process for beginning nurses and an interpretive process based on past-whole-concrete cases with expert nurses. Benner's perspective is inclusive in that it incorporates the formal, analytical definition at novice and advanced beginner levels of practice and the more integrative, qualitative definition at proficient and expert practice levels.

Benner and colleagues (1999) identified six aspects of clinical judgment and skillful comportment that can be viewed as interpretive aspects of critical thinking (Table 7-2). These six aspects were identified and described through study of critical care nursing practice. They constitute components of the thinking-in-action

TABLE 7-2 Critical Thinking in Nursing Practice with Benner's Philosophy

| Aspects of Clinical Judgment and Skillful Comportment | Definition |
|---|---|
| 1. Reasoning in transition | Practical reasoning in an ongoing clinical situation |
| 2. Skilled know-how | Embodied intelligent performance, which involves knowing what to do, when to do it, and how to do it |
| 3. Response-based practice | Adapting interventions to meet changing needs and expectations of patients |
| 4. Agency | One's sense of and ability to act on or influence a situation |
| 5. Perceptual acuity and involvement | Ability to tune in to a situation and hone in on the salient issues by engaging with the problem(s) and the person(s) |
| 6. Links between clinical and ethical reasoning | Understanding that good clinical practice cannot be separated from ethical notions of good outcomes for patients and families |

Developed from Benner, P., Hooper-Kyriakidis, P., & Stannard, D. (1999). *Clinical wisdom and interventions in critical care: A thinking-in-action approach*. Philadelphia: Saunders.

approach required in acute and critical care. (1) *Reasoning in transition* involves the thinking-in-action demanded as an ongoing situation evolves over time. (2) *Skilled know-how* refers to embodied knowing described earlier. (3) *Response-based practice* involves the ability to read a situation and respond flexibly and proactively to changing needs and demands. (4) *Agency* is the nurse's ability to function within a given situation. (5) *Perceptual acuity and involvement* refer to acquiring a good grasp of the situation through emotional engagement with the problem and interpersonal involvement with patients and families. "Notions of good guide the actions of nurses and help them notice clinical and ethical threats to patients' well-being" (Benner, et al., 1999, p. 17), thus (6) *linking clinical and ethical reasoning*.

In this work Benner and colleagues (1999) sought to generate "a dialogue with practice and theory to create an enlarged view of rationality that is dialogic, relational, and cumulative rather than a collection of decisions and facts" (p. 22). The second edition of this work (Benner, et al., 2011) presents educational strategies to address practice. According to Benner and colleagues (1999), "[c]linical reasoning requires reasoning-in-transition (or reasoning about the changes in a situation) about particular patients and families" (p. 10). The term *thinking-in-action* is intended to convey "the innovative and productive nature of the clinician's active thinking in ongoing situations" (Benner, et al., 1999, p. 5). According to Benner and Benner (1999):

Clinical practice is a socially embedded knowledge that draws on theoretical and scientific empirical knowledge but also on the practical know how, compassionate meeting of the other, and front-line knowledge work of practitioners.... The practitioner, whether nurse, physician, lawyer, teacher, or social worker, reasons about the particular across time, observing transitions in the client's condition, and also transitions in his or her own understanding of the clinical situation (p. 22).

Benner has suggested that both practical clinical knowledge and caring practices have been minimized in modern health care. It is her hope that identification and description of these practices on which health care institutions depend will promote their recognition and legitimacy (Benner, 1994a). These aspects of practice have particular relevance to minimizing errors and promoting safety in health care situations (Benner, Malloch, & Sheets, 2010).

CASE HISTORY OF DEBBIE

Debbie is a 29-year-old woman who was recently admitted to the oncology nursing unit for evaluation after sensing pelvic "fullness" and noticing a watery, foul-smelling vaginal discharge. A Papanicolaou smear revealed class V cervical cancer. She was found to have a stage II squamous cell carcinoma of the cervix and underwent a radical hysterectomy with bilateral salpingo-oophorectomy.

Her past health history revealed that physical examinations had been infrequent. She also reported that she had not performed breast self-examination. She is 5 feet, 4 inches tall and weighs 89 pounds. Her usual weight is about 110 pounds. She has smoked approximately two packs of cigarettes a day for the past 16 years. She is gravida 2, para 2. Her first pregnancy was at age 16, and her second was at age 18. Since that time she has taken oral contraceptives on a regular basis.

Debbie completed the eighth grade. She is married and lives with her husband and her two children in her mother's home, which she describes as less than sanitary. Her husband is unemployed. She describes him as emotionally distant and abusive at times.

She has done well following surgery except for being unable to completely empty her urinary bladder. She is having continued postoperative pain and nausea. It will be necessary for her to perform intermittent self-catheterization at home. Her medications are (1) an antibiotic, (2) an analgesic as needed for pain, and (3) an antiemetic as needed for nausea. In addition, she will be receiving radiation therapy on an outpatient basis.

Debbie is extremely tearful. She expresses great concern over her future and the future of her two children. She believes that this illness is a punishment for her past life.

In Benner's work nursing practice is an interpretive (hermeneutic) of the patient situation. She agrees with Good and Good (1981) that "all clinical encounters have a hermeneutic dimension; clinicians and patients interpret one another's meanings to bring to light an underlying coherence or sense" (p. 208). She maintains as do Good and Good (1981) that "the negotiation by the healer and the patient of a common understanding of the cause of suffering, the construction of a shared illness reality, provides the basis for the therapeutic efficacy of many healing transactions" (p. 193). For Benner, nursing practice is constituted by a circular hermeneutic process between the nurse, the patient, and the ongoing situational context.

Nursing Care of Debbie with Benner's Approach

This case is presented in a factual outside-in way that Foucault (1963) called the *clinical gaze*—that is, we observe but do not meet Debbie. Presumably, the nurse would meet Debbie and discover her concerns to develop a shared understanding of how to proceed. The clinical hermeneutic takes place as the nurse interprets nursing care.

Domain: The Helping Role

The helping role domain is a good place to start in thinking about Debbie's care. In establishing a healing relationship with Debbie, you would begin by getting to know her as a person. By learning Debbie's unique life situation, beliefs, values,

needs, and goals, you develop an understanding of the meanings this illness experience has for her. At the same time, who the nurse is, what the nurse's background experiences have been, and what the nurse's level of competence is in caring for women with cancer influence how the particular nurse-patient transaction develops over time. Debbie's relationships with each of the nurses involved in her care will vary in some ways according to each nurse's competence, unique personality, and approach to care.

Benner and colleagues (1996) describe the experiential learning associated with learning the skill of involvement. Learning how to be engaged in the clinical situation and how to be connected with patients and families in helpful ways is ongoing. This skill requires attunement to the situation and to the individuals involved because what is an appropriate level of involvement at one phase may be inappropriate at another. Also, different individuals have different comfort zones and expectations, and these may change during the course of an illness. By engaging in ongoing dialogue about the situated meanings of Debbie's illness experience, you can personalize her care and help Debbie discover her own situated possibilities. Debbie and you can plan her care together and modify it according to transitions as the situation evolves.

Other salient issues might emerge in the helping relationship, including maximizing Debbie's participation and control in her recovery, interpreting kinds of pain, and selecting appropriate strategies for pain management and control. Guiding Debbie through the emotional, physiological, social, and developmental changes of losing her uterus and ovaries at 29 years of age is also important here. No general techniques can be offered because treatment depends on identification of Debbie's concerns and her openness and readiness to discuss them. The patient-nurse relationship uncovers situated possibilities. For example, Debbie may be fearful that she might die, but such fears are best discussed when she indicates that she is ready. You can follow Debbie's lead by asking well-timed questions. To do this, however, you must address your own fears of dying to be open to Debbie's.

Domain: The Teaching-Coaching Function

Teaching-coaching functions may be relevant in Debbie's situation depending on your assessment of her readiness to learn. For example, her tears might signal a readiness to engage in discussion of her fears, or they may indicate sadness and depression. Understanding the meaning of Debbie's tears requires attentive listening and open-ended questioning to make the necessary qualitative distinctions. If Debbie appears to be receptive to learning, coaching her about the implications of her illness and recovery in her unique life situation can proceed in an individualized way.

Domain: The Diagnostic and Monitoring Function

During all points of Debbie's care, you will anticipate future problems and attempt to understand the particular demands of Debbie's illness. For example, you will anticipate care needs related to Debbie's catheterizing herself at home, managing her pain, and controlling her nausea. Based on your and Debbie's assessments of

her potential for wellness and responses to various treatment strategies, you will develop a discharge plan and discuss this plan with the home-care nurse.

Domain: Organizational and Work-Role Competencies

Building and maintaining a therapeutic team to provide optimum therapy for Debbie is a relevant competency from this domain. No information is available on the staffing situation in Debbie's nursing unit, so the significance of the other competencies in this domain is unknown. However, communicating Debbie's concerns will be crucial.

CASE HISTORY OF ROSA

This case is a narrative exemplar shared by two of the nurses in Brykczynski's peer-identified nurse expert project (1993-1995; Brykczynski, 1998). It illustrates the development of new clinical knowledge and skills when nurses expand into new practice areas. A group of eight obstetric (OB) nurses who had recently received training in critical care took care of Rosa in the labor and delivery (L&D) unit during her hospital stay. This training in critical care was provided to enable these nurses to care for the increasingly high-risk maternity patients who were having babies at their institution. Previously, obstetric patients requiring critical care were transferred to the ICUs.

Rosa is a pseudonym for a 22-year-old young woman from South America who spoke only Spanish. She had moved to the southwestern United States and was admitted to our institution for the birth of her first baby. She was a full-term primipara. The father of the baby was Mexican-American and had family who lived approximately 5 hours from the hospital. Rosa was not married to the baby's father; however, he was identified as the father before the baby's birth.

Rosa became comatose secondary to acute fatty liver of pregnancy following delivery of her healthy baby girl. She was intubated, placed on a ventilator, and required hemodialysis. Her electroencephalograms (EEGs) showed minimal brain wave activity. At one point Rosa had been considered a possible candidate for a liver transplant, but because of multisystem failure, she was eventually designated as "do not resuscitate" (DNR), and the transplant was not pursued further. In fact, the family was asked to consider donating her organs.

In contrast to the physicians' hopeless prognosis for Rosa's recovery, the nurses sensed possibility in this extreme situation and they sought to put her body in the best condition for healing. For example, they provided an environment enriched with sound and touch. They spoke to Rosa in Spanish whenever possible and placed Rosa's baby across her chest, where Rosa could hear and feel her presence. They provided ongoing supportive care while Rosa's liver regenerated. The supportive nursing care included nutrition via tube feedings, passive range-of-motion exercises, pulmonary toileting, care of the mouth and skin, and frequent position changes. They also provided (in Spanish, whenever possible) updates about her baby and explanations of what was happening. The nurses also included the baby's father in their care.

Continued

CASE HISTORY OF ROSA—cont'd

Posted in the nurses' station are two photographs: The picture of Rosa and her baby taken just before discharge shows Rosa's swollen, jaundiced body. The other photo, taken during a return visit to the hospital clinic, shows Rosa as a tiny, attractive woman. These photos serve as a reminder to the nurses to be attentive to recognizing situations in which it might be imperative to buy time while the patient's body heals itself.

Nursing Care of Rosa with Benner's Approach**Domain: The Helping Role**

The holistic interpretive perspective of the nurses enabled them to perceive Rosa's situation very differently from the objective clinical gaze of the physicians (Foucault, 1963). As one of the nurses narrates:

Neuro came in and looked at her head—that was what they saw, her head and lack of neurological function. GI came in and they saw just the liver. Renal came in and saw her kidneys. OB came in and saw a comatose postpartum woman. Anesthesia came in and so on (Brykczynski, 1998, pp. 355-356).

This excerpt illustrates that the objective clinical gaze is depersonalizing and divides the person into the separate organs and systems of interest to different specialties.

The nurses were aware that Rosa was a young, healthy woman before developing this rare pregnancy-induced illness, and they had developed the clinical perceptual acuity to follow the lead of Rosa's body toward restoration of health. In understanding how the nurses established a healing climate for Rosa, it is important to know that no mother had ever been declared a "do not resuscitate" (DNR) in this labor and delivery (L&D) unit before. Having no experience with such a situation, the nurses did what was necessary to maintain and support Rosa so that her body could heal itself—if that was to be. This is an example of the common meaning Benner (1984) calls *situated possibility*, in which nurses learn that even the most deprived illness circumstance has its own possibility. Knowing that the hormonal stress response associated with abandoning hope can influence the course of an illness (Benner, 1985a), both the nurses and the family members remained hopeful. They stayed nearby and prayed for Rosa throughout her hospital stay. The power of prayer in influencing healing is recently receiving more research attention as spirituality is becoming more widely recognized (Byrd, 1997).

The following two obvious aspects clearly affected the development of a collaborative relationship between Rosa and her nurses:

1. Rosa was comatose and unable to communicate in any obvious way with the nurses caring for her.
2. The majority of the nurses spoke only English and knew few, if any, words in Spanish.

In striving to create a healing climate for Rosa, the nurses realized that she probably could hear but was unable to acknowledge this. For this reason, they spoke to her while they provided her care. If an interpreter was not available, they spoke to her in English, hoping to convey their feelings and concern by the tone of their voices. The nurses reported that when Rosa returned to the conscious state, she recognized those who had cared for her by their voices.

Domain: The Teaching-Coaching Function

The nurses reported that they described what they were doing while they cared for Rosa and consistently provided ongoing feedback about her condition and her family to promote her participation in care as much as possible. They were involved with the father of the baby, who was struggling with this very difficult situation. The nurse reported:

At times he would cry if he was holding the baby and not want to cry—especially being a Hispanic male. This was not something he wanted to do and tried not to. We encouraged him to hold the baby himself. We realized that this was not something he had planned on—you know basically the woman is expected to help with the baby and integrate the baby into the household. It was kind of like, “here’s the baby,” and it was really hard for him. He had a lot of mixed emotions. He wasn’t sure what he was going to do (Brykczynski, 1993-1995).

In coaching the father through this uncharted illness experience, the nurses received much support from a social worker who was fluent in Spanish.

Domain: The Diagnostic and Monitoring Function

Understanding the particular demands and experiences of Rosa’s illness was crucial in anticipating her care needs. The nurses reported reading everything they could find about Rosa’s rare condition (acute fatty liver of pregnancy) to increase their understanding of her illness and enhance their ability to assess her potential for wellness and for responding to various treatment strategies.

Domain: Administering and Monitoring Therapeutic Interventions and Regimens

All the competencies in this domain were significant in this situation. In an effort to normalize the situation as much as possible—for the nurses as well as Rosa—they continued to bring Rosa’s baby in to her and place the baby on her chest. One of the critical care nurses participating in the interviews recalled a postpartum woman in ICU for whom the nurses played a tape of her baby’s sounds during her stay in the ICU. Rosa was fortunate that she was not transferred to the ICU but instead received care from obstetrics (OB) nurses who recently received critical care training. One nurse describes how bringing the baby to the mother helped them as well as Rosa:

Part of it I think initially when we were bringing the baby in was it helped us in a way too because we didn’t want the baby staying in the nursery for 4 or 5 days without really being nurtured (Brykczynski, 1993-1995).

The nurses developed the idea of providing nutritional support for Rosa. They reported approaching every specialty physician team involved in Rosa's care, including OB, neurology, renal, and gastrointestinal (GI), until one specialty service agreed to order a nutritional consult so that Rosa could receive tube feedings. Based on their assessment of the physiological parameters and experience with patients with this rare condition who did not do well, the physicians' prognosis for Rosa was bleak. Their attitude toward the nurses was one of humoring them. They reasoned that "if it makes the nurses feel better, they can feed her," because they felt it would not do her any harm. As it turned out, nutritional support was essential to her recovery, particularly for her liver regeneration.

Domain: Organizational and Work-Role Competencies

Building and maintaining a therapeutic team to provide optimum therapy was an important competency in this situation. As noted, the group of eight OB nurses who had recently participated in critical care training experiences, which prepared them to care for high-risk women during labor and delivery, formed the team of nurses who cared for Rosa. Their obstetric nursing background and recent critical care experience made them uniquely capable of individualizing Rosa's care. By expanding into a new area of nursing practice, the nurses established the opportunity to develop new knowledge in high-risk OB nursing. For example, as OB nurses they were acutely aware that not hearing the sounds of her baby could make Rosa feel that her baby was not alive. An interesting aspect of this situation was that, as OB nurses, nutrition was not generally a particularly salient issue for them. One nurse related:

It's real common for us not to feed our patients. When they are on mag [magnesium sulfate] they may go for three days without food. Or even postpartum for PIH [pregnancy-induced hypertension], so we're used to starving our patients because it really is in the back of our minds that it is okay not to feed a patient because they are usually normal, healthy people who are pregnant. [The idea of feeding her] developed from our experiences rotating through the critical care units where we came in contact with TPN (total parenteral nutrition) and hepatic A tube feedings and that made us more aware of nutrition as a support for this patient (Brykczynski, 1998, p. 356).

Domain: Monitoring and Ensuring the Quality of Health Care Practices

The group of specially trained OB nurses had ready access to the critical care nurses, with whom they had recently worked, thereby providing readily accessible backup for safe care. This combination of obstetric and critical care knowledge and skill enabled them to ensure that optimal supportive care was provided. They made adjustments to the care plan far beyond those recommended by the physicians. Examples included bringing the baby to the mother and providing nutritional support.

One of the two nurses who described this exemplar in Brykczynski's (1998) study reported caring for Rosa as she regained consciousness. This nurse related that she was performing the standard neurological check and noticed a slight

change in Rosa's pupil reaction, which was nonexistent before. She rechecked the pupils and had another nurse verify that there was a slight response. The physician who was summoned did not detect any pupillary reaction. Gradually, however, Rosa became more and more alert throughout this nurse's shift and was able to be extubated. Rosa's baby was crying in the room when Rosa regained consciousness. Remarkably, Rosa's liver had regenerated; she recovered with no residual brain damage; and she was discharged home to be with her baby and the baby's father. This case history constitutes an exemplar of nursing provided in an open, receptive, adaptive, creative, and hermeneutic manner as described by Benner and colleagues as a reasoning-in-transition approach (Benner, et al., 1999). For teaching students this case can be presented as an unfolding case study to help students learn how clinical reasoning changes over time (Benner, Sutphen, Leonard, et al., 2010).

CRITICAL THINKING EXERCISES

1. Reflect on a situation from your practice as a nurse that taught you to modify, refine, and embody knowledge in a very practical way. Describe the situation in narrative story form and include as many specific contextual details as possible using the following as a basis: Who? Where? When? What? Why? How? See "Guidelines for Writing Nursing Narratives" in Benner and colleagues (2011, pp. 542-544) for more information.
2. Using the novice to expert model, describe a situation illustrating how a nurse functioning primarily at a competent level of expertise can promote learning for a new graduate functioning as a novice nurse.
3. You have been asked by your nurse administrator to develop a draft revision of the institution's nursing service clinical ladder. Use Benner's approach and develop your draft for presentation to the administrative council.
4. As student representative to the curriculum committee in the school of nursing, how would you present the idea of using Benner's work for enhancing and evaluating the curriculum?
5. Reflect on the approach of the physicians caring for Rosa and the reasoning-in-transition approach followed by the nurses in their care of Rosa. Consider this case in terms of evidence-based practice. Is it a useful exemplar for approaching situations in which there is little, if any, evidence or the evidence is inconclusive? How does it highlight the importance of individualizing care?

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Johnson's Behavioral System Model in Nursing Practice

Bonnie Holaday

Nursing is “an external regulatory force that acts to preserve the organization and integration of the patient’s behavior at an optimal level under those conditions in which the behavior constitutes a threat to physical or social health or in which illness is found.” The goal of nursing is to “restore, maintain or attain behavioral integrity, system stability, adjustment and adaptation, efficient and effective functioning of the system.

(Johnson, 1980, p. 214)

History and Background

The Johnson Behavioral System Model (JBSM) was conceived and developed by Dorothy Johnson while she was a professor of nursing at the University of California, Los Angeles (UCLA). The process of developing this model began in the late 1950s as she examined the explicit goal of action of patient welfare that was unique to nursing. The task was to clarify nursing’s social mission from the perspective of a theoretically sound view of the client. The conceptual model that resulted was presented at Vanderbilt University in 1968 (Johnson, 1968). Since that time, other noteworthy presentations of the model have been offered (Auger, 1976; Dee, 1990; Derdiarian, 1990, 1993; Grubbs, 1974; Johnson, 1980, 1990). Johnson retired from UCLA in 1978, but she maintained her interest in “systems” through her hobby of shell collecting. She traveled extensively to collect shells and later donated them to a museum in Sanibel, Florida. Johnson died in February 1999. Johnson’s papers, documents, and letters, per her request, are available at the Eskind Biomedical Library Special Collections at Vanderbilt University in Nashville, Tennessee.

The JBSM offers useful guidelines for nursing practice. Used in conjunction with the nursing process, it has provided a useful conceptual map to plan patient care. Poster, Dee, and Randell (1997) provided evidence supporting the efficacy

of the JBSM as a tool for evaluating patient outcomes. Auger and Dee (1983) developed the UCLA Neuropsychiatric Institute and Hospital Classification System, based on the JBSM. This system was integrated with the nursing process and is used as a clinical measure of patient progress.

The work of Auger and Dee led to the development of behavioral indices, with each subsystem operationalized in terms of critical adaptive and maladaptive behaviors. The behaviors were ranked into categories according to their assumed level of adaptiveness. Nurse clinicians can rate each behavior for compliance by using an activity rating scale of 1 to 4. This scale provided a basis for allocating nursing resources at the UCLA Neuropsychiatric Institute (Dee & Randell, 1989).

Derdiarian used the JBSM to develop the Derdiarian Behavioral System Model (DBSM) instrument (Derdiarian, 1983, 1988; Derdiarian & Forsythe, 1983). The DBSM's 22-category interview generated data pertaining to the major changes in the behavioral systems as a result of illness, as well as the positive or negative effects of these changes. Specifically, two types of subjective data were generated. This included the "set"-related variables (the variables that potentially predict or influence the patient's usual behavior) and the behavior resulting from illness. Overall, research findings suggested that the DBSM instrument improved the focus, comprehensiveness, and quality of nursing assessment, diagnoses, interventions, and evaluation of outcomes of adult patients with cancer, acquired immunodeficiency syndrome (AIDS), and myocardial infarction (Derdiarian, 1983, 1988).

Other studies have also documented the utility of the JBSM for nursing practice. Holaday (1980) used the model to assess health status and to develop nursing interventions for children undergoing surgical procedures. Wang and Palmer (2010) used the model to conduct an analysis of the concept of women's toileting behavior related to urinary elimination. Dee, van Servellen, and Brecht (1998) found that the JBSM could be used to derive meaningful conclusions about the impact of managed care on nursing care problems, and Coward and Wilkie (2000) demonstrated that the JBSM could be used to plan pain management for cancer patients. Colling, Owen, McCreedy, and colleagues (2003) planned a continence program for the frail elderly; Brinkley, Ricker, and Toumey (2007) used the model to examine esthetic knowing with a hospitalized obese patient; and Tamilarasi and Kanimozhi (2009) developed an intervention to improve the quality of life in breast cancer survivors.

Holaday's work demonstrated identification of subsystem disorders, validated the notion of behavioral subsystems and their utility and usefulness in nursing practice, broadened the understanding of the role of "set," and examined the relationship between sustenal imperatives and action (Holaday 1974, 1981, 1982, 1987; Holaday, Turner-Henson, & Swan, 1996). Derdiarian's research demonstrated the factor-isolating and categorizing potential of the JBSM, validated the notion of behavioral subsystems, and provided empirical descriptions of central concepts in the theory (Derdiarian, 1983, 1988, 1990; Derdiarian & Forsythe, 1983). Meleis (2012) described the body of research related to nursing practice that the JBSM has generated and noted that it provided "significant developments in the conceptualization of the nursing client" (p. 280).

Overview of Johnson's Behavioral System Model

Johnson's model for nursing presents a view of the client as a living open system. The client is seen as a collection of behavioral subsystems that interrelate to form a behavioral system. Therefore, the behavior is the system, not the individual. This behavioral system is characterized by repetitive, regular, predictable, and goal-directed behaviors that always strive toward balance (Johnson, 1968).

Johnson (1968) proposed that the nursing client is a behavioral system with behaviors of interest to nursing and is organized into seven subsystems of behavior: achievement, affiliative, aggressive, dependence, eliminative, ingestive, and sexual. Nurses using the model believed that an additional area of behavior needed to be addressed (Auger, 1976; Derdiarian, 1990; Grubbs, 1974; Holaday, 1980). They added an eighth subsystem, restorative. Each subsystem has its own structure and function. Each subsystem comprises a goal based on a *universal drive, set, choice,* and *action*. Each of these four factors contributes to the observable activity of a person. Boxes 8-1 and 8-2 provide examples of how one might operationalize the function and structure of each subsystem. Grubbs (1980) provides excellent definitions of the concepts and terms used in the JBSM.

The goal of a subsystem is defined as "the ultimate consequence of behaviors" (Grubbs, 1974, p. 226). The basis for the goal is a *universal drive*, the existence of which is supported by existing theory or research. The goal of each subsystem is the same for all people when stated in general terms; however, variations among individuals occur and are based on the value placed on the goal and drive strength.

The second structural component is *set*, which is a tendency to act in a certain way in a given situation. Once they are developed, sets are relatively stable. Set formation is influenced by such societal norms and variables as culture, family, values, perception, and perseverative sets. The preparatory set describes one's focus in a particular situation. The perseverative set, which implies persistence, refers to the habits one maintains. The flexibility or rigidity of the set varies with each person. Set plays a major role in determining the choices a person makes and actions eventually taken.

Choice refers to the alternate behaviors the person considers in any given situation. A person's range of options may be broad or narrow. Options are influenced by such variables as age, gender, culture, and socioeconomic status.

The *action* is the observable behavior of the person. The actual behavior is restricted by the person's size and abilities. Here the concern is the efficiency and effectiveness of the behavior in goal attainment.

Each of the subsystems also functions in a manner analogous to the physiology of biological systems (e.g., the urological system has both structural and functional components). The goal of the subsystem is a part of the structure. It is not entirely separate from its function.

For the eight subsystems to develop and maintain stability, each must have a constant supply of "functional requirements" or sustenal imperatives (Johnson, 1980, p. 212). The environment must supply the functional requirements or sustenal imperatives of protection from unwanted, disturbing stimuli; nurturance

BOX 8-1**Affiliative Subsystem****FUNCTION**

- To form cooperative and interdependent role relationships within human social systems
- To enjoy interpersonal relationships
- To belong to something other than oneself
- To share
- To achieve intimacy and inclusion

STRUCTURAL COMPONENTS

Goal: To relate or belong to something or someone other than oneself, to achieve intimacy and inclusion.

Perseveratory Set: A consistent approach (or pattern of behavior) to establishing affiliative relationships; a consistent tendency to select a certain individual or group for the purpose of affiliation; inherited generic characteristics that determine the influence of affiliative behaviors; development of self-identity and self-concept to a group; cultural beliefs and customs.

Preparatory Set: Perception of a situation as requiring particular role behaviors required by the interaction setting; selective inattention to social behaviors; mood.

Choice: Selection from among the alternatives available in the situation as perceived through set, the behaviors considered appropriate to meet the goal. Within the context of the situation, the behaviors include affiliation, avoidance, nonreciprocated relationships, noncontingent social relationships, maintenance of a relationship, and affiliation with animals or other objects.

Acts: Any directly observable behavior that facilitates movement toward others in the environment. Specific acts include smiling, visual contact, talking (social greeting, conversation, extending invitations), facial expression, motor behaviors (touching, holding, hugging), and other actions that establish or maintain a reciprocal relationship between two or more individuals.

Sustenal Imperatives: Conditions that serve to protect, stimulate, and mature behaviors related to affiliation. Included are learned behaviors to initiate and maintain a social exchange: presence of an environment where these skills can be taught and nurtured; development of trust; kinship; awareness of one's self-identity; self-esteem; ability to communicate verbally and nonverbally; membership in groups; knowledge of formal and informal guidelines for interpersonal processes; and secure parent-infant attachment.

through giving input from the environment (e.g., food, caring, conditions that support growth and development); encouragement; and stimulation by experiences, events, and behavior that would “enhance growth and prevent stagnation” (Johnson, 1980, p. 212).

The subsystems maintain behavioral system balance as long as both the internal and the external environments are orderly, organized, and predictable and each of the subsystems' goals is met. Behavioral system imbalance arises when structure, function, or functional regimen is disturbed. The JBSM differentiates four

BOX 8-2**Ingestive Subsystem****FUNCTION**

- To sustain life through the intake of food and fluids and oxygen
- To obtain knowledge or information useful to the self
- To obtain pleasure or gratification through the intake of nonfunctional materials such as smoking, alcohol, or drugs
- To restore a felt deficiency within the self system
- To relieve pain or other psychophysiological systems

STRUCTURAL COMPONENTS

Goal: To internalize the external environment.

Perseveratory Set: Status of sensory modalities; digestive system, respiratory system, fluid and electrolyte balance; oral cavity conditions; socialization into food types; drinking habits; smoking use; oral medications; subcutaneous, intravenous, and intramuscular injections; sensory assistance, such as hearing aids, glasses, and dentures. Beliefs and values about times and places for eating and drinking; types of foods and beverages preferred by the social group; attitudes toward alcohol and smoking; beliefs about efficiency of oral, intravenous, and subcutaneous medication. Perception of self as fat or thin; abstainer or alcoholic, addict, smoker, asthmatic.

Preparatory Set: Awareness of being hungry or thirsty, in need of a drink; wish to be high; relief of pain; time for eating, availability of food, fluid or medication resources; barriers to respiration, desire for information; awareness of ignorance.

Choice: Behavioral options available for food and fluid, medication, air supply, tobacco, alcohol, marijuana, narcotics; supplies available in the environment; selections are made on the basis of set and situation. Choice includes deferred gratification and overindulgence. Options are available for taking in information.

Acts: Behaviors may include visual, auditory, olfactory, and gustatory acts or overindulgences (or less than optimal) and preferences for particular substances. Ingestive acts may be directed toward goals other than ingestion. Sensory acts (seeing, hearing, smelling, tasting, and sensations) are used in all other subsystems to serve other goals. When sensory acts are directed toward obtaining information, the acts are ingestive goal-oriented. The process of hearing also requires ingestive acts. The ingestion may be for achievement goals.

diagnostic classifications to delineate these disturbances: insufficiency, discrepancy, incompatibility, and dominance.

Nursing has the goal of maintaining, restoring, or attaining a balance or stability in the behavioral system or in the system as a whole. Nursing acts as an “external regulatory force” to modify or change the structure or to provide ways in which subsystems fulfill the structure’s functional requirement (Johnson, 1980, p. 214). Interventions directed toward restoring behavioral system balance are directed toward repairing damaged structural units, with the nurse temporarily imposing regulatory and control measures or helping the client develop or enhance his or her supplies of essential functional requirements.

Critical Thinking in Nursing Practice with Johnson's Model

Making wise choices about nursing care requires the ability to think critically—that is, to analyze the available information, make inferences, draw logical conclusions, and critically evaluate all relevant elements, as well as the possible consequences of each nursing decision. From a constructivist perspective, individuals presented with complex information use their own existing knowledge and previous experience to help them make sense of the material. In particular, they make inferences, elaborate on the information by adding details, and generate relationships between and among the new information and the information already in memory. In short, they think critically about the new and old information (Paul & Elder, 2009). The JBSM provides information in a way that permits problem solving and care planning (Table 8-1).

The focus of the process is to obtain knowledge of the client through interviews and observations of the patient and family to evaluate the present behavior in terms of past patterns, to determine the effect of the present illness or perceived health threat and/or hospitalization on behavioral patterns, and to establish the maximum possible level of health toward which an individual can strive. The behavioral

TABLE 8-1 The Johnson Model and the Nursing Process

| Framework Elements | Nursing Thought |
|---------------------------------|--|
| BEHAVIORAL ASSESSMENT | |
| <i>Eight subsystems:</i> | |
| 1. Achievement | Do I understand the patient's perceptions? |
| 2. Affiliative | How complete are my data collections? |
| 3. Aggressive/protective | Could I have missed something? |
| 4. Dependency | How do I know I have the facts right? |
| 5. Eliminative | What data might need to be verified? |
| 6. Ingestive | How do these data compare with previously collected data? |
| 7. Restorative | How do my client's data compare with accepted standards/ |
| 8. Sexual | behaviors for someone of this age, culture, and disease process? |
| ENVIRONMENTAL ASSESSMENT | |
| <i>Internal:</i> | |
| Biological | What general and specific factors supply the functional requirements for subsystems? |
| Pathological | |
| Psychological | |
| Developmental | |
| Level of wellness | |
| <i>External:</i> | |
| Cultural | |
| Ecological | |
| Familial | |
| Sociological | |

Continued

TABLE 8-1 The Johnson Model and the Nursing Process—cont'd

| Framework Elements | Nursing Thought |
|--|---|
| DIAGNOSTIC ANALYSIS | |
| Behavior subsystem (e.g., achievement) | What subsystem(s) is (are) involved? |
| Structural unit: Goal, set, choice, action | What structural unit(s) is (are) involved? Is behavior succeeding or failing to achieve the goal? Is there a clear relationship between the stated goal of the person, set, and chosen behavior? Does the set of the person result in misperception of the information? Are the choices appropriate? Is the sequence of action orderly and purposeful? |
| Sustenal imperatives: Variables from the environment (e.g., familial) | Which of the sustenal imperatives is causing or influencing the behavior(s)? What regulating and control mechanisms are present? What are the quality and quantity of sustenal imperatives? |
| <i>Diagnostic label:</i> | <i>Questions to guide determination of diagnosis:</i> |
| Insufficiency | What is the meaning of ____? |
| Discrepancy | What are the implications of ____? |
| Incompatibility | What do we already know about ____? |
| Dominance | How does ____ affect ____? Explain why ____. Explain how ____. Why is ____ important? What do you think causes ____? Why? What are the relationships between ____ and ____? |
| PLANNING AND INTERVENTION | |
| Mutual goal setting | <i>Questions to guide development of intervention:</i> |
| Identify focus of intervention | What would happen if ____? |
| Identify mode of intervention | What are some possible interventions for the diagnosis of ____? |
| Identify technique | What are possible unintended consequences of the intervention? |
| EVALUATION | |
| Establish long-term goals | Are goals socially, culturally, and biologically appropriate? |
| Establish short-term goals | Are the goals reasonable? |
| Develop behavioral objectives to measure progress toward goals | Are the goals client-centered? Are the objectives measurable and theory-based? |

systems' analysis approach provides a comprehensive framework in which various types of data can be organized into a cohesive structure.

The assessment gathers specific knowledge regarding the structure and function of the eight subsystems (behavioral assessment) and those general and specific factors that supply the subsystems' functional requirements/sustenal imperatives (environmental assessment). Interview questions in both areas need to be theory-based. For example, Piagetian theory can be used to develop questions to assess a child's ability to express knowledge about illness—eliminative subsystem (Holaday, 1980).

Once the interview has been completed, data analysis (diagnostic analysis; see Table 8-1) is necessary to identify patterns of behavior that are adaptive and functional for the client as well as those that are maladaptive and indicate behavioral systems' imbalance. One component of the analysis seeks to determine congruency among all structural units. Congruency is expressed as stable, patterned behavior, whereas discrepancy among the components is expressed as unstable and disorganized behavior. The second component examines how the functional requirements/sustenal imperatives influence subsystem behavior. For example, how does family interaction style affect the client's affiliative subsystem? The latter analysis is critical because it plays an important role in determining how the nurse needs to function as an "external regulator" (Johnson, 1980, p. 214).

The nursing diagnosis is a summary of the results for the analysis and describes the current level of behavioral system function. It serves as a guide for intervention planning by the nursing team. The overall objective of the nursing intervention is to establish regularities in the client's behavior to meet the goal of each subsystem. The focus on the intervention will be either on a structural part of the subsystem or on the supply of sustenal imperatives/functional requirements.

Identifying goals is essential for evaluating client outcomes and for professional nursing care. To evaluate, the nurse must first predict expected client outcomes. This helps ensure a purposeful, predictable course of client responses. To evaluate effectively, the nurse sets both long-term and short-term goals and behavioral objectives that will indicate progress toward achieving these goals.

Concept mapping is also an effective strategy to combine with use of a nursing theory such as the JBSM (Daley, 1996). A concept map is a graphic or pictorial arrangement of key concepts that address specific subject matter such as behavioral system imbalance. Concept maps are organized with the most important or central concept at the top of or in the center of the paper (Figure 8-1). Related information or issues are to the side or underneath the main topic. There is no right or wrong way to design a concept map. It may be a flowchart or a diagram or even shaped like a heart if the issue were congenital heart disease. The purpose of the concept map is to develop critical thinking skills and problem-solving abilities (All, Huycke, & Fischer, 2003; Ferrario, 2004).

CASE HISTORY OF DEBBIE

Debbie is a 29-year-old woman who was recently admitted to the oncology nursing unit for evaluation after sensing pelvic "fullness" and noticing a watery, foul-smelling vaginal discharge. A Papanicolaou smear revealed class V cervical cancer. She was found to have stage II squamous cell carcinoma of the cervix and underwent a radical hysterectomy with bilateral salpingo-oophorectomy.

Her past health history revealed that physical examinations had been infrequent. She also reported that she had not performed breast self-examination. She is 5 feet, 4 inches tall and weighs 89 pounds. Her usual weight is about 110 pounds. She has smoked approximately two packs of cigarettes a day for the past 16 years. She is gravida 2, para 2. Her first pregnancy was at age 16, and her second was at age 18. Since that time, she has taken oral contraceptives on a regular basis.

Continued

CASE HISTORY OF DEBBIE—cont'd

Debbie completed eighth grade. She is married and lives with her husband and two children in her mother's home, which she describes as less than sanitary. Her husband is unemployed. She describes him as emotionally distant and abusive at times.

She has done well following surgery except for being unable to completely empty her urinary bladder. She is having continued postoperative pain and nausea. It will be necessary for her to perform intermittent self-catheterization at home. Her medications are (1) an antibiotic, (2) an analgesic as needed for pain, and (3) an antiemetic as needed for nausea. In addition, she will be receiving radiation therapy on an outpatient basis.

Debbie is extremely tearful. She expresses great concern over her future and the future of her two children. She believes that this illness is a punishment for her past life.

Nursing Care of Debbie with Johnson's Model**Behavioral Assessment**

The relative behavioral assessment data are as follows.

Achievement

- Debbie has an eighth-grade education, feels a loss of control of her future and that of her children, and has lost the ability to achieve the developmental outcomes of young adulthood.

Affiliative

- Debbie is married but describes her husband as emotionally distant and abusive at times; there may be a possible impairment of emotional endurance.

Aggressive/Protective

- Her emotional endurance may be impaired. Debbie is not protective of herself (she smoked, sought health care infrequently, did not perform breast self-examination). With the loss of her health, she is protective of her children, but her husband is unemployed. Who will provide for the family?

Dependency

- Because she lives with her mother, self-sufficiency may decrease.

Ingestive

- Debbie has experienced weight loss and nausea.

Eliminative

- Debbie is unable to empty her bladder. She is tearful, expressing concern about the future.

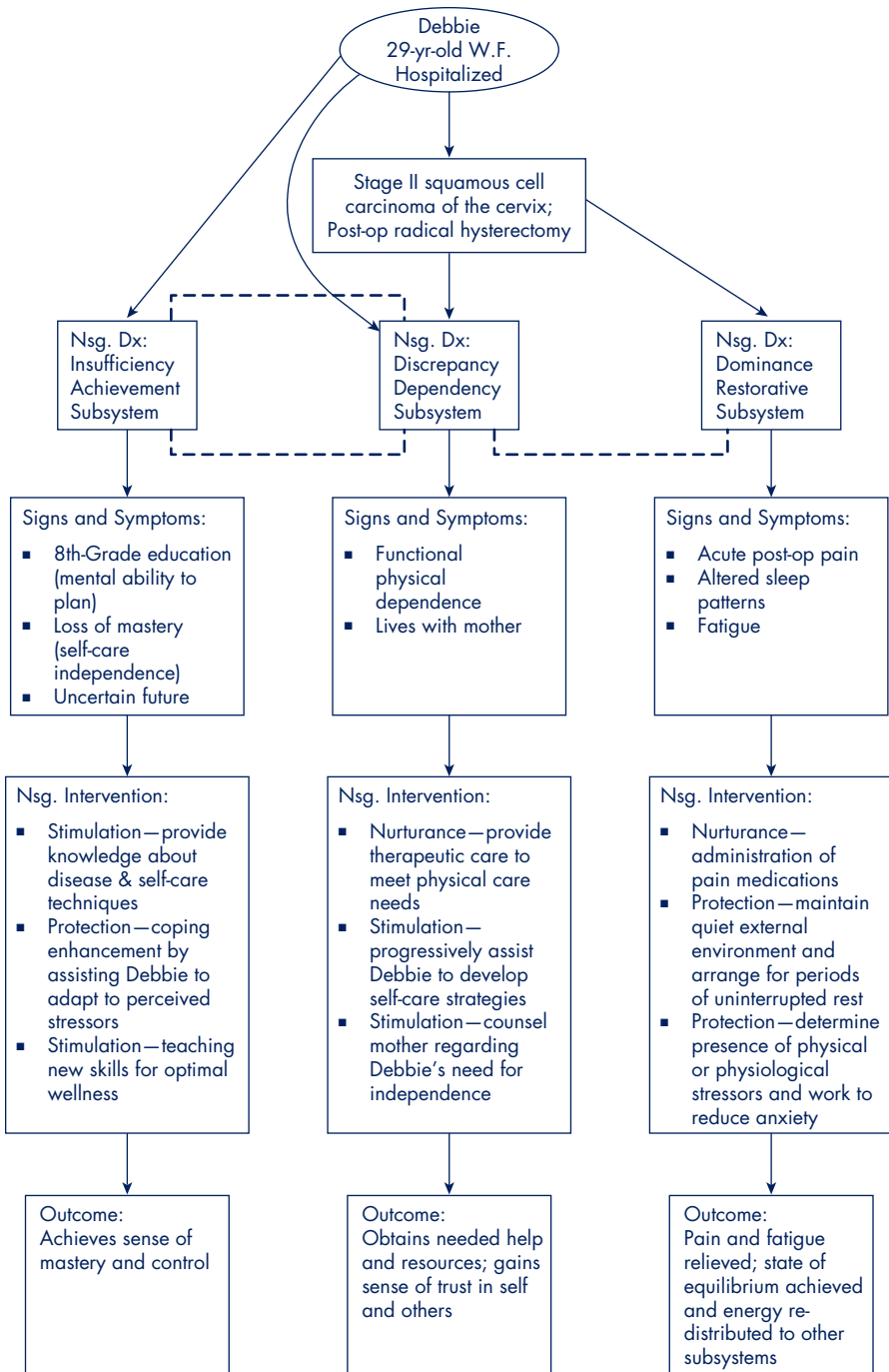


FIGURE 8-1
Concept map for Debbie.

Sexual

- Because Debbie has had a hysterectomy, her sexual relationship with her husband may change and she may have concerns about her feminine identity.

Restorative

- Debbie is experiencing fatigue, pain, and possible sleep disturbance.

Diagnosis and Intervention

The JBSM provides a perspective for nursing practice by viewing Debbie as a biopsychosocial being represented in a behavioral system. The objective and subjective data indicate a problem in the achievement subsystem, as follows:

- *Objective data:* Debbie has class V cervical cancer—stage II squamous cell carcinoma of the cervix with an uncertain prognosis at this time.
- *Subjective data:* Debbie is tearful and expresses concern about her ability to fulfill personal and family needs and responsibilities.

Environmental Assessment

The environmental assessment examines the sources of sustenal imperatives (functional requirements) to determine whether they provide the functional requirements needed to maintain behavioral system balance. If these are present (or have been present in sufficient quantity and quality over time), the subsystems and subsequently the entire system operate at the same level of efficiency and effectiveness and are able to maintain overall balance and stability. If they are not present, the nurse will act as an external regulatory force to provide protection, stimulation, or nurturance; change structural units; or impose external regulatory mechanisms. The critical component of the environmental assessment is to identify the factors that cause or influence behavioral system problems.

The environmental assessment identifies several key factors. From a developmental perspective, Debbie is relatively young and thus many of the developmental tasks of young adulthood, such as raising her children and establishing a career and other future plans, could be impaired. The cancer diagnosis raises questions about her physical ability to achieve personal goals, and the pain, fatigue, and anxiety may impair her mental ability to achieve personal goals. During the first 3 months after diagnosis, Debbie needs to address issues related to the diagnosis, including dying, the future, and the meaning life has had (Eiseman & Lalos, 1999). During this same time, Debbie will be presented with a treatment plan and will simultaneously learn to cope with recovery from surgery and the side effects of cancer therapy and to plan for the future. The significance of this initial period cannot be overemphasized as Debbie attempts to regain control over herself and the environment.

Diagnosis and Intervention

In examining Debbie's perseveratory set, one would note that Debbie's perception of herself as an independent agent generally capable of accomplishing her tasks and goals has been substantially altered. In terms of the preparatory set, her situational context is also substantially altered. She is most likely uncertain about her

choices. The diagnosis is *insufficiency in the achievement subsystem*. In terms of intervention, the nurse may protect Debbie from noxious stimuli because she is not presently able to cope with all situations. The nurse can provide nurturance in terms of providing counseling and help with goal setting. Stimulation in terms of teaching new self-care behaviors can also help. The biological disease process is unique for each person, and the psychosocial response to mastering the situation will be equally unique. Thus frequent reassessment and revision of the care plan will be needed.

Most patients faced with a diagnosis of cancer experience a life crisis. Although death is often the first fear, the potential for other stressors exists. Surgery, adjuvant therapy (radiation), the possible spread of malignancy, and an uncertain prognosis are all stressors. Surgery may lead to an altered body image with accompanying feelings of lost femininity. It is reasonable to assume that Debbie is experiencing some sexual concerns, and the sexual subsystem should be thoroughly examined because objective data indicate the potential for behavioral system imbalance.

The objective data identify that Debbie had a radical hysterectomy, which means the vaginal canal has been shortened. Because the trigone of the bladder and the sigmoid colon may be closely associated with the new vaginal apex, sexual intercourse may be uncomfortable. Debbie will receive radiation therapy. Side effects from this therapy may include fatigue, nausea and vomiting, and infection. The subjective data indicate that Debbie's husband is emotionally distant and sometimes abusive and that Debbie is tearful and worried about the future. The perseveratory set reveals that the current physiological functioning of the sex organs has been disrupted. Past socialization and experience in sex role behaviors may no longer seem applicable to Debbie. Within the context of the present situation (preparatory set), Debbie is most likely unsure where to direct her attention. The selection of a sexual behavior (choice) to meet goals is unclear.

Because the subsystem is not functioning to its fullest capacity, the nurse could diagnose *insufficiency*. If Debbie takes actions that do not meet the intended goal of the subsystem, a diagnosis of *discrepancy* could also be made.

Evaluation

Debbie has a knowledge deficit regarding radiation therapy and needs nurturance in terms of education to help her understand and cope with the situation. A careful assessment to determine Debbie's understanding of the purpose and goal of treatment is needed. Debbie must be taught preventive health practices that decrease the risk of impaired vaginal membrane integrity and comfort measures such as sitz baths and compresses to the perineum. Alternative methods of sexual intercourse can be discussed, especially because sexual intercourse during treatment is encouraged to prevent adhesions and to prevent shortening of the vagina. Counseling Debbie and her husband can help them create their own special intimacy, sense of affection, and physical gratification. The nurse's goal of helping restore the patient's sexual function is tied in closely with goals of restoring or maintaining self-image and self-esteem.

CASE HISTORY OF MARK

Mark is a 12-year-old boy with myelomeningocele and neurogenic bladder. He was also diagnosed with diabetes at age 9. He is admitted for a bladder augmentation and placement of an artificial sphincter. Mark has been hospitalized many times for surgical procedures (shunt, revisions, orthopedic procedures). His mother and father are present during the interview, and his mother does most of the talking. Mark is also interviewed alone. Mark's brothers, ages 17 and 15 years, will visit him in the evenings but are not present during the admission interview.

Nursing Care of Mark with Johnson's Model**Behavioral Assessment***Achievement*

Mark looked at the nurse with a great little smile when he described his school and how it is different. He describes it as a "handicap school." He likes it because there are only "16 kids and 2 teachers and I get lots of help." He is also proud of what he can do on the computer. Mark attributes his success to the presence or absence of ability and attributes little to motivational factors. He enjoyed the Piagetian testing, which placed him in the concrete operations period. Both the nursing staff and his mother note that he requires verbal prompts to perform self-care activities. His mother notes that he has missed a lot of school during the past 2 years, which is why she and her husband removed Mark from regular public school and placed him in a special education school. The classes are ungraded, but his mother says he has made great progress at this school and now reads at a sixth-grade level and has math skills at a fifth-grade level. Mark is worried about "getting behind" while he is in the hospital. Mark has no idea what he wants to be when he grows up. He has not been to camp, nor has he ever spent the night at another child's home. Mark has never been home alone; a parent or sibling is always present.

Affiliative

Mark seems emotionally more attached to his mother than to his father. He likes and admires his older brothers and wishes he "could ride dirt bikes with them." He spends a lot of time at home with his mother and alone watching TV or "messing around on the computer." He watches football games and other sports on TV with his father on the weekends. Mark cannot name a friend at his school or in his neighborhood. His mother states he likes to be "with other kids" and likes when his brothers' friends are at the house. She also could not name a child who was a friend. The nursing staff and his mother describe Mark as shy, and the nurse's observation in the playroom confirms this. He is more talkative when his mother is absent. When Mark's mother is present, he lets her answer questions or asks her to do so.

Aggressive/Protective

His mother and the nursing staff describe him as passive and more likely to sulk than get angry. When the nurse asked what he would do if someone took something of his or hit him, Mark said he “wouldn’t like it.”

Dependency

Mark refused to answer questions about self-care. The nursing staff states that they saw little evidence of self-care activity during previous admissions. He lets the nursing staff or his mother maintain his blood glucose level, inject his insulin, select his menu, and perform his bowel and bladder care. Mark’s mother states that he has become more dependent on her during the past year. He asks for help to dress in addition to his other requests. The staff has noted more independent behavior when the mother and grandmother are absent. Nurses noticed a tremendous difference between the way he acted with them when his mother and grandmother were not present (adult/child to adult/parent with the nurse; and child/parent with mother and grandmother).

Ingestive

Mark states, “I like to eat.” His mother also describes Mark as “loving food” and “eating too much.” The switch to the “diabetic diet has been difficult for him.” The family eats meals together. Postoperatively, he usually has nausea and vomiting and fluid and food intake is poor. Mark is very observant of what goes on around him. He likes to “have tests and things explained” to him when he is in the hospital.

Eliminative

Mark has minimal bowel and bladder control. He has frequent problems with dribbling of urine. Mark himself admits this bothers him. His mother suspects he does not perform intermittent self-catheterization regularly at school because he is embarrassed about sexual changes and about the fact that he must wear sanitary protection pads. As for his communication pattern, Mark tucks his head to his chest and mumbles when he is talking about his feelings or his parents. Sometimes he simply refuses to answer or looks away. The nurse suspects the mumbling and shyness are a means of coping with his overtalkative and overprotective mother and grandmother.

Sexual

Mark looked away when the nurse asked about changes in his body and “becoming a man.” He did not answer questions. He said he did not like “wearing special pants.” When asked who he was most like in his family, he said his mother, who admits that she and her husband have talked with Mark about sex. “We don’t know what to tell him because of his birth defect.” His father has told him the changes “are part of growing up and becoming a man.” His mother is concerned because Mark “hasn’t asked any questions like the other boys.” Mark is Tanner stage 3. She adds, “I think his brothers have talked with him because they joke around about making out.”

Restorative

Mark sleeps 8 hours a night but sleeps less in the hospital “because they wake you up all the time.” He usually gets up around 7 AM on school days and 8:30 AM on the weekends. He has a somewhat restricted repertoire of interests and activities. He spends much time watching TV and rental videos and plays computer games. He participates in no groups, clubs, or regular physical activity. He enjoys family weekend trips to the lake and dune buggy and boat rides.

Environmental Assessment**Familial**

Structure. Mark is the youngest of three boys. His mother works part-time as a secretary and is home in the afternoon when Mark returns from school. His father works as a manager of a large department store. The maternal grandparents live nearby. The grandmother visits frequently.

Dynamics. Mark is included in all family activities, and Mark and his brothers are involved in home activities and chores. It appears that the parents do not fully discuss all aspects of Mark’s illness (sexuality issues, compliance, approaching adolescence) nor do they discuss all issues with Mark. The mother is overly responsible for Mark’s treatments; she encourages Mark’s overdependency. In turn, the mother assumes more responsibility for care.

Social/Cultural

Mark is part of a Protestant, middle-class family who does not attend church regularly. Both parents place a high value on home and family. The father has assumed the patriarchal provider role in the family. The family has lived in the same house for 17 years and has several close friends in the neighborhood who will help whenever needed. The parents have also maintained social relationships with several of the father’s business associates. They belong to no outside social clubs or groups. Insurance covers 90% of Mark’s expenses, and they sometimes face financial troubles. Currently, however, there are no major financial problems.

Developmental

Mark laughed when the nurse said he was about to become a “terrible teen.” He said he has heard adults talk about it, but he would not elaborate. Mark enjoys heavy metal rock, computer games, and watching TV. When asked about girls, he shrugged and looked away. Mark attends a special education school and is behind his grade level. His social skills are not age-appropriate. Medical treatments, parental overprotectiveness, and physical disability all seem to be reinforcing dependence while diminishing any sense of self-control over health. Self-care responsibility is less than what we would expect of a 12-year-old.

Pathological and Biological

Mark stated that he hates “everything about hospitals.” He acknowledged that the increase in restrictions of activity bothered him. The “tests” and “surgery” worry him. He knows the surgery is to try to stop the “leaking” of urine, but Mark is uncertain about where they will operate and exactly what will be done. Mark does

not like diabetes because he can no longer “eat whatever I want.” Mark has a poor understanding of diabetes. He could not explain the role of insulin and diet in the management of the illness. Mark better understands myelomeningocele and how that affects his walking and bowel and bladder control. On admission, Mark’s vital signs are normal. He is in the 25th percentile for height for his age and 90th percentile for weight. His blood urea nitrogen (BUN), creatinine, and blood glucose levels are slightly elevated. His glycohemoglobin level is elevated, indicating poor long-term glucose control.

Ecological

The family owns a home in the suburbs. A park is located about 1 mile from their home, and a school and playground are located about ½ mile from home. The parents describe the neighborhood as safe. No public transportation is available in the area.

Psychological

As a preadolescent, Mark is concerned about body image and is anxious about any bodily disruption or change. He seems self-conscious about his early sexual maturation. His mother has noted Mark’s childlike behaviors and increasing dependency during the past year (e.g., wants help dressing). He is socially isolated from peers, and interaction with his brothers has decreased during the past 2 years. He also needs more emotional support from his mother. His mother calls Mark shy, and the nursing staff’s observations support this assessment. His scores on the self-esteem interview were low. He copes by withdrawing from situations that make him uncomfortable. He does not like to discuss his feelings about sensitive issues (e.g., parents, sexuality, illness). However, he wants information about specific events that are stressful for him (e.g., surgery).



This case study is presented because it reflects both acute and long-term problems associated with managing a chronic illness. It also demonstrates that children’s developmental domains (behavioral subsystems) are often significantly influenced by their illness. One of the strengths of JBSM is that it identifies not only current acute problems but also chronic subsystem disturbances. These alterations involve a disturbance in normal developmental sequences. Without intervention, these alterations may lead to more serious problems as the child matures. This analysis applies the nursing process to an acute problem related to this admission and to a long-term problem.

Diagnostic Analysis

The essential characteristic of human beings is their purposefulness. This purposefulness is based on their ability to select their goals and make choices for achieving them. To successfully intervene in a clinical situation, it is necessary to consider people’s choices and to understand how people make their choices. The JBSM directs the nurse’s attention to human choice phenomena. The degree to which the nurse can help the client restore behavioral system balance depends on the extent to which the client understands behavioral actions. Once an explanation has been

found, the client can obtain behavioral system balance by changing his or her goals or by changing the environmental conditions in such a way that previously established goals can be obtained through changes in behavior. To accomplish this, nurses need to adopt an input-oriented approach to their case-model building. To focus on the proper inputs, nurses need to develop an assessment strategy that allows them to thoroughly understand small segments of behavior at the subsystem level and to integrate that understanding for the entire system.

An output-oriented approach describes only the person's choices, and the description provides only knowledge of the behavior. This information is of some use. However, to understand the behavioral elements in the system, nurses must seek an explanation for a person's action, and this comes only from an input focus. The JBSM's focus on environmental assessment, as well as behavioral assessment, provides input-focused data as well as output-focused data. The two diagnoses addressed in this section provide insight about the process.

Acute Problem

Mark has been admitted to the hospital for a bladder augmentation and placement of an artificial sphincter. He is behind his grade level at school. Piagetian testing places him at the concrete operations level of cognitive development. The subjective data inform the nurse that Mark is worried about tests and surgery and is unsure about specific aspects of the surgery. He has some understanding of myelomeningocele and little understanding of diabetes. However, he does like to have "tests and things" explained to him. Also contributing to this problem is the mother's overprotection of Mark and the apparent failure of the family to openly discuss aspects of the illness.

The goal of the ingestive subsystem is to internalize the external environment, and one of the functions is to obtain knowledge or information useful to the self (Grubbs, 1974). The perseveratory set refers to usual status or habits. All of Mark's sensory modalities—speech, sight, hearing, and touch—are intact, and he values being informed about tests. In terms of the preparatory set, Mark is in the period of concrete operations. He can assimilate new experiences, has developed an awareness of conservation, is capable of seeing the relationships of the part to the whole, and also has developed a concept of causality. *Choice* refers to the alternate behaviors Mark himself sees that are available to him in this situation. Because little preoperative teaching has been done, Mark's choice and actions are limited. The diagnosis is *insufficiency of the ingestive subsystem*. The major stressor is functional—a lack of information. The nurse's goal is to protect the basic goal of the subsystem by providing information. A successful intervention will inform Mark about the surgery to clarify the range of choices and actions.

Planning and Intervention

Given the complexity of this case, the intervention needs to be planned carefully. The intervention could also affect the dependency subsystem (self-care), achievement subsystem (sense of mastery), affiliative subsystem (socialization), and eliminative subsystem (expression of feelings). It was mutually agreed that the preoperative teaching would be done with both Mark and his parents together and then alone with Mark. Diagrams and pictures will be used to explain the surgery, and postoperative

treatments and procedures would also be explained and demonstrated. Thus the nurse will provide the functional requirements of protection and nurturance.

The immediate goal of the intervention is to inform Mark about his surgery and postoperative care. The intermediate goal is for Mark to maintain his healthy physiological system through the intake of food, fluids, and medicine during the postoperative period. This will occur as a result of his understanding the surgical procedure and the postoperative care needed for recovery (e.g., internalizing the external environment). The long-term objective is that the intervention will restore Mark's sense of mastery and of autonomy.

Nursing interventions need to be theory-based. These theories need to be compatible with systems' theory and the assumptions of the JBSM. For example, the technique selected for this intervention is based on Vygotsky's Zone of Proximal Development (ZPD) (Vygotsky, 1962). One of the strengths of the JBSM is the ease with which theories can be incorporated into all phases of the plan of care.

Wertsch and Rogoff (1984) have defined the ZPD as "the phase in development in which the child had only partially mastered a task but can participate in its execution with assistance and supervision of an adult or more capable peer" (p. 1). There are two important dimensions of the ZPD—joint collaboration and transfer of responsibility—in which both the child and the adult actively participate and contribute to some aspect of task performance or problem solution. Joint collaboration is based on the child being guided to actively define and redefine the task situation in terms of the adult's definition (Holaday, LaMontague, & Marciel, 1994).

The second dimension is the transfer of responsibility, which refers to the adult's decreasing role in regulating and managing behavior task performance. This gradual relinquishment and transfer of adult responsibility is described as "guided participation" (Wertsch & Rogoff, 1984, pp. 1-6). Thus as a child's competence increases, effective scaffolders gradually withdraw their support in accord with the child's efforts. *Scaffolding* refers to the gradual decrease and eventual withdrawal of adult control and support as a function of the child's increased mastery of a given task or problem.

Chronic Problem

It is helpful to think of parenting in terms of the JBSM as a set of environmental actions performed by the parents or a set of environmental conditions arranged by parents that assists or impedes the child in carrying out his or her functions. It is important to make clear that in this examination of parenting actions and conditions as elements external to the child, the independence of the child and environment is not implied. Rather, the examination occurs only for the purposes of assessment and the convenience of organization.

From a JBSM perspective, the idea of an external regulator of growth and development is also useful. The idea of nursing care as a set of regulatory acts, aimed at successful adaptation and goal attainment for the child (behavioral system), is consistent with most ecological developmental models and with the general precepts of control systems' theory. However, as potentially useful as the concept of an external regulator might be in classifying the actions and conditions of nursing care (i.e., in terms of adjusting parenting actions or environmental conditions arranged by the parent), it carries with it a practical paradox—external regulation is unlikely

to be a simple matter for a complex organism. The JBSM provides a means to approach this issue, but much work remains in building theory in this area. The next care problem clearly addresses the complexity involved.

The data from the environmental assessment identify Mark's mother as over-protective and highly responsible for Mark's care. Mark spends a good deal of time with his mother and seems to be more emotionally attached to her than to his father. Mark takes little responsibility for self-care activities. He is described as shy and cannot name a friend. The goal of the dependency subsystem is to maintain environmental resources needed for obtaining help, assistance, attention, reassurance, and security—in other words, to gain trust and reliance. The primary diagnosis is *dominance of the dependency subsystem*. The behaviors in the dependency subsystem are being used more than any other subsystem regardless of the situation, to the detriment of other subsystems (Grubbs, 1974). A number of secondary diagnoses could also be made in terms of incompatibility between the dependency subsystem (set, choice, action, and goal) and other subsystems (most notably, achievement and affiliative). Problems for both child and parent are evident in terms of set, choice, and action. In terms of the perseveratory set, both parents and child are unsure about the appropriate age at which a child with a chronic health problem should be expected to meet his or her own needs and at which times and places assistance with tasks should be sought. Mark does not perceive himself as self-sufficient and independent. The preparatory set shows that Mark and his parents have difficulty perceiving whether a situation requires task-oriented assistance. Given the problems with set, it is not surprising that the range of choice is narrow and that actions are not always appropriate.

The major stressors are both functional and structural. The functional stressors arise from the environment and are related to parenting style. The structural stressors involve internal control mechanisms and reflect inconsistencies between the subsystem goal and set, choice, and actions.

The short-term goals in this case are to help the parents gain some insight into their behavior and its impact on Mark's behavior and to facilitate a change in Mark's behavior (an increase in independent behaviors while hospitalized). The long-term goal is to promote Mark's optimal development by designing an external regulatory system to do the following:

- Sustain Mark's current level of independence.
- Stimulate activity directed at more independent behaviors.
- Control the amount and pattern of experiences (inputs) that reach Mark to achieve an optimal fit between Mark's current abilities and his projected goals.

The family-centered intervention would be best if carried out by a nurse who has sustained contact with Mark and his parents.

The central goal for the nurse, as an external regulatory force, is to construct a system of caregiving episodes the parents can use to integrate the functional requirements for the environmental/developmental relationship. The nurse helps the parents provide protection and nurturance to maintain Mark's current level of behavior (his internal organizational coherence and environmental relationships) so he can continue to function. The nurse maintains whatever stability is present to avoid encouraging more dependent behaviors. The nurse stimulates incremental

change (alter set, choice, and action) for both the parents and Mark through a process of self-construction. New information and new experiences will be introduced in a controlled fashion, which will lead to successive changes in existing structures. Goal setting is one technique that can accomplish this. People can cognitively construct representations of potential future states. By personal goal setting, individuals disrupt their status quo or disorganize themselves and then organize their behavior to resolve the disruption or create a new coherent organization. They become “producers of their own development” (Lerner, 1982, p. 342). Thus in goal setting, negative feedback reduces a discrepancy but it does so by altering the system through incremental change.

Evaluation

The JBSM directs the nurse's attention toward areas that need to be addressed in practice. Currently no specific interventions delineate this system of caregiving episodes for parents of chronically ill children. What broad, basic regulatory functions of the nurse need to be included in this system of caregiving episodes? The actual episodes and conditions of parenting entail numerous physical/structural properties, not just broad abstractions. From the standpoint of understanding the development of a chronically ill child, what are the more salient dimensions of these real acts and conditions for each of the subsystems? How does the nurse function as an external regulator of chronically ill children's health and development with the goal of a good fit between the child's characteristics, environmental opportunities, and constraints? Using JBSM, the nurse learns that a chronically ill child's developmental pathways do not unfold along a predetermined course; they are constructed through processes of living that involve continuities, discontinuities, and uncertainties. The nurse as an external regulator and source of functional requirements plays a critical role in helping a family achieve optimal development outcomes for a special-needs child.

CRITICAL THINKING EXERCISES

1. Think back to the last health problem you experienced. Recall your behaviors and assess their structure (drive, set, choice, and action) according to the behavioral assessment of the subsystems as outlined in Table 8-1.
2. Recall your environment at a time when you were ill and assess your sustenal imperatives using the guide in Table 8-1.
3. Considering the assessment of Debbie according to the achievement subsystem, how might her choices of actions be altered by different goals (drive) or set? How would this difference have altered the structure of Debbie as a behavioral system?
4. What other two subsystems would have been altered by different goals or set? How might these different goals alter the structure of Debbie's behavioral system?
5. Describe the focus of the JBSM in relation to a child, like Mark, with a chronic illness. How does the analysis of each subsystem provide insights about the developmental effect of a chronic illness for a child?
6. Construct an online concept map of Mark's case. Go to IHMC CampTools (<http://cmap.ihmc.us/download>) to download free concept-mapping software.

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King's Conceptual System and Theory of Goal Attainment in Nursing Practice

Mary Gunther

Nurses are the key persons in the health care system who identify the goals and the means to help individuals and families attain goals.

(King, 1995b, p. 24).

History and Background

In the mid-1960s, Imogene King wrote of the need for focus, organization, and use of a nursing knowledge base (King, 1968). She proposed that knowledge for nursing resulted from the systematic use and validation of knowledge about concepts relevant to nursing situations. The use of knowledge in critical thinking results in decisions that are implemented in professional nursing practice.

In 1971, King proposed a conceptual system for nursing around four concepts she considered universal to the discipline of nursing: social systems, health, perception, and interpersonal relationships. These areas were identified from the synthesis and reformulation of concepts using inductive and deductive reasoning, critical thinking, and extensive review of nursing and literature from other health-related disciplines. Concepts were organized around individuals as personal systems, small groups as interpersonal systems, and larger social systems such as community and school (King, 1971). Role, status, social organization, communication, information, and energy were identified as basic concepts of functions of systems. King proposed that concepts were interrelated and could be used across systems to identify the essence of nursing.

The author and editor wish to thank Maureen A. Frey who authored this chapter in previous editions of this text.

King expanded the conceptual system during the 1970s by further explicating the nature of persons and environment, strengthening the general systems orientation, and expanding the concepts. A more formalized conceptual system of personal, interpersonal, and social systems was presented in 1981. Concepts in the personal system were perception, self, growth and development, body image, time, and space. Concepts in the interpersonal system were human interaction, communication, transactions, role, and stress. Concepts in the social system were organization, authority, power, status, and decision making.

Also presented in the 1981 text was the Theory of Goal Attainment, derived from the personal and interpersonal systems and a process model of human interactions. The Theory of Goal Attainment specifically addresses how nurses interact with patients to achieve health goals. The initial concepts of the theory (perception, communication, interaction, transaction, self, role, and decision making) represented the essence of nursing (King, 1981, 2006a,b). The model of human interaction defines the observable behaviors in nurse-patient interactions that lead to transactions.

Although no major changes were made to the conceptual system or Theory of Goal Attainment since *A Theory for Nursing: Systems, Concepts, Process*, King provided clarification, explanation, and some additional concepts up until her death in 2007. The concepts of learning and coping were added; the concept of space was redefined as personal space; and the concept of stress was expanded to include stressors (King, 1990, 1991, 2008). King explicated the philosophical basis and enduring nature of the conceptual system and theory for nursing with emphasis on the twenty-first century and the world as community (Fawcett, 2001; King, 1990, 1994, 1995a,b, 1996, 1997, 1999, 2006a, 2006b, 2007, 2008). Contemporary themes and applications include information systems, nursing diagnoses, technological advances, changes in organization and delivery of health care for individuals and families (Alligood, 2010; Fewster-Thuente & Velsor-Friedrich, 2008; Frey & Sieloff, 1995; Gianfermi & Buchholz, 2011; Killeen & King, 2007; Sieloff & Frey, 2007; Sieloff, Killeen, & Frey, 2010; Sieloff & Messmer, 2010). In addition, others have extended the conceptual system by developing and testing middle-range theories (Alligood, 2007; Doornbos, 2007; duMont, 2007; Ehrenberger, Alligood, Thomas, et al., 2007; Fairfax, 2007; Frey, 1995; Hernandez, 2007; Kameoka, Funashima, & Sugimori, 2007; Killeen & King, 2007; May, 2007; Reed, 2007; Shartz-Hopko, 2007; Sieloff, 2007; Sieloff & Bularzik, 2011; Walker & Alligood, 2001; Wicks, Rice, & Talley, 2007; Zurakowski, 2007). Practice applications are numerous and cross all health care settings, age groups, and diagnoses (Sieloff, Killeen, & Frey, 2010). Overall, King's conceptual system and Theory of Goal Attainment represent significant theoretical structures for theory development and theory-based practice for nursing.

Overview of King's Conceptual System and Theory of Goal Attainment

King's conceptual system is based on the assumption that human beings are the focus of nursing. The goal of nursing is health promotion, maintenance, and/

or restoration; care of the sick or injured; and care of the dying (King, 1992). King (1996) states that, “nursing’s domain involves human beings, families, and communities as a framework within which nurses make transactions in multiple environments with health as a goal” (p. 61). The linkage between interactions and health is behavior, or human acts. Nurses must have the knowledge and skill to observe and interpret behavior and intervene in the behavioral realm to assist individuals and groups cope with health, illness, and crisis (King, 1981). Concepts gleaned from an extensive review of the nursing literature organize knowledge about individuals, groups, and society (King, 1971, 1992). King notes that the concepts are often interrelated and can be applied across systems. According to King (1981, 1988, 1991), concepts are critical because they provide knowledge that is applicable to practice. Systems and concepts within King’s conceptual system and Theory of Goal Attainment are described and defined in the following section.

Personal Systems

Individuals are personal systems (King, 1981). Each individual is an open, total, unique system in constant interaction with the environment. Interactions between and among personal systems are the focus of King’s conceptual system. Patients, family members, friends, other health care professionals, clergy, and nurses are just a few examples of individuals who interact in the nursing practice environment. The following concepts provide foundational knowledge that contributes to understanding individuals as personal systems:

- *Perception*: “A process of organizing, interpreting, and transforming information from sense data and memory” (King, 1981, p. 24).
- *Self*: King (1981) cites developmental psychologist’s A. T. Jersild’s (1952) definition of self when explaining that “knowledge of self is a key to understanding human behavior because self is the way I define *me* to myself and to others. Self is all that I am. I am a whole person. Self is what I think of me and what I am capable of being and doing. Self is subjective in that it is what I think I should be or would like to be” (p. 26). Self is a dynamic, action-oriented open system.
- *Growth and development*: “The processes that take place in an individual’s life that help the individual move from potential capacity for achievement to self-actualization” (King, 1981, p. 31).
- *Body image*: “An individual’s perceptions of his/her own body, others’ reactions to his/her appearance which results from others’ reactions to self” (King, 1981, p. 33).
- *Learning*: “A process of sensory perception, conceptualization, and critical thinking involving multiple experiences in which changes in concepts, skills, symbols, habits, and values can be evaluated in observable behaviors and inferred from behavioral manifestation” (King, 1986, p. 24).
- *Time*: “Duration between the occurrence of one event and occurrence of another event” (King, 1981, p. 24).

- *Personal space*: “Existing in all directions and is the same everywhere” (King, 1981, p. 37).
- *Coping*: King (1981) used the term *coping* in her discussion of the concept of stress in the interpersonal system and in later discussions of the Theory of Goal Attainment (King, 1992, 1997) without explicit definition.

Interpersonal Systems

Interpersonal systems are formed by the interactions of two or more individuals (King, 1981). As the number of individuals increases, so does the complexity of the interaction. These groups may range in size from two or three interacting individuals to small or large groups. King's process of nursing occurs primarily within the interpersonal systems between the nurse and patient. Concepts critical to understanding interactions between individuals are defined as follows:

- *Communication*: “Information processing, a change of information from one state to another” (King, 1981, p. 69).
- *Interaction*: “Acts of two or more persons in mutual presence” (King, 1981, p. 85). “The process of interactions between two or more individuals represents a sequence of verbal and nonverbal behaviors that are goal-directed” (King, 1981, p. 60).
- *Role*: “Set of behaviors expected when occupying a position in a social system” (King, 1981, p. 93).
- *Stress*: “Dynamic state whereby a human being interacts with the environment to maintain balance for growth, development, and performance which involves an exchange of energy and information between the person and the environment for regulation and control of stressors” (King, 1981, p. 98).
- *Stressors*: Events that produce stress (King, 1981).
- *Transaction*: “Observable behaviors of human beings interacting with their environment” (King, 1981, p. 147). “In the interactive process, two individuals mutually identify goals and the means to achieve them. When they agree to the means to implement the goals, they move toward transactions.... Transactions are defined as goal attainment” (King, 1981, p. 61).

Social Systems

Social systems are composed of large groups with common interests or goals. A social system is defined as “an organized boundary system of social roles, behaviors, and practices developed to maintain values and the mechanisms to regulate the practice and rules” (King, 1981, p. 115). Examples of social systems include health care settings, workplaces, educational institutions, religious organizations, and families (King, 1981). Interactions with social systems influence individuals throughout the life span. Concepts that are useful to understand interactions within social systems and between social and personal systems are defined as follows:

- *Organization*: “A system whose continuous activities are conducted to achieve goals” (King, 1981, p. 119).
- *Authority*: “Transactional process characterized by active, reciprocal relations in which members' values, backgrounds, and perceptions play

a role in defining, validating, and accepting the [directions] of individuals within an organization” (King, 1981, p. 124).

- *Power*: “The capacity or ability of a group to achieve goals” (King, 1981, p. 124).
- *Status*: “The position of an individual in a group or a group in relation to other groups in an organization” (King, 1981, p. 129).
- *Decision making*: “Dynamic and systematic process by which a goal-directed choice of perceived alternatives is made, and acted upon, by individuals or groups to answer a question and attain a goal” (King, 1981, p. 132).

King’s conceptual system provides both structure and function for nursing. Clearly stated assumptions about persons, environment, health, nursing, and systems provide a conceptual orientation of holism and dynamic interaction, specify health as the goal of nursing, and actively include the patient (individual, family, or community) in decisions about setting goals and the behavior necessary to achieve health goals.

Theory of Goal Attainment

The Theory of Goal Attainment addresses nursing as a process of human interaction. Indeed, King (1981) stated that the Theory of Goal Attainment is a normative theory; that is, it should set the standard of practice for all nurse-patient interactions. King (1997) recalled finding an index card on which she had written the following 15 years previously: “King’s law of nurse-patient interaction: Nurses and patients in mutual presence, interacting purposefully, make transactions in nursing situations based on each individual’s perceptions, purposeful communication, and valued goals” (p. 184).

The nurse and patient form an interpersonal system in which each affects the other and in which both are affected by situational factors in the environment. Drawn from both the personal and interpersonal system concepts, the Theory of Goal Attainment comprises the concepts of perception, communication, interaction, transaction, self, role, growth and development, stress/stressors, coping, time, and personal space. King (1981, 1991) identified that perception, communication, and interaction are essential elements in transaction. When transactions are made, goals are usually attained. The human interaction and conceptual focus dimensions of the theory guide the nursing process dimension (Figure 9-1).

King demonstrated linkages between the Theory of Goal Attainment and the traditional nursing process as shown in Table 9-1 (King, 1992). King (1993) viewed the traditional nursing process as a system of interrelated actions—the method by which nursing is practiced. In contrast, knowledge of the interrelated concepts in the Theory of Goal Attainment (King, 1992) provides the theoretical basis for nursing practice. King (1995b) underscored the importance of nursing process as both method and theory when she stated, “Nurses are first, and foremost, human beings who perform their functions in a professional role. It is the way in which nurses, in their role, do with and for individuals that differentiates nursing from other health professionals” (p. 26). In this way, King illustrated how “nursing theory serves to connect philosophical reflection with nursing practice” (Whelton, 2008, p. 79).

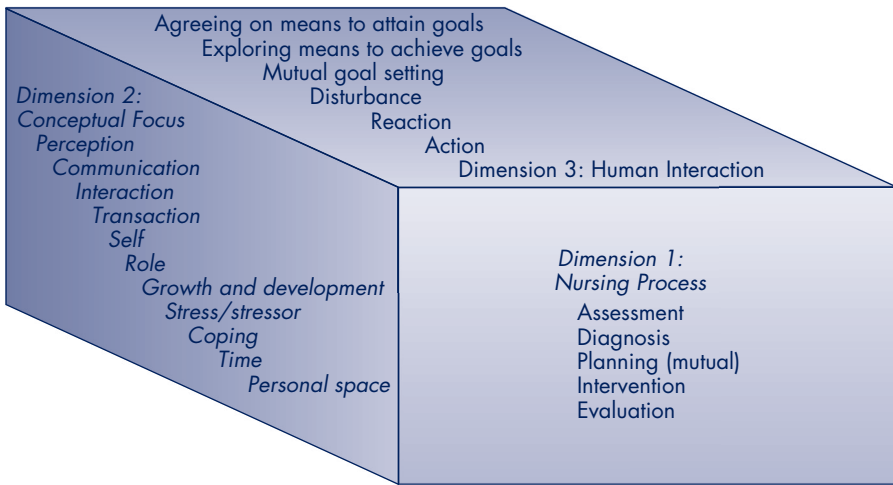


FIGURE 9-1 Three-dimensional nursing process based on King's Theory of Goal Attainment. (Modified from Alligood, M. R. [1995]. Theory of goal attainment: Application to adult orthopedic nursing. In M. A. Frey & C. L. Sieloff [Eds.], *Advancing King's systems framework and theory of nursing* [p. 212]. Thousand Oaks, CA: Sage.)

TABLE 9-1 Nursing Process: Theory and Method

| Nursing Process as Method* | Nursing Process as Theory† |
|----------------------------------|--|
| A system of interrelated actions | A system of interrelated concepts |
| Assess | Perception of nurse and client Communication of nurse and client |
| Plan | Interaction of nurse and client Decision making about goals Agree to means to attain goals |
| Implement | Transactions made |
| Evaluate | Goal attained (if not, why not?) |

*Yura, H., & Walsh, M. (1983). *The nursing process*. Norwalk, CT: Appleton-Century-Crofts.

†King, I. M. (1981). *A theory for nursing: Systems, concepts, process*. New York, John Wiley (now published by Delmar, Albany, NY).

From King, I. M. (1992). King's theory of goal attainment. *Nursing Science Quarterly*, 5(1), 23, with permission from Sage Publications.

Critical Thinking in Nursing Practice with King's Conceptual System

It is generally agreed that critical thinking is knowing how to think, how to apply, how to analyze, how to synthesize, and how to evaluate. Whereas the traditional

nursing process of “assess, plan, implement, and evaluate” provides a method, the critical thinking process emphasizes the intellectual skills of apprehension, judgment, and reasoning.

Rubinfeld and Scheffer (1999) conducted a study to define critical thinking in nursing. They formulated the following consensus statement to reflect the essence of critical thinking in nursing:

Critical thinking in nursing is an essential component of professional accountability and quality nursing care. Critical thinkers in nursing exhibit these habits of the mind: confidence, contextual perspective, creativity, flexibility, inquisitiveness, intellectual integrity, intuition, open-mindedness, perseverance, and reflection. Critical thinkers in nursing practice the cognitive skills of analyzing, applying standards, discriminating information seeking, logical reasoning, predicting, and transforming knowledge (Rubinfeld & Scheffer, 1999, p. 5).

The development and use of critical thinking in nursing has received considerable attention both in nursing education and in practice over the past two decades. However, critical thinking has always been an integral component in King’s perspective of nursing. In an early publication, Daubenmire and King (1973) presented a diagram (Figure 9-2) titled “Methodology for the Study of Nursing Process.” Critical thinking is illustrated by the use of terms such as *analyze*, *synthesize*, *verify*, and *interpret*. King explicitly linked critical thinking to the mental acts of judgment that are implicit in perception, communication, and interactions leading to transaction (King, 1992) and the concept of decision making (King, 1999). Later, King (1999) added that ethical theories and principles, along with the nursing process, had structured critical thinking and its pedagogy in most nursing programs.

The delivery of nursing care to patients involves a process of thinking as well as doing. In contrast to the traditional nursing process as a system of interrelated actions, King’s perspective of the process reflects the science of nursing. Critical thinking provides the rationale for actions taken by the nurse and serves as an excellent fit with the premises of this text.

The following discussion illustrates critical thinking questions based on concepts within King’s systems framework that are essential in carrying out activities of assessing, planning, implementing, and evaluating.

At the first step of King’s process of nursing, the nurse meets the patient and communicates and interacts with him or her. Assessment is conducted by gathering data about the patient based on relevant concepts. The nurse considers the following questions:

- What are the patient’s perceptions of the situation?
- What are my perceptions of the situation?
- What other information do I need to assist this patient to achieve health?
- What does this information mean to the situation?
- What conclusion (judgment) does the patient make?
- What conclusions (judgments) do I make?

The end result of these critical thinking activities is a comprehensive patient assessment tailored to the patient and his or her situations.

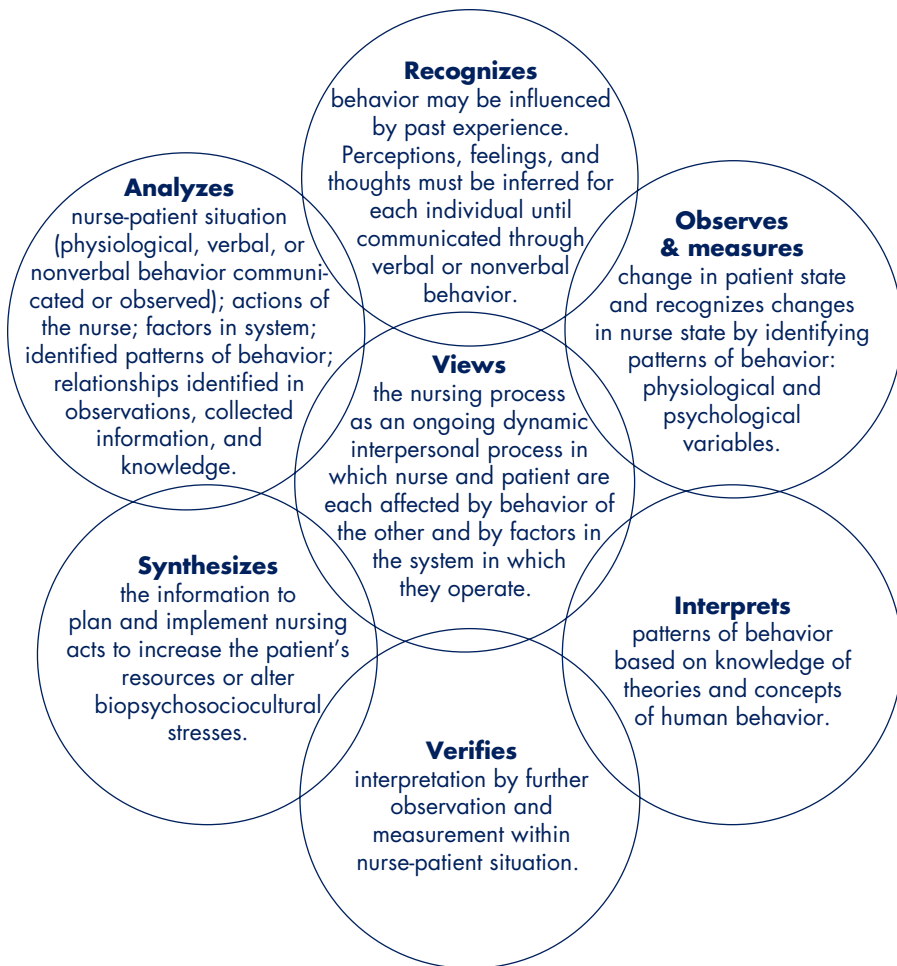


FIGURE 9-2

Methodology for the study of the nursing process. (From Daubenmire, M. J., & King, I. M. [1973]. Nursing process: A system approach. *Nursing Outlook*, 21[8], 515.)

The next step of King's process of nursing is identifying goals and planning to achieve those goals. The nurse considers the following questions:

- What goals do I think will serve the patient's best interest?
- What are the patient's goals?
- Are the patient's goals and my professional goals congruent?
- If the goals are not congruent, what further communication and interaction are needed to achieve congruence?
- What are the priority goals?
- What does the patient perceive as the best way to achieve the goals?
- Is the patient willing to work toward the identified goals?

- What do I perceive as the best way to achieve the goals?
- Are the goals short-term or long-term?
- What mutual modifications need to be made to achieve goals in the plan?

This step is congruent with planning in the traditional nursing process.

The third step in King's process of nursing results in transactions being made. Transactions occur as a result of perceiving the other person(s) and the situation, making judgments about those perceptions, and taking some action in response. Reaction to action(s) leads to interaction between the nurse and patient, which leads to transactions that reflect a shared view and commitment. The nurse considers the following questions:

- Am I doing what the patient and I have agreed upon?
- How am I carrying out the actions?
- When do I carry out the action?
- Why am I carrying out the action?
- Is it reasonable to think that the identified goals will be reached by carrying out the action?

This step reflects implementation in the traditional nursing process.

The fourth step in King's process of nursing is goal attainment or failure to attain the goal. During this process the nurse considers the following questions:

- Are my actions helping the patient achieve our mutually defined goals?
- How well are the goals being met?
- What actions are working?
- What actions are not working?
- How is the patient responding to my actions?
- What other information do the patient and I need to modify our plan?
- Are there barriers hindering goal achievement?
- How might the plan be changed to achieve goals?

This exercise in critical thinking is comparable to the evaluation step in the traditional nursing process.

Although nurses are expected to exercise critical thinking, King (1999) emphasized that patients also engage in the critical thinking process. The nurse has the responsibility to communicate and interact with the patient to ensure that their thinking is transparent to one another. Goals cannot be mutually achieved unless the nurse and the patient share their perceptions, feelings, values, and conclusions. King (1999) used the term *participative decision making* to make the active role of the patient explicit.

In summary, the traditional nursing process is a system of interrelated actions, the methods by which nursing is practiced. The critical thinking process reflects highly developed thinking skills essential for nursing practice in the twenty-first century. The transaction process (goal attainment) requires knowledge of concepts from King's conceptual system as well as knowledge of those professional interactions described in the Theory of Goal Attainment. King (1999) compared the nursing process, the critical thinking process, and the transaction process to illustrate the application of her theory when addressing ethical issues in contemporary nursing practice. Relationships among the nursing process, the critical thinking process, the transaction process, and the ethical decision-making process are shown in Table 9-2.

TABLE 9-2 Relationship Among the Four Processes

| Nursing Process | Critical Thinking Process | Transaction Process | Ethical Decision-Making Process |
|---|----------------------------------|--|---|
| Assess and apply knowledge of relevant concepts | Conceptualize | <p>Patient and nurse perceive each other and situation, make judgments, mental action, and reactions. Interaction is an ongoing process characterized by communication.</p> <p>The nurse:</p> <ul style="list-style-type: none"> • Gathers additional information • Validates perception • Delineates and validates patient concerns • Establishes mutuality and trust | <p>Identify ethical issues.</p> <p>Gather information about ethical issues.</p> |
| Identify goals and plans to achieve | Analyze and synthesize | <p>Make decisions about goals. Goal must be mutually set. Make decisions for actions to meet goals.</p> | <p>Incorporate ethical decision making into a plan of action related to goals and means to achieve goals.</p> |
| Implement actions to meet goals | | <p>Transactions made:</p> <ul style="list-style-type: none"> • Not directly observed • Inferred from interactions | <p>Take action to resolve ethical issues.</p> |
| Evaluate goal attainment | Evaluate | <p>Goals attained; if not, why not? Unmet goals can result from:</p> <ul style="list-style-type: none"> • Identification of incorrect or incomplete data • Incorrect interpretation as the result of perceptual error, lack of knowledge, or goal conflict • Contributing nurse, patient, system barriers | <p>Ethical issues resolved? If not, why not?</p> |

Modified from King, I. M. (1999). A theory of goal attainment: Philosophical and ethical implications. *Nursing Science Quarterly*, 12(4), 292-296.

The applicability of these interrelated processes in contemporary professional nursing practice is illustrated in the nursing care of the cases of Debbie and Clare that follow.

CASE HISTORY OF DEBBIE

Debbie is a 29-year-old woman who was recently admitted to the oncology nursing unit for evaluation after sensing pelvic “fullness” and noticing a watery, foul-smelling vaginal discharge. A Papanicolaou smear revealed class V cervical cancer. She was found to have stage II squamous cell carcinoma of the cervix and underwent a radical hysterectomy with bilateral salpingo-oophorectomy.

Continued

CASE HISTORY OF DEBBIE—cont'd

Her health history disclosed that physical examinations had been infrequent. She also reported that she had not performed breast self-examination. She is 5 feet, 4 inches tall and weighs 89 pounds. Her usual weight is approximately 110 pounds. She has smoked approximately two packs of cigarettes a day for the past 16 years. She is gravida 2, para 2. Her first pregnancy was at age 16, and her second was at age 18. Since that time, she has taken oral contraceptives on a regular basis.

Debbie completed the eighth grade. She is married and lives with her husband and her two children in her mother's home, which she describes as less than sanitary. Her husband is unemployed. She describes him as emotionally distant and abusive at times.

With the exception of being unable to completely empty her urinary bladder, Debbie has done well following surgery. She is having continued postoperative pain and nausea. It will be necessary for her to perform intermittent self-catheterization at home. Her medications are (1) an antibiotic, (2) an analgesic as needed for pain, and (3) an antiemetic as needed for nausea. In addition, she will be receiving radiation therapy on an outpatient basis.

Debbie is extremely tearful. She expresses great concern over her future and the future of her two children. She believes that this illness is a punishment for her past life.

Nursing Care of Debbie with King's Conceptual System

In King's conceptual system, Debbie is conceptualized as a personal system in interaction with other systems. Many of these interactions influence her behavior and her health. The diagnosis of class V cervical cancer and subsequent treatment, both major stressors, also influence her health. Together, Debbie and the nurse interact, communicate, engage in mutual goal setting, and make decisions about the means to achieve goals.

Nursing care for Debbie begins with assessment that includes collection, interpretation, and verification of data. Sources of data are Debbie herself—primarily her perceptions, behavior, past experiences, knowledge of concepts in the systems framework, critical thinking skills, ability to use the nursing process, and medical knowledge about the diagnosis, treatment, and prognosis of class V cervical cancer. Care for Debbie may well cover the full range of nursing practice: promotion of health, maintenance and restoration of health, care of the sick, and care of the dying (King, 1981).

In nursing situations the nurse forms an interpersonal system with Debbie. The transaction process begins with perception, judgments, mental actions, and reactions of both individuals. The nurse assesses and applies knowledge of concepts and processes. Although all of the concepts in King's framework will likely contribute to the care of Debbie, the critical concepts are perception, self, coping, interaction, role, stress, power, and decision making.

The nurse's perception serves as a basis for gathering and interpreting information. Debbie's perceptions of her past, present, and future influence her thoughts and actions and are assessed through verbal and nonverbal behaviors. Because

perceptual accuracy is important to the interaction process, the nurse validates with Debbie her own perceptions and interpretation of Debbie's perceptions. Debbie's perceptions might be influenced by her emotional state, stress, or pain. The nurse's perceptions are influenced by culture, socioeconomic status, age, knowledge (of Debbie's diagnosis and treatment), and professional skill (King, 1981).

Perceptions form the basis for development of the self. According to King (1981), the self is the conception of who and what one is and includes one's subjective totality of attitudes, values, experiences, commitments, and awareness of individual existence. Debbie reveals important information about self. She is tearful and expresses fear, concern, uncertainty, and blame. Debbie's past neglect of her health influences her present feelings. Feelings about self and situation are clearly psychological stressors. Debbie has physical and interpersonal stressors as well. Physical stressors result from the illness and surgery. Bladder function, pain, and nausea are identified as immediate problems, and radiation treatment may result in other changes in physical status.

In the interpersonal system, Debbie identifies a distant and sometimes abusive husband, which constitutes a major lack of emotional support during this very difficult time. He is unemployed, and she is unable to work; therefore, financial troubles and lack of other basic resources are likely to be stressors as well. Her husband's inability to provide basic emotional and material support most likely contributes to Debbie's concern for her children, especially with changes that may occur in her own role with them. Her living situation is another stressor. It is unsanitary and seems quite crowded. Further nursing assessment of the situation can clarify whether her home situation truly will interfere with necessary postoperative care. It is also possible that the lack of personal—and perhaps family—space contributes to stress. Coping with personal and interpersonal stressors is likely to influence both health and illness outcomes. Debbie may need additional resources to help her cope with the immediate situation and the future.

Communication is the key to establishing mutuality and trust between Debbie and the nurse and is the means to validating perceptions, establishing patient priorities, and moving the interaction process toward goal setting. Debbie is expected to participate in setting goals. However, Debbie's overwhelming needs and lack of resources likely may necessitate direction from the nurse, especially in setting intermediate goals. Nurses can find direction for assisting patients to identify goals based on the assumptions that underlie King's conceptual system. For example, the overall goal of nursing is to assist persons to function in their roles (King, 1981). Debbie has expressed major concerns about her children. These concerns may involve the maternal role. However, Debbie is also in the patient role—one that may change based on the recovery, progression, or remission of cancer. Another basic assumption is that nurses assist patients to adjust to changes in their health status. Decisions about goals must be based on the capabilities, limitations, priorities of the patient, and situation. In this situation the priority goal seems to be control of postoperative pain and nausea, although this needs to be validated with Debbie. A subsequent goal will be to prepare Debbie to perform self-catheterization.

It is important to determine the extent to which Debbie's fears, worries, and anxieties interfere with her ability to participate in goal setting or to identify and participate

in actions to meet goals. If these problems do interfere, the first nursing action would be to obtain psychological consultation. Other important actions might be directed toward mobilizing resources, especially family support. Although Debbie's mother may not be a very good housekeeper, she may be a good source of emotional support and direct aid and service such as transportation to and from outpatient treatments. It is possible that professional goals and patient goals may be incongruent. Continuous analysis, synthesis, and validation are critical to keep on track.

In addition to decisions about goals, Debbie is expected to be involved in decisions about actions to meet goals. Involving Debbie in decision making may be a challenge because of her sense of powerlessness over the illness, treatment, and ability to contribute to family functioning. Yet empowering Debbie is likely to increase her sense of self, which in turn can reduce stress, improve coping, change perceptions, and lead to changes in her physical state.

Goal attainment requires ongoing evaluation. Follow-up with Debbie on pain, nausea, and bladder function soon after discharge will be necessary. One way to do this might be to arrange for in-home nursing services, which would constitute a nursing action to meet a goal. Having a professional in the home also contributes to further assessment of the family, validation of progress toward goals, and modifications in plans to achieve goals.

According to King, if transactions are made, goals will be attained. Goal attainment can improve or maintain health, control illness, or lead to a peaceful death. If goals are not attained, the nurse needs to reexamine the processes of nursing, critical thinking, and transaction. Unmet goals may result from an incorrect or incomplete data, perceptual errors, lack of knowledge, lack of mutuality in the relationship, goal conflict, and other nurse, patient, or system factors.

CASE HISTORY OF CLARE

Clare was born on March 31, 1999, at 37 weeks' gestation by an emergency cesarean section because of a late deceleration pattern in fetal heart rate during labor. This was her mother's second pregnancy. She had received prenatal care, and both pregnancies were uneventful.

Clare's mother is 33 years old, and her father is 35. Their first child is a 6-year-old boy who was hospitalized at birth and now has severe developmental delays. He requires constant care but is in a special program during the daytime hours.

At birth Clare weighed 3665 g (about 8 pounds) and had Apgar scores of 8 and 9, which indicated that she was in good condition. However, respiratory distress developed several hours after birth. Clare was intubated and placed on a ventilator, but she required increasing amounts of oxygen and pressure, and blood gases did not improve. At 36 hours of age, she was transferred to a tertiary-level neonatal intensive care unit (NICU), and within 2 hours she started receiving extracorporeal membrane oxygenation (ECMO). During the next few days she experienced sepsis, seizures, and renal failure. One or both of Clare's parents visited daily.

CASE HISTORY OF CLARE—cont'd

After 8 days Clare was doing well enough to have ECMO discontinued but remained intubated on ventilator support. She was stable for the next 3 days but then began to require increased ventilator support to the point that her survival was questionable. Because there were no other options to offer the family, Clare began experimental nitric oxide treatment for “compassionate” support. Over the next few days Clare’s condition was very unstable and she experienced many ups and downs.

The family, including the paternal grandparents, talked to the neonatologist about Clare’s survival, the quality of her life if she survived, and any pain or discomfort she might be experiencing at the time. They also discussed the possibility of organ donation. On the sixth day of nitric oxide treatment, Clare’s condition deteriorated even further and she was not expected to survive more than a few hours. The family asked for the hospital chaplain to perform an emergency baptism.

In spite of such critical condition, Clare showed signs of improvement over the next few days, although she remained on a ventilator. Then another setback occurred. Chest tubes to drain fluid accumulation in her chest were inserted. However, 1 week later she was tolerating gavage feedings well despite the chest tubes. Blood gas levels continued to improve, and Clare was eventually extubated. Her condition stabilized, and she began to make steady progress. It was anticipated that Clare would be discharged to her family when her physiological problems were resolved and growth was adequate.

Nursing Care of Clare with King’s Conceptual System

On April 3, 1999, Anne arrives for her day shift in the neonatal intensive care unit (NICU) and is assigned to Clare as her primary nurse. Concepts that King (1981) articulates in her conceptual system and Theory of Goal Attainment provide a basis for the critical thinking that Anne uses during the process of caring for Clare and her family.

Three time periods are described in Clare’s case history. The first period covers the first 2 weeks, during which Clare was administered extracorporeal membrane oxygenation (ECMO) and began to recover. The next period is the week when Clare’s death seemed likely. The last period describes stabilization and progress toward eventual discharge. Only the first two time periods will be used to illustrate the use of King’s work in nursing practice because of the complexity of the case.

The first step in the process is conceptualization and assessment that uses each of the concepts identified within each system. Anne begins to think about Clare and her family in terms of three interrelated systems: the personal, interpersonal, and social. In Clare’s case, Anne identifies four individual or personal systems: Clare, her mother, her father, and Anne. Interpersonal systems are formed when two or more personal systems interact. Anne recognizes the presence of multiple interpersonal systems that may affect Clare. Social systems are larger groups that influence

the personal and interpersonal systems. Anne takes note of Clare's extended family, particularly her grandparents. Religious systems could also play a role in this case because Clare's survival is uncertain. Anne also recognizes that the NICU is a social system with its own inherent and often overwhelming power and authority, values, patterns of behavior, and role expectations.

One value that is strongly held in this NICU is the philosophy of family-centered care, which recognizes and respects the role of families in the care of their children. King's conceptual system is consistent with the principles of family-centered care in the NICU. Interactions, transactions, and mutual goal setting can be implemented with Clare's parents to promote the health of the family system by assisting Clare's parents to function in their roles as parents.

Now that Anne has conceptualized Clare and her family in terms of the three interacting systems, she gathers data and applies knowledge of the concepts identified within the personal system: perception, self, growth and development, body image, time, and personal space. Anne recognizes that the most salient concept to apply to Clare as a newborn is growth and development. Anne knows that Clare's illness and its treatment will interfere with normal newborn behavior, which could impede parental interaction and, possibly, attachment. It is also possible that Clare will not meet developmental milestones, either on time or at all. It is also likely that growth and development will be less problematic for Clare at this point in her life than for her parents. The sense of chronic sorrow that accompanies the "loss" of a perfect, healthy infant may well be magnified for these parents because of their experience with their son.

Anne then turns her attention to concepts that are important for assessing Clare's parents. Clare's father visited at least once a day and phoned often during the first 4 days of Clare's life, but Anne was not on duty when he visited. During that time, he had to provide care for his son and support his wife, who was recovering from a cesarean section.

Clare's parents visited together for the first time on the fourth day of her hospitalization. It was important to assess their perceptions of her health status and the situation. Clare's mother was very upset and sobbing; her father appeared overwhelmed. After providing them an opportunity to express their emotional tensions and grief, Anne engaged them in conversation about Clare. They expressed shock over the events following her birth. They had waited 6 years to have another child, until their son was in school and they felt they could handle the demands of a newborn. Despite the health status of their son and the fact that no specific causes for his delays were ever identified, they had no reason to expect anything but a normal, healthy child this time. Both parents expressed concern for Clare's survival and also for any long-term health implications. Anne perceived that they were exhibiting a normal, appropriate reaction to the present situation. Their perceptions of Clare's status were congruent with those of Anne, were a fair estimation of the reality and uncertainty of the situation, and clearly were influenced by their past experience.

Another important concept is self. Clare's parents bring a unique self to this experience that defines them as individuals. They already had established themselves as mother and father with their firstborn. They also had 6 years of experience with their developmentally disabled son. Anne also considers the possibility that Clare's parents may be experiencing guilt and anger about having another child

with major health problems because they repeatedly question why they could not have a normal child.

The concept of personal space is pertinent in the care of Clare and her parents. There is no personal, private space in the NICU in which Clare's parents can express themselves, interact with Clare, or interact with others. Four other infants are in the same room as Clare. Furthermore, the space around Clare's warmer is congested because of the number of life support machines in use. The unit does have several screens that Anne uses to provide some small amount of privacy for short periods.

Time is another concept within the personal system that affects Clare's parents. Time represents a continuous flow of events, one after the other, that leads to the future. The uncertainty surrounding Clare's medical status requires continual adjustment in terms of time. Clare's parents repeatedly asked when ECMO would be discontinued. For them, that event represented movement toward the future, to survival. When Claire finally stopped receiving ECMO, her parents expected that in time she would be ready to go home. Unfortunately, this time sequence was disrupted by other life-threatening crises.

Growth and development is also a relevant concept for Clare's parents. The addition of another family member signals a development change; now the family unit is expanded to four. Clare's parents will continue to grow and develop as parents as they assimilate Clare into the family. This process might be challenged by the special needs of both children.

Pertinent concepts in the interpersonal system that Anne considers include interaction, communication, transaction, role, and stressors/stress. Anne communicates with Clare's parents throughout Clare's hospitalization and provides them with the information they need to function in their parental role. This open communication with Clare's parents enables Anne to validate their perceptions and judgments and understand their actions and reactions. Such communication establishes mutuality and trust between Clare's parents and Anne, which in turn leads to interactions and ultimately transactions. One characteristic of interactions is reciprocity, interdependence in the relationship in which there is an exchange between the persons involved. Clare's mother regularly brought cookies or doughnuts for the nursing staff as a way of giving something back to the staff in exchange for their support and care of Clare and her family.

Anne recognizes that multiple psychological and social stressors inherent in the NICU experience cause stress for Clare's parents. The uncertain outcome and prognosis of Clare's illness is a major stressor. Clare's parents verbalize that it is difficult to adjust to changes in Clare's condition. At one moment they feel hopeful, and the next they feel despair. Other times they do not know what they hope the outcome will be.

The NICU itself is a noisy, bustling, tension-filled environment. All kinds of alarms and buzzers send out signals of potential disaster, which heighten concerns for Clare's parents. They often comment on unexpected and unplanned stress in their day-to-day lives: they must continue to provide for their older son; they feel compelled to visit Clare daily; they must drive back and forth to the hospital; they must maintain the normal routines of doing laundry, shopping for groceries, and going to work.

Role is another important concept in the interpersonal system. Anne knows that parents often feel inadequate compared with the nurse who cares for their

infant. An alteration in the parenting role may interfere with the ability of Clare's parents to engage in mutual goal setting that leads to transaction. Anne brings a strong commitment to family-centered care to her nursing practice. Initially, she defines the goal of helping Clare's parents establish their parental role and also plans to redefine that goal with them when they are ready.

The concepts of authority, power, status, and decision making are characteristics of social systems that are relevant in Clare's case. Anne knows that for most parents the NICU represents a highly technological, threatening arena unlike any other social situation they have experienced. As a social system, the NICU possesses authority and power that appear to exceed those of the parents. Parents often perceive that they have little status. Physicians and nurses have expertise and skills with which parents cannot compete in caring for their child. Unless the NICU supports a philosophy of family-centered care, parents may not be actively involved in care or care decisions.

At one point, Anne observed that Clare's mother had a tendency to focus on the details of the technological care but that Clare's father would tell her "not to sweat the small details." Although Anne recognized that Clare's parents had different coping styles, she also perceived that Clare's mother might be feeling powerlessness in the present situation. In addition, Anne recognized that a loss of control might threaten the self. Clare's mother may feel threatened and therefore make issues out of little things. Anne took an opportunity to discuss her perceptions with Clare's mother, who validated that she did not feel like a mother to Clare because the nurses did everything.

Taken together, the concepts of interaction, perception, communication, transaction, self, role, stressors/stress, growth and development, time, and personal space constitute the Theory of Goal Attainment. Through communication and interaction, Clare's parents and Anne clarified their perceptions of the situation and mutually established the goal of identifying aspects of care that they could provide within the constraints of Clare's physical condition, treatment, and the NICU environment. Anne's role was to teach and assist them to care for Clare safely and to maximize opportunities for Clare's parents to provide comfort measures. Within several days, Anne observed that Clare's mother independently initiated aspects of care and was becoming adept at performing them even within the confined space. As her confidence increased, Clare's mother became less focused on minor changes in blood gas levels or ventilator settings and began to function in her role as parent. Clare's mother demonstrated growth and development in behavioral activities related to parenting in the environment and social system of the NICU. Anne observed that verbal and nonverbal manifestations of stress decreased for both parents.

The process of goal attainment occurs within the context of time, with one event leading to another. Discussion and clarification of perceptions lead to judgment, action, and reaction for both Clare's parents and Anne. These actions were followed by establishing mutual goals during the process of interaction, which led to achievement of goals. Achievement of goals is transaction. Transactions lead to improved health—in this case, the ability to be parents to their infant.

At one point during Clare's hospitalization, her parents faced a major ethical dilemma. They had to make a decision to use an experimental treatment (nitric oxide) to try to save her life. Anne used the nursing process and King's transaction process model to help Clare's parents arrive at a decision (King, 1999).

Anne first assessed their perceptions of the situation. The fact that they had discussed organ donation indicated that Clare's parents understood that Clare might not survive. They were also concerned about any pain and suffering that Clare might be experiencing. In addition, they did not seem sure of the best outcome for their daughter. Anne knew that it was critical to communicate with Clare's parents and to interact with them.

Acknowledging that an ethical dilemma is present in a situation is a very difficult step. Engaging in dialogue about it is even more difficult, considering the emotional roller-coaster that Clare's parents have experienced. Anne is able to help them explore their values and beliefs regarding this situation. She provides them with specific information about the nitric oxide treatment and about the process of organ donation, should treatment be unsuccessful.

It is clear that Clare's parents are concerned about the issue of quality versus sanctity of life. They are not sure what impairments Clare may have as a result of this illness, and the uncertainty makes a decision less clear. Clare's parents appear to value the sanctity of life. They consider experimental treatment for their daughter because they want to try to save her life at all costs. The fact that they have a son who is developmentally delayed but still want Clare to have a chance to survive despite any later difficulties is testimony to their support for the sanctity of life. They also appear to value the quality of life. They waited 6 years to have another child so they could devote themselves to their son, maximize his opportunities to develop, and give their second child the care and attention she would need.

Once Clare's parents have had an opportunity to interact with the physicians and Anne, they decide on a plan of action. Clare's parents decide to give Clare the chance to survive by agreeing to the experimental treatment, which represents a transaction, according to King (1999). Despite the deterioration of Clare's condition, the ultimate goal was achieved and Clare survived. Clare's parents understand that it will be a long time before they will be able to evaluate their decision. As they raise their daughter, they will reflect on whether any limitations she develops detract from her quality of life to the point that they wish they had made a different decision. Anne knows they will agonize over whether they have made the right decision. She continues to communicate and interact with Clare's parents to help them explore their perceptions and evaluate the outcome of their decision.

Over time, Clare's physical condition continues to improve to the point at which survival is likely, but the need for special care when she is discharged home remains high. This represents a critical time for parental participation in setting goals and developing plans to meet those goals so they are prepared to assume full-time parenting roles and to incorporate any special care needs into their daily routines. For example, infants who have been receiving ECMO are often slow to establish bottle-feeding. Anne will communicate this information to Clare's parents (1) to decrease potential stress caused by unrealistic expectations, and (2) to coordinate a consultation with

occupational therapy to teach Clare's parents feeding strategies that will promote adequate weight gain and growth.

The challenge to nurses working in the NICU is to see beyond the technological care they provide to the importance of interaction and transaction early in the hospitalization of a sick infant. Families expect technological care to be appropriate and competent. In addition, they need a caring relationship with nurses. As one mother put it when discussing her son's NICU experience, "The facts of his history will remain the same. How we perceive the experience may be changed. The memories are tempered by the relationships we formed. In partnership, you will make a permanent, positive difference in the life in an NICU family" (Busch, 1992, p. 8).

King's (1981) conceptual system, Theory of Goal Attainment, and model of transaction provide direction for nursing practice because they emphasize the processes of communication, interaction, and transactions, which are the foundations for promoting and maintaining the health status of individuals and families (Allgood, 2010). The relationships that nurses establish based on mutual respect and trust attain the goal of nursing, which is "to help individuals to maintain their health so that they can function in their roles" (King, 1981, pp. 4, 5). Nurses who work to mutually establish and attain goals influence health outcomes of personal and interpersonal systems.

CRITICAL THINKING EXERCISES

1. What are the relevant assessment data in the case of Debbie? What mutual goals would you be working toward with Debbie? Prioritize three potential nursing diagnoses for those mutual goals. Use Figure 9-1 to trace the logic of your plan.
2. Conduct a comprehensive assessment of Clare and her parents, focusing on the ethical dilemma they face. Which concepts from each of King's systems are most relevant (personal, interpersonal, and social) to apply as you help Anne think about the care of this family? What additional information does Anne need? Why do you need this information?
3. The case of Clare and her parents identifies several goals. Assess the level to which these goals were attained. Explain why you think the goals were attained or unattained. List the behaviors of Anne and Clare's parents that may have contributed to attained or unattained goals. Identify additional nursing actions that could be taken to achieve mutually set goals.
4. Individuals are viewed as personal systems in King's conceptual system. The concept of self is relevant for understanding Anne as a human being and a professional nurse. What attitudes and values appear to influence Anne's practice as a professional nurse? If you were the nurse caring for Clare, what would you do differently?
5. Select a patient from your practice and follow the dimensions in Figure 9-1. Conduct an initial assessment (Dimension 1), assess the patient further according to the Personal System concepts (Perception through Self in Dimension 2), and progress to establish mutual goals (Dimension 3). Consider your nursing actions in each dimension and reflect on your practice and the patient's response to it. How did this theoretical perspective affect or expand your nursing practice?

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Levine's Conservation Model in Nursing Practice

*Karen Moore Schaefer**

Nursing is a profession as well as an academic discipline, always practiced and studied in concert with all of the disciplines that together form the health sciences.... Scientific knowledge from many contributing disciplines is, in fact, connected to nursing, as an adjunct to the knowledge that nursing claims for its own.
(Levine, 1988, p. 17)

History and Background

The conservation model was originally an organizing framework for teaching undergraduate nursing students (Levine, 1973a). Levine's book *Introduction to Clinical Nursing* (1973a) addressed the "whys" of nursing actions. Levine taught the skill of nursing and the rationale for the actions. She demonstrated high regard for the contribution of the adjunctive sciences to a theoretical basis of nursing in a clear voice for discipline development and attention to the rhetoric of nursing theory (Levine, 1988, 1989b,c, 1994, 1995).

The universality of the conservation model is supported by its use with a variety of patients of varied ages in a wide range of settings, including critical care (Langer, 1990; Litrell & Schumann, 1989; Lynn-McHale & Smith, 1991; Taylor, 1989; Tribotti, 1990), acute care (Foreman, 1991; Molchany, 1992; Roberts, Brittin, Cook, et al., 1994; Roberts, Brittin, & deClifford, 1995; Schaefer, 1991; Schaefer, Swavelly, Rothenberger, et al., 1996), and long-term care (Burd, Olson, Langemo, et al., 1994; Clark, Fraaza, Schroeder, et al., 1995; Cox, 1991). It is also used with neonates (Tribotti, 1990), infants (Deiriggi & Miles, 1995; Mefford, 1999, 2004; Mefford & Alligood, 2011a,b; Newport, 1984), young children (Dever, 1991; Savage & Culbert, 1989), pregnant women (Ober, 1988; Roberts,

*This chapter is dedicated to the memory of Myra E. Levine.

Fleming, & Yeates-Giese, 1991), young adults (Pasco & Halupa, 1991), women with chronic illness (Schaefer, 1996), long-term ventilator patients (Delmore, 2003), and the elderly (Cox, 1991; Foreman, 1991; Happ, Williams, Strumpf, et al., 1996). It has been successfully used in communities (Dow & Mest, 1997; Pond, 1991), emergency departments (Pond & Taney, 1991), extended care facilities (Cox, 1991; R. Cox, personal communication, February 21, 1995), critical care units (Molchany, 1992), primary care clinics (Schaefer & Pond, 1994), and operating rooms (Crawford-Gamble, 1986; Piccoli & Galvao, 2001) as well as for wound care and enterostomal therapy (Cooper, 1990; Leach, 2006; Neswick, 1997), care of intravenous sites (Dibble, Bostrom-Ezrati, & Ruzzuto, 1991), management of patients on long-term ventilation (Higgins, 1998), and care of patients undergoing treatment for cancer (Mock, St. Ours, Hall, et al., 2007; O'Laughlin, 1986; Webb, 1993).

The model is used for quantitative and qualitative research addressing practice issues. Melacon and Miller (2005) found massage therapy effective as complementary support for patients, reducing their low back pain intensity and preventing further decline. Mock, Pickett, Ropka, and colleagues (2001) used the model to study the effect of exercise on fatigue in patients with cancer. Coyne and Rosenzweig (2006) studied fatigue and functional status in women with cancer metastasis, using the model to assess energy and structural, personal, and social integrity. Hanna, Avila, Meteer, and colleagues (2008) found that comprehensive exercise for patients with cancer results in significant improvements in functional status, fatigue, and mood in treatment and recovery. Zalon (2004) found that pain, depression and fatigue, and return of functional status in older adults after major abdominal surgery were significantly related to patient perception of functional status and recovery.

Chang (2007) studied swaddling guided by Levine's model and found swaddling conserved energy because the heart rates of swaddled infants increased less than those of the control group. Watanabe and Nojima (2005) proposed a middle-range theory describing the "calm delivery" and conservation of social integrity relationship based on key indicators of parental relationships, person-environment relationship, family function, dyadic relationship between parents, and dyadic relationship between the generations. Gregory (2008) found premature infants who did not receive fortified enteral breast milk feedings developed necrotizing enterocolitis when respiratory support was increased to maintain oxygenation. Mefford (2004; Mefford & Alligood, 2011a) developed and tested a theory of health promotion for preterm infants.

Ballard, Robley, Barrett, and colleagues (2006) applied the conservation model for a phenomenological study of patients' recollections of therapeutic paralysis in intensive care. They found that patients reconstruct their lives in concert with care given by nurses who modified physiological stress to reduce chances of mortality and maintain wholeness. Delmore (2006) studied fatigue and protein calorie malnutrition in adult long-term ventilated patients during the weaning process, and found patients experienced moderate to severe fatigue during weaning and prealbumin levels affected the level of fatigue experienced. Jost (2000) studied staff nurse productivity, burnout, and satisfaction issues.

Overview of Levine's Conservation Model

According to Levine (1973a), "Nursing is human interaction" (p. 1). "The nurse enters into a partnership of human experience where sharing moments in time—some trivial, some dramatic—leaves its mark forever on each patient" (Levine, 1977, p. 845). As a human science, the profession of nursing integrates the adjunctive sciences (e.g., chemistry, biology, anatomy and physiology, psychology, sociology, anthropology, philosophy, medicine) to develop the practice of nursing.

Three major concepts form the basis of the model and its assumptions: (1) conservation, (2) adaptation, and (3) wholeness. Conservation is a natural law fundamental to many sciences. Levine (1973a) explains that individuals continuously defend their wholeness.

Conservation is the keeping together of the life system. *To keep together* means to maintain a proper balance between active nursing interventions and patient participation, in which the patient participates within the safe limits of his or her ability. Individuals defend that system in constant interaction with their environments and choose the most economical, frugal, energy-sparing options available to safeguard their integrity. Energy sources cannot be directly observed but the consequences (clinical manifestations) of their exchange are predictable, manageable, and recognizable (Levine, 1991). Conservation is about achieving balance between energy supply and demand within the unique biological realities of the individual.

Adaptation is an ongoing process of change in which individuals retain their integrity within the realities of their environments (Levine, 1989a). Change is the life process, and adaptation is the method of change. The achievement of adaptation is "the frugal, economic, contained, and controlled use of environmental resources by the individual in his or her best interest" (Levine, 1991, p. 5). Individuals possess a range of adaptive responses unique to them. The ranges vary with ages and are challenged by illness. For example, the hypoxic drive stimulates breathing in individuals with chronic obstructive pulmonary disease. History, specificity, and redundancy characterize adaptations that await the challenges to which they respond (Levine, 1995). The severity of responses and the adaptive patterns vary based on specific genetic structures and influences of social, cultural, spiritual, and experiential factors.

Redundancy represents the fail-safe anatomical, physiological, and psychological options available to individuals to ensure continued adaptation (Levine, 1991). Levine (1991) proposed that "[a]chieving health is predicated on the deliberate selection of redundant options" (p. 6). Survival depends on redundant options that are challenged and limit illness, disease, and aging.

Wholeness exists when interactions with and adaptations to the environment permit assurance of integrity (Levine, 1991). Nurses use of the conservation principles to promote wholeness. Recognition of an open, fluid, constantly changing interaction between the individual and the environment is basic to holistic thought. Wholeness is health; health is integrity. Health is the pattern, and well-being is the goal of adaptive change.

Levine (1988) referred to the metaparadigm concepts of person, environment, health, and nursing as *commonplaces of the discipline* because they are necessary

for any description of nursing. Persons are holistic beings who are sentient, thinking, future-oriented, and aware of their past. Wholeness (integrity) of individuals demands that “isolated aspects...have meaning outside of the context within which the individual experiences his or her life” (Levine, 1973a, pp. 325, 326). Persons are in constant interaction with the environment, responding to change in an orderly, sequential pattern, adapting to forces that shape and reshape their essence. According to Levine (1973a), the person can be defined as an individual, a group (family), or a community of groups and individuals (Pond, 1991).

The environment completes the wholeness of the person. Each individual has his or her own internal and external environments. The internal environment includes physiological and pathophysiological aspects of the patient that are challenged by changes in the external environment. External environmental factors impinge on and challenge the individual. Acknowledging the complexity of environment, Levine (1973a) adopted three levels of environment identified by Bates (1967): (1) perceptual, (2) operational, and (3) conceptual. Perceptual environment includes aspects of the world that individuals intercept or interpret through the senses. Operational environment includes elements that physically affect individuals but are not directly perceived (e.g., radiation, microorganisms). Conceptual environment includes cultural patterns that affect behavior characterized by spiritual existence and mediated by symbols of language, thought, and history (e.g., values, beliefs).

Health and disease are patterns of adaptive change with the goal of well-being (Levine, 1971b). Health is socially defined by the following question (Levine, 1984): “Do I continue to function in a reasonably normal fashion?” Health (wholeness) is the goal of nursing and implies the unity and integrity of the individual. Illness is adaptation to noxious environmental forces. Levine (1971a) proposes that “[d]isease represents the individual’s effort to protect self-integrity, such as the inflammatory system’s response to injury” (p. 257). Disease is unregulated and undisciplined change that must be stopped to prevent death (Levine, 1973a).

Nursing involves engaging in “human interaction” (Levine, 1973a, p. 1). Individuals seek nursing care when they are no longer able to adapt. The goal of nursing is to promote adaptation and maintain wholeness. This goal is accomplished through the conservation of energy and structural, personal, and social integrity.

Energy conservation depends on free exchange with environment so living systems can constantly replenish their supply (Levine, 1991). Conservation of energy is integral to individual ranges of adaptive responses. Conservation of structural integrity depends on the defense system that supports repair and healing in response to challenges from internal and external environments. Conservation of personal integrity recognizes individual wholeness in response to environment as the individual strives for recognition, respect, self-awareness, humanness, holiness, independence, freedom, selfhood, and self-determination.

Conservation of social integrity recognizes individual functioning in a society that helps establish the boundaries of the self. Social integrity is created with family and friends, workplace and school, religion, personal choices, and cultural and ethnic heritage (Levine, 1996). With political and economic control, the health care system is part of the social system of individuals. Levine (1991) contends that

“[c]onservation of integrity is essential to assuring wholeness and providing the strength needed to confront illness and disability” (p. 3).

Levine (1973a) stresses that patient understanding of plans of care and diagnostic studies is vital. To this understanding the nurse contributes knowledge of nursing science, a careful history of the patient's illness, the patient's perception of the current predicament, information gained from family and friends, and acute observation of the patient and his or her interactions with others (Levine, 1966a). This integrated approach to patient-centered care provides the basis for collaborative care and the establishment of partnerships in the delivery of comprehensive care. Treatment focuses on the management of the organismic responses, including the following:

1. Flight/fight response is the most primitive.
2. Inflammatory/immune system response provides structural continuity and promotes healing.
3. Stress response develops over time as experiences accumulate, leading to system damage if prolonged.
4. Perceptual awareness response observes the environment and converts observations to meaningful experience.

These four responses work together to protect the individual's integrity as essential components of the individual's whole response.

The goal of patient care is promotion of adaptation and well-being. Because adaptation is predicated on redundant options and rooted in history and specificity, therapeutic interventions vary depending on the unique nature of each person's response.

Theories for Practice from the Model

The model provides a basis for the following four theories for practice (Mefford, 2004):

1. The Theory of Conservation
2. The Theory of Therapeutic Intention
3. The Theory of Redundancy
4. The Theory of Health Promotion for Preterm Infants (Mefford, 2000)

The Theory of Conservation, rooted in the universal principle of conservation, is foundational for the model (Alligood, 1997, 2006, 2010). The purpose of conservation is to “keep together.” According to Levine (1973a), “To keep together means to maintain a proper balance between active nursing interventions coupled with patient participation on the one hand and the safe limits of the patient's abilities to participate on the other” (p. 13). The patient interacts with the environment in a singular but integrated fashion. The person represents a system that is more than the sum of its parts and reacts as a whole being. As part of the patient's environment the nurse supports patient responses. All nursing acts of conservation are devoted to restoring symmetry of response with the goal of maintaining wholeness (Levine, 1969).

In developing the Theory of Therapeutic Intention, Fawcett (2005) cites Levine's model for its capacity to organize nursing interventions using biological

realities that nurses confront and proposed therapeutic regimens to support the following goals (Fawcett, 2000):

- Facilitate integrated healing and optimal restoration of structure and function.
- Provide support for a failing autoregulatory portion of the integrated system.
- Restore individual integrity and well-being (Gagner-Tjellesen, Yurkovich, & Gragert, 2001).
- Provide supportive measures to ensure comfort and promote human concern.
- Balance a toxic risk against the threat of disease (Piccoli & Galvao, 2001).
- Manipulate diet and activity to correct metabolic imbalances and stimulate physiology.
- Reinforce or antagonize usual response to create therapeutic change.

Levine's Theory of Redundancy, grounded in adaptation, has the capacity to expand our understanding of aging (Fawcett, 2005). Redundancy is predicated on the ability of a human to "monitor its own behavior by conserving the use of resources required to define its unique identity" (Levine, 1991, p. 4). Inherent in the ability to select from the environment is availability of options from which choices are made.

Mefford (2000; Mefford & Alligood, 2011a,b) tested the validity of her Middle Range Theory of Health Promotion for Preterm Infants and found that consistency of nurse caregivers mediated the infant's integrity at birth and the age that health was obtained, and an inverse relationship between the use of resources by preterm infants during their initial hospital stay and consistency of caregivers. Watanabe and Nojima (2005) developed a middle-range theory with substruction using Levine's Conservation Model to describe, "calm delivery." Literature review identified 22 concepts related to the four integrities of the model. Conservation of social integrity was the integrity related to a cluster of five concepts, including social support; dyadic relationships between parents, generations, and environment; and family function. They identified significant cues for researchers to conduct studies in this area.

Anecdotal reports are supportive of the theories in practice. For example, a patient with diabetes who follows a diet and exercise program is more likely to control his or her blood sugar levels (therapeutic intention) than one who does not follow the same program. Patients with emphysema who space activities to conserve energy will be more satisfied with daily life than patients who do not space activities (conservation). Patients with chronic illness manage their lives better when given options for treatment than patients who are not provided with options (redundancy). According to Levine (1991), failure of redundant options (loss of hearing in one ear) helps explain aging. The Theory of Redundancy might explain the process of aging because as one ages organ function declines, in some cases as a part of the aging process. If a kidney fails, the Theory of Redundancy no longer is valid because only one kidney remains. This is also true if a patient can only hear from one ear; the option to hear with both ears no longer exists. Of course, a hearing aid may help restore hearing in the ear with less than optimal function, supporting the Theory of Redundancy through the use of technology.

Critical Thinking in Nursing Practice with Levine's Model

Levine (1973a,b) proposes that nurses use their scientific and creative abilities to provide nursing care to patients using a process incorporating ability to think critically. Table 10-1 describes Levine's nursing process using critical thinking the nurse used to guide Debbie's care.

CASE HISTORY OF DEBBIE

Debbie is a 29-year-old woman who was recently admitted to the oncology nursing unit for evaluation after sensing pelvic "fullness" and noticing a watery, foul-smelling vaginal discharge. A Papanicolaou smear revealed class V cervical cancer. She was found to have a stage II squamous cell carcinoma of the cervix and underwent a radical hysterectomy with bilateral salpingo-oophorectomy.

Her past health history revealed that physical examinations had been infrequent. She also reported that she had not performed breast self-examination. She is 5 feet, 4 inches tall and weighs 89 pounds. Her usual weight is about 110 pounds. She has smoked approximately two packs of cigarettes a day for the past 16 years. She is gravida 2, para 2. Her first pregnancy was at age 16, and her second was at age 18. Since that time, she has taken oral contraceptives on a regular basis.

Debbie completed the eighth grade. She is married and lives with her husband and her two children in her mother's home, which she describes as less than sanitary. Her husband is unemployed. She describes him as emotionally distant and abusive at times.

She has done well following surgery except for being unable to completely empty her urinary bladder. She is having continued postoperative pain and nausea. It will be necessary for her to perform intermittent self-catheterization at home. Her medications are (1) an antibiotic, (2) an analgesic as needed for pain, and (3) an antiemetic as needed for nausea. In addition, she will be receiving radiation therapy on an outpatient basis.

Debbie is extremely tearful. She expresses great concern over her future and the future of her two children. She believes that this illness is a punishment for her past life.

Nursing Care of Debbie with Levine's Model

Debbie is very concerned about her future and the future of her children. She requires nursing care and assessment of environmental challenges threatening her integrity and ability to adapt.

Challenges to Debbie's Internal Environment

Challenges that reduce Debbie's energy resources include her 20-pound weight loss and her cigarette smoking. She has had radical surgery, which challenges her

TABLE 10-1 Levine's Nursing Process Using Critical Thinking

| Process | Decision Making |
|--|---|
| ASSESSMENT | |
| Collection of provocative facts through interview and observation of challenges to environments, with consideration of conservation principles | Nurse observes patients for organismic responses to illness, reads medical reports, evaluates results of diagnostic studies, and talks with patients about their needs for assistance. Nurse assesses patient challenges for internal and external environments. Guided by conservation principles, nurse assesses for challenges that interfere with*: |
| 1. Energy conservation | 1. Balance of energy supply and demand |
| 2. Structural integrity | 2. Body's defense system |
| 3. Personal integrity | 3. Person's sense of self-worth and personhood |
| 4. Social integrity | 4. Person's ability to participate in social system |
| | These data are provocative facts. |
| JUDGMENT—TROPHICOGNOSIS[†] | |
| Nursing diagnosis—gives provocative facts meaning | Provocative facts are arranged in a way that provides meaning to patient's predicament. Judgments made about patient's needs for assistance are known as trophicognosis. [†] |
| HYPOTHESES | |
| Direct nursing interventions with goals of maintaining wholeness and promoting adaptation | Based on their judgment, nurses seek validation with the patient about his or her problem. Nurse hypothesizes about problem and its solution—this is the plan of care. |
| INTERVENTIONS | |
| Tests hypothesis | Nurse uses hypotheses to direct care. In essence, nurse tests proposed hypotheses. Interventions are designed based on conservation principles: conservation of energy, structural integrity, personal integrity, and social integrity. Goal of the approach is to maintain wholeness and promote adaptation. |
| EVALUATION | |
| Observation of organismic response to interventions | Hypothesis testing is evaluated by assessing outcome for organismic responses that do or do not support hypothesis. Outcomes of care may be therapeutic or supportive: therapeutic consequences improve one's sense of well-being and supportive consequences provide comfort when course of illness no longer is being influenced. If hypotheses are not supported, the plan is revised and new hypotheses are proposed. |

*Although the conservation principles guide the assessment of environmental challenges, this was not included in the original model. It is helpful for the novice nurse, in particular, to organize provocative facts in a manner that directs the hypotheses, as illustrated in the nursing care of Debbie. Experienced nurses integrate the assessment of the environments, as illustrated in the presentation of nursing care of Alice.

[†]*Trophicognosis* is a nursing care judgment deduced through the use of the scientific process (Levine, 1966b). The scientific process is used to make observations and select relevant data to form hypothetical statements about the patient's predicaments (Schaefer, 1991).

structural integrity. The loss of reproductive ability poses a possible challenge to her personal integrity. She is having difficulty completely emptying her bladder. Smoking and taking oral contraceptives on a regular basis pose risk. Her diagnostic studies and vital signs are additional indices of challenges to her internal environment.

Challenges to Debbie's External Environment

Debbie reports her husband is emotionally distant and at times abusive. Considering this fact, the nurse reviews available patient records for Debbie, assessing for bruises, burns, or fractures that may have been noted on other health care visits. Debbie lives in a home that she describes as "less than sanitary" and has voiced concern about her own future as well as that of her children.

Assessment

Energy Conservation

Challenges that drain Debbie's energy resources include recent weight loss, nausea, pain, and smoking. She has pain despite pain medication and she is concerned about care of her children.

Debbie's structural integrity is threatened by a surgical procedure with potential for skin breakdown and infection. She is receiving an antibiotic prophylactically to prevent infection of the surgical wound. In addition, she is having difficulty emptying her bladder. Her risks include use of oral contraceptives, smoking, history of early childbirth, and recent diagnosis of cancer. On discharge, she is to undergo radiation therapy, which poses additional challenges of skin breakdown, destruction of normal cells, pain, and hair loss in the irradiated area.

Personal Integrity

Debbie feels her illness is punishment for past behaviors. The surgery and the consequences of surgery may jeopardize her sense of self-worth. Debbie is only 29 years old and she may have wanted more children. The impact of not being able to give birth could be devastating. Further, there is consideration of the impact of this situation on the family. Debbie recognizes her husband is emotionally distant and she wonders if he is capable of the emotional support she needs.

Social Integrity

Debbie will experience early menopause and the emotional and physical effects of that experience. Many young women her age have infants and menstrual cycles; she will not. Debbie also experiences anxiety and fear about her own future as well as that of her children. Debbie's relationship with her husband may experience additional strain due to the emotional impact of the surgery on him and his potential to be abusive.

Judgments

The following 10 trophicognoses (diagnoses) are identified for Debbie:

1. Inadequate nutritional status
2. Pain
3. Engaging in risky behavior

4. Potential for wound and bladder infection
5. Need to learn self-catheterization
6. Preparation for radiation therapy
7. Decreased self-worth, feelings of guilt
8. Potential for abuse
9. Premature menopause
10. Concern for her children's future

Hypotheses

Using the conservation model the nurse proposes hypotheses about Debbie's needs to develop a plan of care with her. The hypotheses might include the following:

- Providing Debbie with a nutritional consultation will help her find foods she can tolerate, increasing her energy level, strength, and healing capacity.
- Careful use of food and medicine for nausea will improve her tolerance for food.
- Teaching and return demonstration of urinary self-catheterization will reduce the potential for infection.
- Observation and cleansing of the surgical wound will reduce the chance for infection.
- Preparing Debbie for radiation treatment by discussing expected side effects and ways to minimize those effects will promote both structural integrity (maintenance of skin integrity) and personal integrity (sense of control).
- Encouraging Debbie to talk about her concerns and fears about having a hysterectomy will help her resolve fears, defuse myths, and prepare for some of the emotional/physical effects, including premature menopause.
- Visiting nurse follow-up (after discharge) will provide Debbie with emotional (sharing) and physical support (self-catheterization reinforcement).
- Teaching Debbie about her medications will maximize their effect (pain relief) and reduce the risk of potential side effects.
- Teaching alternate approaches for pain management (relaxation) will enhance the effects of the pain medication.
- Providing Debbie information about risky behaviors and ways to reduce those behaviors will give Debbie control over her health.
- Providing Debbie with time to talk about why she thinks her diagnosis is punishment for past behavior will help her understand that she did not cause her illness and subsequently will improve her sense of self-worth.

Nursing Interventions

When providing care to Debbie, the nurse uses the conservation principles to maintain wholeness and promote adaptation.

Energy Conservation

A nutritional consultation will assist Debbie in identifying foods that reduce nausea, improve caloric intake, and maintain required intake to meet her needs. If nausea continues, careful administration of the medication before eating may help reduce associated nausea. The frequency and intensity of pain may be controlled by identifying activities that aggravate her pain and offering medication to Debbie before she performs these activities. Because patients commonly experience fatigue after a total hysterectomy and radiation, Debbie will be prepared to expect fatigue and balance her activity and rest periods. Rest will become very important while her body heals.

Structural Integrity

Debbie's wound is assessed for signs of healing. The antibiotic is administered as ordered, and she is given instructions on how to take it at home. The nurse stresses the importance of completing prescriptions as ordered. Debbie needs to learn self-catheterization; return demonstrations will improve her confidence in performing the task. Before discharge, Debbie is prepared for outpatient radiation treatments and the following three points are stressed:

1. The importance of laboratory work to monitor the body's response to the therapy
2. The importance of skin protection to reduce irritation associated with the radiation
3. The importance of avoiding situations that support infection (e.g., a child with a cold) because of the body's decreased ability to fight infection

Personal Integrity

Debbie is encouraged to talk about what having her uterus removed means to her. If she chooses to not discuss her feelings, the nurse respects Debbie's privacy. Because Debbie feels that her illness is punishment for her past behavior, she needs to be reassured. A referral to a mental health nurse specialist is considered.

Social Integrity

The nurse assesses the potential for abuse from Debbie's husband and considers family support. The nurse explores resources available in the community (e.g., church, support groups, shelters) to support Debbie and her family.

Organismic Responses

The nurse observes for the following possible organismic responses:

- Abdominal wound healing
- Clean urinary self-catheterization
- Dialogue about how Debbie feels about a hysterectomy and cancer
- Improved appetite and weight gain
- Recognition that her past behavior did not cause her disease
- Restful sleep and increased energy
- Controlled pain
- Husband and children providing assistance within their capabilities

CASE HISTORY OF ALICE

Alice was diagnosed with fibromyalgia (FM) in 1988. At the time of the assessment she was 44 years old, married, and childless. She worked as a secretary for temporary services that required computer skills but had to quit her full-time job because of extreme stress of the environment and overtime hours it required. The nurse first met her when she inquired about a study to examine the health patterns of women with FM. She described herself as desperate for anything that would help her. The nurse clarified that the study was not designed to help her but to describe patterns of health that women experience with FM.

Alice had been missing a lot of work because of the pain and fatigue she was experiencing in the morning. Her pain was so severe she was unable to lift a cup of coffee. At times she had difficulty cleaning herself after bowel movements because of pain in her arm when she extended it backward. Sometimes her pain and fatigue were severe enough to cancel social engagements. This situation resulted in feelings of self-pity and bouts of crying. Severe headaches were of particular concern for her. She reported that her libido was significantly decreased and her husband thought she had a split personality. When she was not tired, she was fine; but when she was getting tired, she was mean and verbally abusive. Her husband was trying to understand but his patience was wearing thin.

Her physician prescribed an antidepressant; however, she chose not to take any medication except an antiinflammatory medication for menstrual cramps. She was particularly opposed to taking the antidepressant because of stigma associated with depression. Her physician ruled out all other possible sources of pain through a diagnostic workup and a consulting neurologist. She was searching for help and considered going to support group meetings but had not gone. She was continually trying to determine what she did or ate that might cause her pain and fatigue so she could change patterns even during a single day. She had learned that pacing herself when she had a lot to do reduced the intensity of her pain. Massage temporarily reduced the achiness and pain. She had observed that she felt worse on damp, rainy days. The nurse asked her to keep a daily diary to help identify her patterns of health and illness, hoping that this might yield information about her condition and give her a sense of control of her health.

Nursing Care of Alice with Levine's Model

Fibromyalgia (FM)—a chronic condition of widespread muscular pain and fatigue—is most commonly diagnosed in women to men at an approximate rate of 20:1 (Bennett, 2010). The symptoms mimic the flu and include muscle aches and pains, stiffness, nausea, insomnia, and fatigue (Bennett, 2003). However, in spite of these symptoms, most individuals with FM will have normal diagnostic studies.

According to Levine (1971a), nursing care focuses on maintenance of wholeness (integrity, oneness) and promotion of adaptation. Alice was open and discussed

what she might be able to do for herself. She was desperate and frustrated because nothing seemed to help her. The continuous pain and fatigue were getting her down. She continued visiting her physician who ordered additional tests to ensure nothing new was causing her pain. In the interim, Alice continued to search for relief. Levine's conservation model directs nurses to involve patients in decisions about their care.

As the nurse entered into a relationship with Alice, she asked Alice to describe her situation. Attention to environmental factors and integrities lead the nurse to ensure the patient's sense of oneness during the initial encounter. Patients may doubt their integrity and come to believe, as Alice does, that they do not have control over their lives, they will not be taken seriously, and their concerns are not perceived as valid (Schaefer, 1995).

Challenges to Alice's Internal Environment

Assessment revealed that Alice had "been treating pains for years." Her diagnostic tests were normal. She reported a history of difficult menstrual periods, premenstrual syndrome (PMS), and migraine headaches. All physiological and pathophysiological aspects of her internal environment were normal.

Challenges to Alice's External Environment

Alice noticed she experienced migraine headaches after eating Italian food and concluded she might be allergic to the sauce. She claimed she felt better since she had begun being more careful. This finding supported Levine's notion that people seek, select, and test information from the environment in the context of their definition of self, thus defending their safety, identity, and purpose (Levine, 1991).

Adaptation to conceptual environment is sometimes threatened by a response that implies the complaints associated with the illness are not valid. Alice was fortunate that her physicians acknowledged her pain; however, family members had difficulty believing something really was wrong. Socially, she thought people viewed her as malingering, and she felt sorry for herself when unable to keep social engagements.

Judgment (Trophicognosis)

Alice was diagnosed with FM, a chronic illness about which little is known. The major problems are fatigue and pain, which threatens the ability to adapt and maintain wholeness. Considering the conservation principles, the nurse helped her adapt in a positive manner and return to a level of perceived wholeness.

Hypotheses

Using the conservation model, the nurse proposes hypotheses about Alice's needs to develop a plan of care with her. The hypotheses might include the following:

- Encouraging combined use of pharmacological and nonpharmacological sleep interventions (relaxation, hot showers) will improve the subjective quality of Alice's sleep and her energy level.
- Losing weight will help reduce Alice's aches and pains.
- Keeping a diary of her symptoms and recording the internal and external environmental challenges to her integrity will improve Alice's understanding of her unique patterns of FM.

- Teaching about the medications Alice can take for FM will help her use pharmacological interventions safely.
- Encouraging open, honest communication will help reduce Alice's anger.
- When Alice feels better and engages in social activities she will feel better about herself.

Nursing Intervention

Energy Conservation

Both emotional stress and management of multiple responsibilities at work and home drained Alice's energy. She elected to work part-time to avoid an environment that seemed unhealthy for her.

Alice recorded in her diary that she frequently had difficulty getting a good night's sleep and noticed the more restless her night, the more pain she experienced in the morning. Sleep improved slightly when she used relaxation tapes to fall asleep. The nurse suggested sleep is often improved by taking a warm bath before bedtime, drinking warm milk at bedtime, and avoiding heavy foods 3 to 4 hours before bedtime. Alice was encouraged to establish a bedtime routine to be practiced daily because routine is critical to these interventions.

When discussing ways to improve Alice's sleep, the nurse reviewed the drugs Alice was taking and their possible effects. It was at that time Alice indicated she had a prescription for an antidepressant but chose not to take it. The nurse informed Alice that the drug frequently helped reduce the severity and frequency of pain and that it takes up to 3 weeks to notice the benefits. She also shared that women have stopped taking the drug because of inability to tolerate side effects. They reviewed the side effects of dry mouth, feeling "hung over," fast pulse rate, and constipation, and the nurse noted that eating a diet with grains and vegetables, taking the medication 1 to 2 hours before bedtime, and drinking 10 glasses of water a day reduce side effects. Alice found that if she took the drug every night she felt much better and had more energy. She subsequently was able to plan social outings without the constant fear that she would have to cancel her plans because of pain and fatigue.

Alice had learned to pace activities when she had a lot to do. This included planning for additional sleep during times of stress (e.g., deadlines at work, illness, menstrual periods). When sleep was not possible, rest and relaxation, such as slow, rhythmic breathing and imagery, were suggested to replenish energy.

Alice was about 10 pounds overweight. She agreed to try to slowly lose some of the weight. Her physician believed that the weight reduction would reduce the strain on Alice's back and help control her aches and pains. Alice had noticed that foods such as tomatoes or spices precipitated her headaches; therefore, she was encouraged to keep a record of foods she ate and her pattern of symptoms.

A subsequent review of Alice's diary, reported experiences, and correlation analysis revealed that weather changes lagged the pain and fatigue by up to 2 days. This helped Alice to realize some pain and fatigue was temporary and decreased as the weather changed. This understanding helped her deal with discomfort in a more positive way, such as getting more rest when challenged by external environmental factors.

Structural Integrity

Alice understood that uncertainty about the symptoms necessitated ruling out other illnesses to ensure appropriate interventions. Because Alice was taking antidepressants, she knew about the possibility of weight gain, dry mucous membranes, and constipation. She needed to eat complex carbohydrates to reduce the hunger associated with increased serotonin levels. Drinking more water and eating a balanced diet may reduce the dryness and constipation. Heart rate changes, associated with some antidepressants, should be reported to the physician or nurse practitioner. She was reassured that alternative medications are available if she is unable to tolerate the prescribed drug. Because she expressed interest in homeopathy, she was warned about herbs and over-the-counter remedies that may be harmful and encouraged not to take them without supervision. She was encouraged to continue taking warm showers in the morning and listening to her tapes at night. Since she admitted having a few alcoholic drinks before bed, she was encouraged to limit herself to two drinks a day and to avoid drinking 3 hours before bedtime.

Personal Integrity

Regaining a sense of selfhood for Alice meant being able to do things around the house and enjoy social events with her husband and family. She expressed satisfaction that she “seemed to be getting better” and could participate in most of her desired activities.

Social Integrity

Alice was encouraged to join a support group. Alice stated it was exciting to be in a support group because she met people who have the same problem, she learned a lot about her illness, she liked interacting with the other members, and she felt good when she attended meetings. Alice is an outgoing person and with her pain under control she has been able to reach out to others in the group. It is important to encourage the patient to communicate openly and honestly. Alice felt that her husband did not understand her illness; he simply tolerated it. This not only made her angry but also gave her cause for concern about their marriage. After Alice attended the support group and shared her positive experience with her husband, she had her first “emotional feeling” talk with him in years and felt good about this.

Organismic Responses

Success of the interventions is measured through the observation of organismic responses. Responses observed in Alice included the following:

- Reduction in reported pain or need for pain control
- Reported improved quality of sleep
- Reported improved ability to anticipate and plan for exacerbations
- Better understanding of illness
- Comfort in sharing of stories
- Reduction in stress
- Reported improved quality of life
- Better communication with her husband
- Increased energy
- Satisfaction because she was feeling better

CRITICAL THINKING EXERCISES

1. Identify a case of interest to you from your clinical practice. Use Levine's conservation model to evaluate the health and health care of the individual from your practice. Consider the medical plan of care, environmental challenges, and organismic responses. Evaluate your use of the model capacity to identify nursing needs of the patient and use of the model as a guide to promote adaptation and maintain wholeness. How did the patient reflect adaptation and wholeness? What questions would you ask to gather that information? Compare your questions with the questions suggested when using Levine's conservation model. What strengths and weaknesses of the model did you observe when using it to guide your thinking?
2. Using the reflection on a patient case in question 1, consider another patient in whom this model would have helped you design care and intervene. Given the nature of the illness, what was needed for the patient to feel well? What were the actual outcomes of that case? How could you have used the conservation model to change or support those outcomes?
3. List the assumptions of Levine's conservation model in one column. Now list your own beliefs for comparison in the next column. Identify the knowledge base of Levine's assumptions and the knowledge base of your own beliefs.
4. For review, select from the references a research article based on Levine's model. Use the following guidelines to direct your review of the study: What variables/concepts were measured, how were they measured, how were the findings explained based on the model, and what implications for practice and research were provided?

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Neuman Systems Model in Nursing Practice

Kathleen M. Flaherty

The philosophic base of the Neuman Systems Model encompasses wholism, a wellness orientation, client perception and motivation, and a dynamic systems perspective of energy and variable interaction with the environment to mitigate possible harm from internal and external stressors, while caregivers and clients form a partnership relationship to negotiate desired outcome goals for optimal health retention, restoration and maintenance.

(Neuman, 2011, p. 12)

History and Background

The Neuman Systems Model was first developed in 1970 to assist graduate students to consider patient needs in wholistic terms (Neuman, 1974, 2011).* “Helping each other live” is Neuman’s basic philosophy (Neuman, 2011, p. 333) and the Neuman Systems Model is a synthesis of systems thinking and wholism that provides a comprehensive systems approach for wellness-focused nursing care. Neuman’s model has been developed and influenced by personal experiences, open systems theories (Lazarus, 1981, 1999; von Bertalanffy, 1968), Selye’s (1950) construct of environmental stressors, holism (Cornu, 1957; de Chardin, 1955), gestalt theories of environment and person interaction (Edelson, 1970), and Caplan’s (1964) concept of prevention interventions, among others (Neuman, 2011).

Neuman developed the current conceptual model over almost four decades (Neuman, 1974, 1980, 1982a, 1989a, 1990, 1995a, 1996, 2002, 2011; Neuman & Young, 1972). Since 1980, a special nursing process format has been developed to facilitate model use in practice, the concept of environment has been expanded and clarified, a distinct spiritual variable has been added and explicated, the use of the term *client* has replaced *patient*, and clarifications of model components

*Portions of the Neuman Systems Model explanation and overview are modified on the basis of Geib (2003).

and relationships among these components have been provided (Neuman, 2011). The most recent publication of the Neuman Systems Model text uses the original diagram and presents the model components within the nursing metaparadigm of person, environment, health, and nursing (Neuman, 2011). This publication also provides guidelines for implementation of the model in clinical practice, nursing research, nursing education, and nursing administration, in addition to current and anticipated future applications (Neuman & Fawcett, 2011). Enhanced understanding of model components—client, reconstitution, and created environment—are provided (de Kuiper, 2011; Gehrling, 2011; Jajic, Andrews, & Jones, 2011; Tarko & Helewka, 2011).

In 1988, Neuman established the Neuman Systems Model Trustees Group to “preserve, protect, and perpetuate” the use of the model (Neuman & Fawcett, 2011, p. 355). The trustees established the Institute for Study of the Neuman Systems Model to provide support in the origination and testing of middle-range theories developed from the model (Neuman & Fawcett, 2011). Nurses continue to test and apply the Neuman Systems Model in nursing research, clinical practice, education, and administration. The utility of the model in each area is evidenced within Neuman’s books (Neuman, 1982b, 1989b, 1995b; Neuman & Fawcett, 2002, 2011). Fawcett compiled a bibliography of Neuman Systems Model applications. Scholars, practitioners, and students can access this bibliography, updated through July 2011 (an ongoing project), at the Neuman Systems Model website (<http://neumansystemsmodel.org>). Recent literature describes use of the Neuman Systems Model in research and praxis in a variety of applications. Some of these treatments include use of the model for evidence-based practice development (Breckenridge, 2011); Merks, Verbeck, de Kuiper, et al., 2012), promoting student coping and success (Das, Nayak, & Margaret, 2011; Pines, Rauschhuber, Norgan, et al., 2012; Yarcheski, Mahon, Yarcheski, et al., 2010), family participation in critical care (Black, Boore, & Parahoo, 2011), spirituality in adults (Cobb, 2012; Lowry, 2012), nurse stress in emergency care (Lavoie, Talbot, & Mathieu, 2011), and application in nursing administration (Shambaugh, Neuman & Fawcett, 2011).

Neuman considers “client” to be an individual, a group, a family, or a community system. Each client is viewed with five variables that interact synergistically in relation to each other and reciprocally with the internal, external, and created environments in which the client exists. The five client variables essential to the Neuman model are physiological, psychological, developmental, sociocultural, and spiritual. Intrapersonal, interpersonal, or extrapersonal environmental stressors can affect potential or actual reactions within the client system.

A continuum of increasing wellness to increasing illness, and even death, is the basis by which wellness is understood. Whenever the system has more energy stored than needed, the client is considered within the range of wellness. Conversely, whenever system energy depletion occurs, variances from wellness (illness) are exhibited in clients. In the Neuman model, optimal system stability is the greatest degree of client wellness. Consequently, the major goal of nursing is to assist the client in achieving system stability through the attainment, retention, and maintenance of optimum health. Accordingly, it is the nurse who creates the connections among the client, environment, health, and nursing that lead to system

stability. Nurses practicing according to the Neuman model promote system stability through primary, secondary, or tertiary prevention-as-interventions.

Client system stability is significantly affected by clients' perceptions that in turn have a significant effect on the increase or decrease in energy available to them. Therefore, if the nurse is to facilitate energy use in wellness promotion, accurate appreciation of the client's perception of the health care situation is essential (Neuman, 2011).

Neuman uses the term *wholism* to reference biological and philosophical concepts "implying relationships and processes arising from wholeness, dynamic freedom, and creativity in adjusting to stressors in the internal and external environments" (Neuman, 2011, p. 10). The Neuman Systems Model incorporates the structure and process components of open systems models (Sohier, 2002). Such incorporation of open systems models to her conceptual framework is demonstrated by Neuman's technical use of the word *wholism* as opposed to *holism*. The "homologous" (Neuman, 2011, p. 9) nature of open systems, the model and nursing concepts empowers the nurse using the Neuman Systems Model to fulfill two concurrent responsibilities inherent to the model. First, Neuman's emphasis on wholism motivates nurses to view the client as an interrelated whole different from and greater than the sum of the parts. Second, nurses using the Neuman model are able to focus on a particular subpart of a client situation without neglecting the interrelatedness of the system.

Overview of Neuman Systems Model

The aim of the Neuman model "is to set forth a structure that depicts the parts and subparts and their interrelationship for the whole of the client as a complete system" (Neuman, 2011, p. 12). As depicted in Figure 11-1, and beginning from the center of the figure, the Neuman model identifies a basic structure of energy resources, variables, system boundaries, and the environment as the core subparts of the system.

At the core of the diagram, energy resources are noted. A constant energy exchange occurs between the client system and environment. The client maintains and augments system stability by using energy, regarded as a positive force available to the system. As such, stability is not static but adaptive and developmental in nature because the client system is considered an open system in a state of constant change.

A series of protective rings encircle the center structure and protect the system from environmental stressors. Each system component is intersected by five variables (physiological, psychological, sociocultural, developmental, and spiritual). These five variables interact synergistically and wholistically within all parts of the client system (Neuman, 2011).

As noted, Neuman considers "client" to be an individual, a group, a family, or a community system. Accordingly, the substance of each of the five variables depends on which client system is being considered. For example, the physiological variable is defined as "body structure and internal function" (Neuman, 2011, p. 16). Therefore, circulation could be considered a physiological variable for an

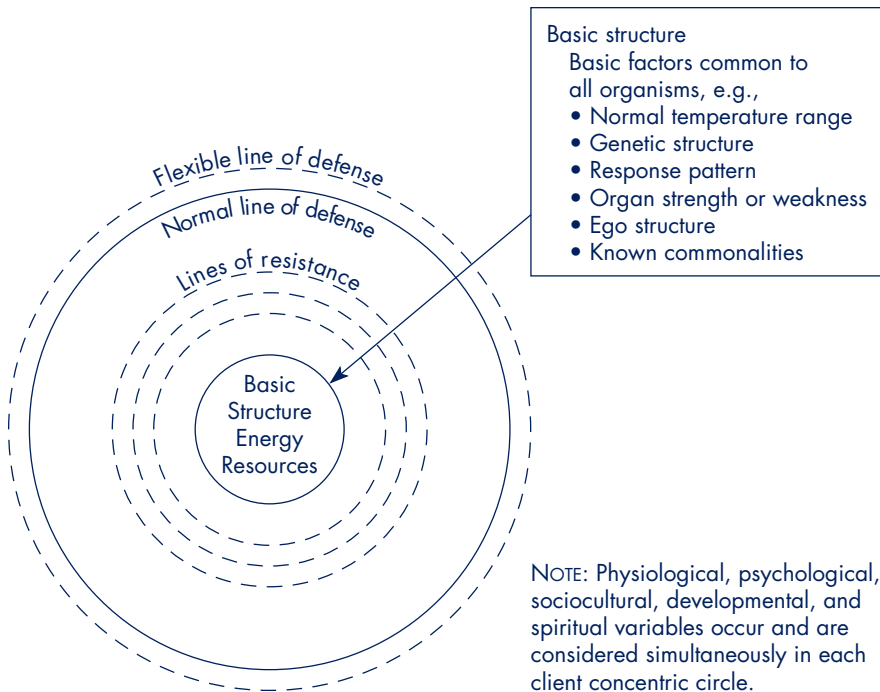


FIGURE 11-1

The Neuman Systems Model. (From Neuman, B., & Fawcett, J. [2011]. *The Neuman Systems Model* [5th ed., p. 15]. Boston: Pearson.)

individual. Objective data that reflect the physiological variable of circulation would include vital signs, peripheral pulses, and heart sounds. However, for a community system, the physiological variable could include vital statistics, morbidity, mortality, and general environmental health (Hassell, 1998, Jajic, et al., 2011). Psychological variables include “mental processes and interactive environmental effects...” (Neuman, 2011, p. 16). For example, self-esteem and its effect on relationships for the individual and communication patterns for a family could be considered components of the psychological variable. The developmental variable refers to life developmental processes and/or developmental tasks that relate to life changes (e.g., individual adjustment to aging parents or “empty nest syndrome” for a couple). The combination of social and cultural functions or influences defines the sociocultural variable. Both ethnic cultural practices and health belief practices are examples and important components of this variable regardless of how the client system is defined. Client belief influence is exhibited in the spiritual variable. As an example, spiritual factors could include a person’s worldview and perceived sources of strength or hope, or the predominant religious culture of a community system (Hassell, 1998). Neuman proposes each of these five variables as system subparts that are open, with energy exchange existing within and between the client system and the environment (Neuman, 2011). As noted in Figure 11-1, these five variables are considered simultaneous influences on the system.

At the center of the diagram is the client's basic structure composed of energy resources that Neuman calls "survival factors" (Neuman, 2011, p. 16). Within the basic core, the five interacting variables (physiological, psychological, developmental, sociocultural, and spiritual) contain commonly known norms (Neuman, 2011). For example, the individual as client possesses common resources such as organ structure and function, mental status, and coping mechanisms that are integral to core system stability. Alternatively, the client as family has a basic structure that includes specific roles, attitudes, and cultural beliefs that provide energy resources and stability.

Lines of resistance protect the client's basic structure. These are defenses activated by the client when internal or external environmental factors stress the client system. Broken lines that circle the basic structure diagrammatically represent these lines of resistance. The internal immune system is an example of a physiological variable activated within the lines of resistance when infection invades an individual. The client system restabilizes for wellness/energy conservation (restitution) whenever these lines of resistance effectively mobilize internal and external resources. Energy depletion and ultimately death occur whenever the lines of resistance are ineffective (Neuman, 2011). Ineffective lines of resistance can be seen when an individual has had extensive chemotherapy (an external stressor), with the result of the immune system being severely compromised. This compromise of the immune system is an example of system energy depletion. Mobilization of external resources (transfusion) helps the client's internal resources and strengthens the lines of resistance. The outcome of these added external resources is a more physiologically stable client.

Neuman regards the normal line of defense as the usual or standard client level of wellness that protects the basic structure as the client system reacts to stressors. A solid line that circles the lines of resistance and basic structure represents this protection. The standard level of wellness is achieved by the interaction of the five variables over time. Clients' usual level of wellness (the normal line of defense) is maintained, increased, or decreased as stressed clients react to a stressor encounter (Neuman, 2011).

The normal line of defense is encircled by the flexible line of defense, represented by broken lines that suggest the constant interaction of the environment and the open nature of the system. The flexible line of defense expands and contracts depending on the protection available to the client at any point in time. For example, healthy lifestyles and effective coping mechanisms function as possible expanders of the flexible line of defense. Stressors may invade the client/client system but are buffered by this line, thereby freeing clients from reactions to those stressors. The protection of the client system is proportionate to the distance between the flexible line of defense and the normal line of defense (Neuman, 2011).

Neuman has clarified and expanded the concept of environment to include three discrete yet interactive environments that influence the system. Neuman's most recent publication (2011) describes how the internal and external factors that interact with the client/client system are considered part of the environment. The intrapersonal environment is the *internal environment* that includes influences within the system. The *external environment* is considered both interpersonal and

extrapersonal in nature. The *created environment* is the third distinct aspect of Neuman's construct of environment. Neuman describes this created environment as unconsciously developed by the client system and as "a symbolic expression of system wholeness" as it mobilizes all system components towards wellness (Neuman, 1989, p. 32; 2011, p. 20).

The maintenance of purposeful system stability involves constant energy interchange with the internal, external, and created environments. The manner in which the individual client processes a life event such as pain is based on past experiences with pain. This is an example of the interaction of internal, external, and created environments. The client's past experiences with pain and the elicited coping mechanisms and outcomes result in the creation of a perceptual reality for the interpretation of the current situation. This created perceptual reality (created environment) influences the client's response to the painful situation (de Kuiper, 2011).

Client system stability can be affected by internal or external environmental factors, which Neuman defines as *stressors*. Neuman considers the effect of these stressors, whether they are positive or negative, to be dependent on the client's perception of the stressor. When stressors penetrate the flexible and normal lines of defense and the lines of resistance are activated, energy depletion and system instability occur. However, system stability may be maintained when stressors are deflected or modulated by the interaction of the five system variables within the flexible and normal lines of defense and the lines of resistance (Neuman, 2011).

Stressors that can influence client system stability are classified in three ways: intrapersonal, interpersonal, and extrapersonal. First, internal stressors that occur within the client system boundary are classified as *intrapersonal*. Atherosclerosis and resultant hypertension are examples of an individual client's intrapersonal stressors. Second, stressors that occur in the external environment outside but proximal to the client system boundaries are classified as *interpersonal*. The individual client's role in the family, perceptions of caregiver, and friend relationships are examples of these forces. Third, *extrapersonal* stressors are those that occur distally to the client boundary. Community resources, financial status, and employment of the individual client are examples of extrapersonal stressors. Because of the complexity of human beings, all three stressors may be exhibited in clients and observed by nurses in any nursing situation (Neuman, 2011).

Application of the Neuman Systems Model in nursing praxis can occur in any setting. In each nursing situation, the nurse completes a wholistic assessment of actual or potential stressors, client variables, and boundary impact. The nurse determines the client's perspective before the analysis and synthesis of the objective and subject data collection. In addition, client strengths, weaknesses, and resources are considered.

Identification and differentiation of both nurse and client perceptions in the health care situation are required by the Neuman Systems Model. This requirement is rooted in the understanding that client stability and optimal health outcomes can be compromised by incongruities between nurse and client perceptions. These incongruities can be avoided by developing a partnership between the nurse and the client, with care based on their complementary perceptual understandings. The result of such a complementary partnership is joint planning of care based on goal

clarification. Because perception can influence client response and resistance to a stressor, resolving the potential perceptual differences for nurses and clients is essential within the Neuman model. Neuman has provided a formalized nursing process that includes specific subjective data gathering about the client perspective (Neuman, 2011). Once data collection is complete, the nurse analyzes and synthesizes the data and in conjunction with the client determines nursing diagnoses, goals, outcomes, and interventions.

There are three different intervention modalities or nursing actions specific to the actual or potential stressor response from the client system described by Neuman. These interventions are dynamic and cyclical in nature and are labeled as *primary*, *secondary*, and *tertiary prevention-as-interventions*. Nurses may use the three intervention modalities concurrently to achieve a synergistic effect. Optimal client wellness or system stability is the ultimate goal of these three interventions. Primary interventions retain, secondary interventions attain, and tertiary interventions maintain system energy (Neuman, 2011).

Before the client system reacts to stressors and to prevent a stressor invasion, nursing actions should be implemented as primary prevention interventions to strengthen the flexible line of defense. This preemptive nursing act promotes the retention of client system wellness (Neuman, 2011). Nursing actions such as instituting a wellness program that integrates healthy nutrition and exercise would be an example of primary prevention-as-intervention.

Nursing actions necessary for the client system to attain restabilization (reconstitution) through energy conservation and the use of internal and external resources are considered secondary preventions. These interventions protect the basic structure of the system. The nurse implements secondary prevention actions whenever stressor reactions occur and symptoms are present. Symptom treatment of hypertension is an example of secondary intervention. Dynamic system stability is achieved and the basic structure is protected whenever the lines of resistance are strengthened. “Reconstitution may be viewed as feedback from the input and output of secondary intervention” (Neuman, 2011, p. 29). If secondary preventions are not successful in reconstituting client system energy to counterbalance system reaction, death can occur (Neuman, 2011).

After a therapeutic modality and reconstitution, the maintenance of client system stability is achieved by tertiary prevention-as-interventions (Neuman, 2011). Nursing actions such as education and reinforcement about nutrition, exercise, and medications that can maintain the reconstitution of the client with hypertension are examples of tertiary prevention. Applications of the Neuman Nursing Process Format to specific client situations are provided later in this chapter.

Critical Thinking in Nursing Practice with Neuman’s Model

The Neuman Systems Model provides a structure for critical thinking in several ways. As a systems-based model, conceptualization of clinical nursing phenomena can be approached holistically while appreciating the interaction of the part and subpart components of the system that adapt synergistically and developmentally to promote system persistence (Fawcett, 2005; Neuman, 2002). In addition, this

systems-based model allows for reconceptualization when clinical situations undergo rapid change. In such rapid change situations, the Neuman Systems Model allows for the identification of interrelationships between identified systems, parts, subparts, and the environment, leading to consequent and rational nursing actions. Therefore, this conceptualization of nursing phenomena promotes efficacious critical thinking processes such as application, analysis, synthesis, and evaluation. The Neuman Systems Model nursing process categories of nursing diagnoses, nursing goals, and nursing outcomes create a format for purposeful critical thinking and problem solving that translates to action (Freese, Neuman, & Fawcett, 2002; Freiburger, 2011).

Freese and colleagues (2002) identify guidelines for Neuman Systems Model-based clinical practice using Neuman's Nursing Process Format. These guidelines include the process of praxis, diagnostic taxonomy, typology of clinical interventions, and typology of outcomes (p. 38). The Neuman Systems Model-based clinical practice guidelines are congruent with the current standards of nursing practice articulated by the American Nurses Association (2004) as the nursing process. Both depictions of the nursing process are construed as iterative and overlapping sub-processes of thought rather than a linear process. Table 11-1 presents the relationship between critical thinking and the Neuman Systems Model nursing process.

Comprehensive assessment based on the Neuman Systems Model requires a conceptualization of each model component (client perspective, variables, basic structure, environmental stressors, and boundaries) by the nurse and is essential to determine current client status accurately. The nurse-client relationship begins at first contact and is conceived as an ongoing partnership between the nurse and client. Through this partnership, the nurse purposefully discovers the client's perspective and resolves any perceptual discrepancies between the nurse and client. Maintenance of this relationship throughout each phase of the nursing process requires reflective, thoughtful, interactive communication by the nurse. Systematic data collection that considers the potential or actual effect of environmental stressors on the client system is accomplished through interview and physical assessment (Neuman, 2011).

The Neuman Systems Model guidelines give a framework for the development of comprehensive diagnoses, determination of appropriate interventions, and evaluation of outcomes. For example, the nurse-client partnership identifies a stressor that may penetrate the flexible line of defense and lead to a variance from wellness. The nurse considers the application of relevant nursing and related theories and in conjunction with the client develops diagnoses, interventions, and goals to prevent or ameliorate stressor impact on the client system. Logical outcomes are then formulated to measure client system reconstitution (Neuman, 2011).

Neuman directs the nurse to use model concepts for the determination of nursing diagnoses (Neuman, 2011). Authors have suggested several approaches to this application. Ziegler (1982) describes a taxonomy derived from the Neuman model. Newman (2002) further adapted this taxonomy to include evolutionary model changes (Freese, et al., 2002; Russell, 2002). Neuman and Martin (1998) suggest that the Neuman Systems Model and the Omaha System are complementary. Others have used the Neuman Systems Model and the North American Nursing

TABLE 11-1 Critical Thinking and the Neuman Systems Model Nursing Process

| Critical Thinking Focus | Neuman Systems Model Nursing Process | Nurse-Client Partnership Relationship |
|---|--|---|
| Conceptualization Analysis Observation Experience Reflection Communication | <p>Nursing Diagnosis:</p> <ul style="list-style-type: none"> • Assessment of physiological, psychological, developmental, sociocultural, spiritual variable interactions for the following components: <ul style="list-style-type: none"> • Basic structure and function, strengths, and resources • Potential or actual environmental stressors (intrapersonal, interpersonal, extrapersonal) to include major areas of stress, changes in patterns of living, previous coping patterns, current coping behaviors, anticipated consequences and expectations for self, from health care system and others • Characteristics of client’s flexible and normal lines of defense, lines of resistance, degree of potential or actual reaction, and reconstitution | Interview, physical examination, and diagnoses by nurse occur with ongoing partnership and validation by client and resolution of any perceptual discrepancies between nurse and client. |
| Synthesis Reasoning Communication | <p>Variances from wellness are identified; applicable nursing and applied theories are appraised</p> <p>Diagnoses are identified based on data from client system, level of system or subpart response, variables, stressor source, and/or type of stressor and then prioritized</p> | |
| Synthesis Reasoning Communication | <p>Nursing Goals:</p> <p>Nurse develops specific outcome goals and primary, secondary, tertiary prevention-as-intervention modalities based on related factors, client perceptions, and resources to promote optimal system stability</p> | Outcome goals and nursing interventions are developed in ongoing partnership and validation by client with resolution of any perceptual discrepancies between nurse and client. |
| Synthesis, analysis, and evaluation Observation Reflection Communication | <p>Nursing Outcomes:</p> <p>Nurse implements primary, secondary, tertiary prevention-as-intervention modalities and evaluates and modifies outcomes based on client system stability</p> | Implementation and evaluation of prevention-as-intervention modalities and perceived efficacy is processed in partnership and with validation by client. Resolution of any perceptual discrepancies between nurse and client and necessary modifications in plan of care are implemented. |

Data from Fawcett, J. (2005). Neuman’s systems model. In *Contemporary nursing knowledge: Analysis and evaluation of nursing models and theories* (2nd ed.), Philadelphia: F. A. Davis; Freese, B. T., Neuman, B., & Fawcett, J. (2002). Guidelines for Neuman systems model–based clinical practice. In B. Neuman & J. Fawcett (Eds.), *The Neuman systems model* (4th ed., pp. 37-42). Upper Saddle River, NJ: Prentice Hall; Neuman, B. (2011). The Neuman systems model. In B. Neuman & J. Fawcett (Eds.), *The Neuman systems model* (5th ed., pp. 3-33; 338-348). Upper Saddle River, NJ: Prentice Hall; Paul, R. W., & Elder, L. (2002). *Critical thinking: Tools for taking charge of your professional & personal life*. Upper Saddle River, NJ: Prentice Hall.

Diagnosis Association (NANDA–International, 2007) diagnostic taxonomy linking model concepts and nursing diagnoses (Gigliotti, 1998, 2002; McHolm & Geib, 1998). Although Neuman (2011) cautioned lack of congruency between the model and the NANDA nomenclature, earlier Neuman guidelines for use of the model in clinical practice stipulated that the diagnostic taxonomy reflected the model in the following categories: (1) client system (individual, family, group, community); (2) response level (primary, secondary, tertiary); (3) subsystem response (five variables); (4) stressor source (intrasystem, intersystem, extrasystem); and (5) stressor type (five variables) (Freese, et al., 2002, p. 38). It seems clear that the synthetic use of the Neuman Systems Model and nursing process facilitates enhanced critical thinking by the nurse.

CASE HISTORY OF DEBBIE

Debbie is a 29-year-old woman who was recently admitted to the oncology nursing unit for evaluation after sensing pelvic “fullness” and noticing a watery, foul-smelling vaginal discharge. A Papanicolaou smear revealed class V cervical cancer. She was found to have a stage II squamous cell carcinoma of the cervix and underwent a radical hysterectomy with bilateral salpingo-oophorectomy.

Her past health history revealed that physical examinations had been infrequent. She also reported that she had not performed breast self-examination. She is 5 feet, 4 inches tall and weighs 89 pounds. Her usual weight is about 110 pounds. She has smoked approximately two packs of cigarettes a day for the past 16 years. She is gravida 2, para 2. Her first pregnancy was at age 16, and her second was at age 18. Since that time, she has taken oral contraceptives on a regular basis.

Debbie completed the eighth grade. She is married and lives with her husband and her two children in her mother’s home, which she describes as less than sanitary. Her husband is unemployed. She describes him as emotionally distant and abusive at times.

She has done well following surgery except for being unable to completely empty her urinary bladder. She is having continued postoperative pain and nausea. It will be necessary for her to perform intermittent self-catheterization at home. Her medications are (1) an antibiotic, (2) an analgesic as needed for pain, and (3) an antiemetic as needed for nausea. In addition, she will be receiving radiation therapy on an outpatient basis.

Debbie is extremely tearful. She expresses great concern over her future and the future of her two children. She believes that this illness is a punishment for her past life.

Nursing Care of Debbie with Neuman’s Model

Table 11-2 presents an application of the Neuman Systems Model to the care of Debbie. As stated, the nurse-client relationship is paramount to determine wholistic client needs accurately (Neuman, 2011). Although the case study

TABLE 11-2 Application of the Neuman Systems Model to the Care of Debbie

| Model Component | Application to Debbie |
|---------------------------|---|
| Nurse-client relationship | Mutual partnership has been developed during initial assessment. Nurse perceives physiological stressors as being very important. However, Debbie's perceptions of her psychological, developmental, sociocultural, and spiritual stressors may be most important to her. Throughout process of care planning, nurse assesses for possible discrepancies in perceptions. |
| Physiological | Stressors <i>Intrapersonal:</i> Cancer, radiation therapy planned, nausea, pain, urinary retention, weight loss, smokes, compromised immune system, new medications <i>Interpersonal:</i> Self-catheterization <i>Extrapersonal:</i> Effect of situational stress (finances, home situation) on system |
| Psychological | Stressors <i>Intrapersonal:</i> Fear of future, crying <i>Interpersonal:</i> Fear about children's future, lack of support from husband, relationship with mother <i>Extrapersonal:</i> No mention of additional emotional support |
| Developmental | Stressors <i>Intrapersonal:</i> 29-year-old female, 2 children, first pregnancy at 16 years of age <i>Interpersonal:</i> Mother of one teen (13), one preteen (11), questionable unmet relational intimacy needs <i>Extrapersonal:</i> No mention of friends at same life stage |
| Sociocultural | Stressors <i>Intrapersonal:</i> Eighth-grade education, fear of smoking effects <i>Interpersonal:</i> At times abusive, unsupportive husband <i>Extrapersonal:</i> Husband unemployed, lives with mother, limited income, unsanitary environment |
| Spiritual | Stressors <i>Intrapersonal:</i> Fears illness is punishment <i>Interpersonal:</i> No mention of assistance in processing current situation <i>Extrapersonal:</i> No mention of congregational support |
| Affected boundaries | Debbie's flexible and normal lines of defense have been penetrated, and her lines of resistance have been activated. Thus all secondary and tertiary modes of prevention-as-interventions will be implemented to meet her needs. In addition, family members' flexible line of defense enhancement will be evaluated. |
| Nursing process | Nursing Diagnoses Deficient Knowledge (new medication regimen, planned radiation therapy, postoperative symptom management, self-catheterization, lifestyle changes) related to lack of exposure Fear related to unknown future, "punishment" Interrupted Family Processes related to shift in health status, developmental and situational crises, family economics Nursing Goals Promote wellness and sense of control over life events through education and open family communication Nursing Outcomes Debbie's reaction to prevention-as-interventions is evaluated for level of flexible line of defense enhancement, reconstitution of normal line of defense, and needed goal reformulation |

TABLE 11-2 Application of the Neuman Systems Model to the Care of Debbie—cont'd

| Model Component | Application to Debbie |
|--|---|
| Examples of prevention-as-interventions for identified stressors | <i>Primary prevention:</i> |
| | Teach children about smoking and cancer |
| | <i>Secondary prevention:</i> |
| | Teach about medications, postoperative symptom management |
| | Teach clean-technique self-catheterization |
| | Provide for nutritious meals |
| | Teach husband about Debbie's illness |
| | Explore counseling between Debbie and husband |
| | <i>Tertiary prevention:</i> |
| | Teach breast self-examination |
| | Establish cancer support group connections |
| | Provide support for smoking cessation |
| | Explore means to reduce fear of "punishment" |
| Referral to home health agency, social services | |

Data from North American Nursing Diagnosis Association (NANDA-International). (2012). *Nursing diagnoses: Definitions & classification 2012-2014*. Philadelphia: NANDA-International; Newman, D. M. (2005). Complex patient needs? Nursing models can help! *Journal of Christian Nursing* 22(1), 33.

presents some information about Debbie and her situation, gathering further data about client strengths, resources, and interpersonal relationships would be necessary. Stressor occurrences at the system boundaries (e.g., between Debbie and her children, husband, and mother) could cause family system disequilibrium. In addition, needed information about strengths and resources could provide support to client/client family system stability. For example, if Debbie is interested in spiritual matters and has contacts with a local congregation, her flexible line of defense could be strengthened by her beliefs and congregational support. Neuman provides possible questions to obtain the client's perception of major stress areas, changes in patterns of living, previous coping patterns, and current coping behaviors as well as the client's anticipated consequences and expectations in the current situation (Neuman, 2011). Therefore, the nurse informed by the Neuman Systems Model would extend and clarify the assessment data. Answers to each of these questions help contribute to a wholistic database that identifies the perceptions of both the client and the nurse. This type of wholistic database is a hallmark of the Neuman model.

Debbie and Neuman's Nursing Process Format

Neuman describes the importance of conceptualizing the client as an open, wholistic system because "the various interrelationships of the parts and subparts must be appropriately identified and analyzed before relevant nursing action can be taken" (Neuman, 2011, p. 10). Once Debbie's stressors, strengths, and resources are identified, the nurse can analyze the data, identify what system boundaries were affected, and prioritize nursing diagnoses. For example, assessment data may reveal multiple new stressors within Debbie's physiological variable that she has never before experienced and are related to her medical diagnosis of cervical cancer. Using the

Neuman Systems Model, the nurse would recognize that the wholistic nursing focus should be Debbie's ongoing responses to her life changes, not her disease. Debbie's acute need for information, her expressed fears regarding her children and future, and the interrupted family processes in a previously tenuous family situation have penetrated her already compromised flexible line of defense and invaded her normal line of defense (usual state of health). The assessment data reveal that these strong interpersonal and intrapersonal stressors have already penetrated Debbie's lines of resistance. However, this analysis would be tentative until confirmation of client perception is made and the nurse-client partnership agrees on Debbie's needs and the priority of proposed prevention-as-interventions. For example, the nurse's priority might be to first implement nursing interventions to address Debbie's knowledge deficit. However, if Debbie's external environmental stressor of family relationship needs precludes her from learning because she is so concerned about her children, then her interpersonal needs would become a priority.

Table 11-2 presents several broad nursing diagnoses that depict Debbie's intrapersonal and interpersonal stressors, followed by resultant nursing goals and outcomes. Although Debbie's health situation is serious, Neuman's model would suggest the hope that Debbie can develop system stability through energy input. Therefore, nursing interventions derived from the nursing diagnoses-related factors would be focused on supporting the lines of resistance and enhancing the flexible line of defense. Secondary nursing interventions would be developed to support Debbie's lines of resistance within each of the five variables. Tertiary nursing interventions would be developed to strengthen her flexible line of defense, to assist reconstitution of her normal line of defense, and to promote optimal wellness. The nurse would also consider the importance of the setting (environment) of the nursing care. If the initial contact were in an acute care facility, the focus would include discharge and referral for seamless care. If the contact were in an outpatient or home health care setting, the nursing actions would be accordingly modified. In either case, the whole family must be considered in the plan of care. Informed use of the Neuman Systems Model easily facilitates such wholistic considerations and strategic primary, secondary, and tertiary prevention-as-interventions.

CASE HISTORY OF MARY

Mary is a 76-year-old woman who has been widowed for 10 years. She completed her high school general equivalency degree (GED) and worked in a paint factory for many years. She lives on a fixed income in a retirement community. Her only health insurance is Medicare. She drives her own car for short distances and has several female friends from the community with whom she plays cards once a week. Mary attends a nearby Catholic parish. She has a married daughter who lives in the same town and drops by to check on her almost every day. Mary has a medical history of chronic obstructive pulmonary disease (COPD), hypertension, obesity, and episodic depression that dates back more than a decade since her husband died. She smoked two packs of cigarettes a day until 6 years ago, when she had an

CASE HISTORY OF MARY—cont'd

emergency endarterectomy. She has had two hospital admissions for compromised pulmonary function in the past 2 years. Mary dislikes taking medications but does take a prescribed antihypertensive and diuretic.

Mary was admitted to the hospital with vague aches and pains in the chest region. She had these symptoms for approximately 12 hours and spoke with several friends and her daughter about her discomfort before she decided to call the physician. She was diagnosed with angina in the emergency department and, after further evaluation, had an immediate percutaneous transluminal coronary angioplasty (PTCA). She was being monitored in the cardiac step-down unit; her vascular sheaths were removed, and discharge the next day was pending. She mentioned to the nurse that her food seemed tasteless and she felt tired. Mary had many questions about her newly prescribed medications, including whether they were really necessary, and also wondered whether she would be able to drive and be as active as before the hospitalization. She had visits from her priest and daughter, as well as phone calls from friends.

However, overnight Mary becomes increasingly dyspneic and edematous. Her chest x-ray shows mild cardiac enlargement and pulmonary atelectasis and infiltrates. Her cardiac status remains stable. The physician prescribes bilevel positive airway pressure (bi-PAP) treatments. Mary is extremely apprehensive about the treatments and after 10 minutes pulls the mask off her face. After several futile attempts to take the bi-PAP treatments, Mary tells the nurse that her daughter will not like what “they” are doing to her and asserts that she does not want to have any tubes placed in her throat. Mary also tells the nurse that she just wants to go home because she thinks she might die in the hospital. Her dyspnea is increasing, and her oxygen saturation is quickly falling. The nurse anticipates Mary’s possible transfer to the intensive care unit.

Nursing Care of Mary with Neuman’s Model

As stated, application of the Neuman Systems Model in nursing praxis enhances conceptual flexibility in rapidly changing situations. Initially, Mary’s admission and planned discharge seemed a relatively predictable event. However, with the changes Mary is experiencing, the nursing care must also change. The following is a chronological flow of the critical thinking that would be employed by the nurse who is applying the Neuman Systems Model in a rapidly changing situation. An overview of the Neuman Nursing Process Format for Mary is provided in Table 11-3.

Mary’s Care and Neuman’s Nursing Process Format

Before Mary’s acute change in status, the nurse partnered with Mary to ascertain both present and future concerns. The nurse and Mary developed rapport and began

TABLE 11-3 Application of the Neuman Systems Model to the Care of Mary

| Model Component | Application to Mary |
|---------------------------|---|
| Nurse-client relationship | <p>Mutual partnership has been developed during initial and ongoing assessment. Nurse perceives physiological stressors as a priority to prevent further energy depletion but recognizes importance of effect of Mary's perceptions of her psychological, developmental, sociocultural, and spiritual stressors on her status. Synthesis of ongoing assessment data provides nurse meaningful information to create wholistically effective care. Throughout process of care planning, nurse assesses for possible discrepancies in nurse-client perceptions.</p> |
| Physiological | <p>Stressors <i>Intrapersonal:</i> Post-PTCA, hypertension, COPD, obesity, feels tired, episodic depression, dyspneic, edematous, ventilation-perfusion imbalance, chest x-ray pathology, cardiac status stable, new medications <i>Interpersonal:</i> States diet is "tasteless," pulls off bi-PAP mask <i>Extrapersonal:</i> Effect of situational stress (pathology, current fears, future concerns, discharge) on physiological system</p> |
| Psychological | <p>Stressors <i>Intrapersonal:</i> Feels claustrophobic on bi-PAP mask, fear of death, future lifestyle changes, states that she wants to go home <i>Interpersonal:</i> Asks for daughter, possible dysfunctional grieving for loss of husband <i>Extrapersonal:</i> Physical separation from support systems while hospitalized</p> |
| Developmental | <p>Stressors <i>Intrapersonal:</i> 76 years old, high school GED completion because education is important, asks if she is going to die <i>Interpersonal:</i> Widow of 10 years, 1 married adult child, generativity vs. stagnation issues <i>Extrapersonal:</i> Possible loss of autonomy in relationships</p> |
| Sociocultural | <p>Stressors <i>Intrapersonal:</i> Retired factory worker <i>Interpersonal:</i> Frequent interaction with daughter, telephone calls from friends while in hospital, weekly social activities <i>Extrapersonal:</i> Fixed income, Medicare, lives in retirement community, drives self short distances</p> |
| Spiritual | <p>Stressors <i>Intrapersonal:</i> Finds meaning in attending church, speaks of God and prayer <i>Interpersonal:</i> Active in local parish, priest involved <i>Extrapersonal:</i> Unknown future transportation needs</p> |
| Affected boundaries | <p>Mary's flexible and normal lines of defense have been penetrated, and her lines of resistance have been activated. If prevention interventions are not effective, system disequilibrium will cause death. Thus secondary interventions will be implemented to strengthen her lines of resistance and tertiary interventions will be implemented to strengthen her flexible line of defense.</p> |

TABLE 11-3 Application of the Neuman Systems Model to the Care of Mary—cont'd

| Model Component | Application to Mary |
|--|---|
| Nursing process | <p>Nursing Diagnoses</p> <p>Fear related to sensory impairment (ventilation-perfusion imbalance), hospital procedures, separation from support system, acute health changes*</p> <p>Impaired Gas Exchange related to ventilation-perfusion imbalance, feelings of claustrophobia (mask removal)*</p> <p>Risk for Decreased Cardiac Output related to increased pulmonary vascular resistance (altered afterload)*</p> <p>Deficient Knowledge (new medication regimen, lifestyle changes) related to lack of exposure</p> <p>Risk for Spiritual Distress (unknown future, periods of depression, possible unresolved grief)</p> <p>Risk for Activity Intolerance (cardiovascular and oxygenation status)</p> <p>Nursing Goals</p> <p>Promote reconstitution (ventilation-perfusion balance) and sense of control over life events through prescriptions, education, lifestyle changes, and spiritual support to attain highest level functioning</p> <p>Nursing Outcomes</p> <p>Mary's reaction to prevention-as-interventions is evaluated for level of reconstitution of normal line of defense stability, enhancement of flexible line of defense, and needed goal reformulation</p> |
| Examples of prevention-as-interventions for identified stressors | <p><i>Secondary prevention:</i></p> <p>Monitor and intervene for cardiac dysrhythmias, vital signs, PTCA site bleeding, blood laboratory results, and oxygenation</p> <p>Teach about medications, importance of needed lifestyle changes</p> <p>Explore family-friend support during immediate discharge</p> <p>Support spirituality</p> <p><i>Tertiary prevention:</i></p> <p>Contact priest and support spirituality</p> <p>Reinforce teaching</p> <p>Referrals to cardiac-pulmonary rehabilitation, social services for possible visiting nurse support, registered dietitian for heart-healthy diet and weight-loss planning, resource for depression evaluation, and parish nurse for discharge plan and follow-up</p> |

*Data from Mosca, L. et al. (2011). Effectiveness-based guidelines for cardiovascular disease prevention in women: 2011 update (AHA Guidelines), *Circulation*, 123, 1243-1262; North American Nursing Diagnosis Association (NANDA-International). (2012). *Nursing diagnoses: Definitions & classification 2012-2014*. Philadelphia: NANDA-International; Newman, D. M. (2005). Complex patient needs? Nursing models can help! *Journal of Christian Nursing*, 22(1), 33.

to address each other on a first-name basis. The nurse assessed the client in each variable for Mary's intrapersonal, interpersonal, and extrapersonal stressors. After gathering assessment data in each of the five variables, the nurse focused on the physiological variable while wholistically conceptualizing the interrelationships important for a client experiencing cardiac disease. This dual perspective of wholism and subpart kept the nurse from neglecting a wholistic view of the client and minimizing the importance of the client's perspective. While spending time with Mary, the nurse used the Neuman system to assess Mary's personal perception of potential

or actual stressors. The nurse asked questions to determine Mary's primary concerns. Mary spoke about her new diet and how she felt tired. Mary stated concerns about whether she would be able to continue to drive, meet with friends, and go to church. She also spoke about how she did not like to take medicine and wondered whether all the medications were necessary. The nurse also explored how Mary had handled the stress of her husband's death and created an independent life. Mary talked about how, even after 10 years, she would sometimes hear his voice or think that she had seen her husband. The nurse asked Mary what she would do when these things happened, and Mary said that she would sometimes cry but that usually she would ask God to help her, although at times she would just wish to go "home." When the nurse asked what Mary anticipated would happen when she returned to the retirement community, Mary said, "I don't know, I guess that I will do the best I can."

The nurse recognized that the physiological cardiopulmonary and nutritional stressors and Mary's episodic depression had penetrated Mary's flexible and normal lines of defense. The nurse then reflected on the data and current research about women and cardiovascular disease. The nurse remembered that, as in Mary's case, women tend to delay seeking treatment for symptoms of acute myocardial infarction, support persons are less likely to recognize symptoms are cardiac related, and the American Heart Association has provided specific prevention guidelines for women (Hermann, 2008; Mosca, Benjamin, Bara, et al., 2011). However, in conjunction with Mary's weaknesses, the nurse also considered Mary's strengths and resources during the assessment phase. One of Mary's strengths discovered in the sociocultural variable was her solid network of personal relationships. And strength emerged in the spiritual variable when Mary identified her faith as one of her major sources of strength. When the nurse interviewed Mary to determine her psychological variable, Mary revealed a third strength when she indicated a desire to learn about her needed lifestyle changes. The nurse integrated these three discovered strengths and realized that Mary's flexible line of defense could be enhanced. The nurse identified three nursing diagnoses that identified Mary's stressors (see Table 11-3): (1) deficient knowledge, (2) risk for spiritual distress, and (3) risk for activity intolerance.

Primary prevention-as-intervention modalities could enhance Mary's flexible line of defense and would include supporting her spiritual worldview and independence. In addition, the nurse identified secondary interventions that could help Mary's reconstitution from the cardiac event. These interventions could include education about needed lifestyle changes and exploration of family-friendly support systems during immediate discharge. Tertiary interventions could include referrals for other health care support systems as listed in Table 11-3. The nurse proposed that prevention-as-intervention might promote a satisfactory level of wellness for Mary. Before implementing this plan of care, the nurse would have discussed these initial perceptions with Mary to determine perceptual congruency between the nurse and client and to establish appropriate goals and outcomes. However, before the nurse had time to discuss the plan of care with Mary, the client developed complications that required the nurse to change the focus of care.

As the case history describes, Mary is experiencing the onset of an additional physiological stressor, impaired gas exchange. The nurse recognizes the need for reassessment of Mary's variables and her created environment to evaluate Mary's

response to current stressors within her lines of resistance. The nurse uses the Neuman Systems Model to reorganize and reprioritize nursing care in order to meet the client's immediate needs, without neglecting Mary's future discharge planning needs.

Reassessment for Stressors, Strengths, and Resources Within the Variables

Physiological

The nurse reassesses Mary's physiological respiratory variable and recognizes the acute nature of the situation. Mary's physiological variable assessment data reveal both hypoxemia and hypercapnia with attendant signs. Both findings are negatively influencing her system stability. The nurse recognizes that although Mary's cardiac status is stable, the subparts of the system (her cardiac and respiratory status) are interacting synergistically and can be further compromised. Mary's physiological change in oxygenation is the most obvious stressor. This stressor is permeating the client's flexible line of defense, the normal line of defense, eliciting a stressor response in the lines of resistance (hyperventilation), and potentially causing enough energy depletion to cause death. However, the nurse also recognizes that Mary is greater than the sum of her parts and therefore reassesses the other four variables.

Psychological

The nurse listens as Mary talks about her fears of dying and states that she wants to go home. When Mary becomes agitated, pulling off the bi-PAP mask and refusing treatment, the nurse recognizes the importance of the variable interactions in the client's lines of resistance. Although the nurse recognizes that clients who have hypoxemia and are hypercapnic are very anxious, the nurse also explores Mary's concern about tubes. Mary talks about her near-drowning experience as a child and how the mask makes her feel like she is drowning. She also tells the nurse that she does not want to be connected to one of those machines and that her daughter knows this.

Developmental

The nurse also remembers that Mary has a high school GED and needs basic explanations about what is happening to her.

Sociocultural

The nurse calls the daughter to inform her of her mother's change in status and current anxieties. Mary's daughter explains that during her mother's last hospitalization her mother needed bi-PAP treatments and had similar concerns. The nurse and daughter agree to form a partnership to replicate a previously successful approach to Mary's care.

Spiritual

The nurse recognizes that the current situation could overwhelm Mary's spiritual resources in her flexible line of defense that are protecting her normal line of defense. The nurse asks Mary whether prayer might help calm her. Mary affirms this and says that praying always gives her hope. Mary also asks to see the priest again.



The nurse weighs the strengths, weaknesses, and resources in each of the variables and considers the wholistic nature of Mary's perceptions and situation. In addition, Mary's created environment is especially important because although Mary has an acute physiological need, the synergistic interaction of the variables is compounding the physiological problem. The nurse recognizes that Mary's fears and current coping mechanisms must be addressed before interventions for her ventilation-perfusion needs can be successfully implemented. Therefore, the nurse reflects and synthesizes the information and develops two actual nursing diagnoses to direct the care. A third nursing diagnosis that reflects a possible stressor is also identified. The following three priority nursing diagnoses are also listed in Table 11-3:

1. Fear related to sensory impairment (ventilation-perfusion problems), hospital procedures, support system separation, and acute health changes
2. Impaired Gas Exchange related to ventilation-perfusion imbalance and feelings of claustrophobia
3. Risk for Decreased Cardiac Output

The flexibility inherent in the Neuman Systems Model enables the nurse responsively to change the focus from discharge planning to secondary prevention-as-interventions with the goal of system reconstitution. The necessary client outcomes are now decreased anxiety and balanced ventilation-perfusion. The following seven nursing actions will specifically assist in mitigating the stressors of fear and impaired gas exchange within the client's lines of resistance, thus promoting reconstitution:

1. Provide an environment conducive for Mary to pray before and during bi-PAP treatment.
2. Contact the parish priest.
3. Arrange for a family member or friend to be available as possible during bi-PAP treatments.
4. Give Mary a list of treatment times so that she can anticipate and prepare herself.
5. Collaborate with the physician for a prescription for antianxiety medications, and chart Mary's desire that no pulmonary resuscitation should occur (do not resuscitate [DNR]).
6. Reinforce Mary's past effective coping mechanisms during needed hospitalization and bi-PAP therapy.
7. Monitor for signs and symptoms of decreased cardiac output.

The nurse explains the plan of care to Mary and verifies their individual perceptions. Mary agrees, seems somewhat less anxious, and states that she now thinks she can complete the treatments. In addition, the nurse charts the complete plan of care to promote continuity of care for Mary among staff members 24 hours a day. The initial client needs that were identified and the plan of care related to discharge will need to be modified depending on Mary's ongoing needs. However, the individualized plan of care as described in Table 11-3 becomes the working map based on the Neuman model. This exemplar exhibits how the professional nurse can implement the Neuman Systems Model to exhibit effective, wholistic nursing care in rapidly changing situations.

CRITICAL THINKING EXERCISES

1. Reconsider the case of Debbie and apply the Neuman Systems Model to the family as the system. Debbie's stressors have been identified.
 - a. What are the stressors for the husband, the children, and the mother?
 - b. What are the stressors for the family as a system?
 - c. What system boundaries are affected?
2. As you reflect on your interpersonal communication with clients, consider situations when perceptions were different from yours. Focus on one particular case and with Neuman's ideas on the importance of congruency in nurse-client perceptions, consider how to incorporate the client's situational perception into your style of nursing practice.
3. Apply the Neuman Systems Model to a client in your current practice according to the instructions and questions listed in parts (a) and (b), and then examine the outcome.
 - a. Sort the data into the five variables (physiological, psychological, developmental, sociocultural, and spiritual) for your use to plan effective wholistic care.
 - b. Identify stressors, affected boundaries, and prevention interventions for this client.
4. Identify your personal strengths, resources, and potential stressors. Using these data, develop a personal plan of care based on the Neuman Systems Model to help you strengthen your flexible line of defense and promote your optimal wellness.

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Orem's Self-Care Deficit Theory in Nursing Practice

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Nurses work in life situations with others to bring about conditions that are beneficial to persons nursed. Nursing demands the exercise of both the speculative and practical intelligence of nurses. In nursing practice situations, nurses must have accurate information and be knowing about existent conditions and circumstances of patients and about emerging changes in them. This knowledge is the concrete base for nurses' development of creative practical insights about what can be done to bring about beneficial relationships or conditions that do not presently exist. Asking and answering the questions "what is?" and "what can be?" are nurses' points of departure in nursing practice situations.

(Orem, 1995, p. 155)

History and Background

The Self-Care Deficit Nursing Theory (SCDNT) is one of the nursing theories most commonly used in practice (Im & Chang, 2012). Orem's dedication to the concept of self-care resulted in a nursing theory appropriate for present and future health care scenes. The earliest development of the theory occurred in 1956 (Orem, 1985). Orem's purpose was to define the following:

- Nursing's concern—"man's need for self-care action and the pro-vision and management of it on a continuous basis in order to sustain life and health, recover from disease or injury, and cope with their effects" (Orem, 1959, p. 3)
- Nursing's goal—"overcoming human limitations" (Orem, 1959, p. 4)

*The author wishes to thank Irma Lopez, BSN, RN, who assisted with data collection and nursing system design for the case of Ms. Davila.

The concept of self-care evolved into a theory as Orem and colleagues discussed and formulated the concept into a working description of nursing. Orem's model supports nursing through the following three central theories:

1. Nursing is required because of the inability to perform self-care as the result of limitations (Theory of Self-Care Deficit).
2. Maturing or mature adults deliberately learn and perform actions to direct their survival, quality of life, and well-being (Theory of Self-Care).
3. The product of nursing is nursing system(s) by which nurses use the nursing process to help individuals meet their self-care requisites and build their self-care or dependent-care capabilities (Theory of Nursing Systems).

The significance of the utilization of Orem's model in practice has been explicit since the publication of the first edition of *Nursing: Concepts of Practice* (Orem, 1971). Early use of the theory in practice began with the work of the Nursing Development Conference Group (NDCG) (1973). The group initiated their adventure into theory-based practice by integrating the developing concepts of the model into their clinical teaching. As the conceptualizations evolved, they were incorporated into nursing care.

Members of the NDCG were able to address the reality of theory-based nursing practice from their leadership positions that enabled control over nursing systems (Allison, 1973; Backscheider, 1971). Members of the NDCG valued their work in practice settings for supporting their conceptualizations and revealing the importance of the broad conceptualizations to structure practice. The Center for Experimentation and Development in Nursing at Johns Hopkins Hospital was one of the early sites for the development of the theory through practice. Later, in 1976, Allison implemented SCDNT-based practice in the Mississippi Methodist Hospital and Rehabilitation Center (Allison, 1989).

Gradually, SCDNT development in the practice arena began to filter into a variety of practice settings. In the 1980s the influence of the SCDNT on practice was accelerated. This was a time when the theory was being explicated for use with specific nursing situations and in varying types of practice settings. The literature of the 1990s shows SCDNT-guided practice in a variety of settings and situations. The emphasis was on prescriptions for specialized practice and model/theory development. Selected practice settings and conceptual foci are shown in Table 12-1.

With the founding of the International Orem Society for Scholarship and Nursing Science (IOS), an ongoing forum for the exchange of SCDNT practice models was established (Isenberg, 1993). The arrival of the twenty-first century brought with it the development of additional SCDNT practice models. Selected models of this period are displayed in Table 12-2.

This review of the role the SCDNT plays in practice supports the theory's versatility. A product of the post-World War II period, the theory continued into the new millennium as a guidepost for the profession. The timelessness of Orem's theory, its practical approach, and the utility of the theory in decision making are essential to practice.

TABLE 12-1 Utilization of Orem's Model in Selected Practice Settings

| Author | Practice Setting | Conceptual Focus |
|--|------------------------------------|---|
| Allison & McLaughlin-Renpenning, 1999 | Nursing administration | SCDNT |
| Armer, 2006 | Oncology | Self-care deficit, self-care agency |
| Bekel, 2002 | Variety of practice settings | Therapeutic self-care demand |
| Berbiglia & Bekel, 1995 | Variety of practice settings | SCDNT |
| Biggs, 2002 | Skilled nursing, elderly | Self-care |
| Biggs, 2008a | Home health care | Self-care limitations, self-care deficits, nursing systems |
| Biggs, 2008b | Variety of practice settings | SCDNT |
| Brooks & Armer, 2008 | Oncology | Power components, self-care |
| Dennis, 2002 | Normal newborn, postpartal mothers | Particularized self-care requisites, basic conditioning factors |
| Fleck, 2008 | Primary care | Support-educative nursing system, self-care |
| Flues, 2006 | Oncology | Self-care agency |
| Hanucharunkul, 2004 | Diabetes self-management program | Self-care |
| Holoch, Gehrke, Knigge-Demal, et al., 1999 | Pediatric nursing | SCDNT |
| Horsburgh, 2002 | Home dialysis | Dependent-care agency |
| Howard & Berbiglia, 1997 | Korean women's health care | Basic conditioning factors, developmental self-care requisites |
| Jesek-Hale, 2008 | Community prenatal clinic | Self-care |
| Kongsuwan, Kools, Sutharangsee, et al., 2008 | School | Self-care deficits, basic conditioning factors, self-care |
| Lorensen, 2000 | Rehabilitation, elderly | Self-care agency |
| Matchim, Armer, & Stewart, 2008 | Community | Self-care |
| Mohamed, 2006 | Outpatient clinic | Supportive-educative nursing system, self-care |
| Moore & Pawloski, 2006 | Community | Self-care |
| Norris, 1991 | Transplant outpatient service | Nursing systems |
| Orem, 2001 | Variety of practice settings | Nursing systems |
| Orem, 2004 | Variety of settings | Nursing practice science |
| Schmidt, 2006 | Variety of practice settings | Self-care in a supportive-educative nursing system |
| Taylor & McLaughlin, 1991 | Community | Self-care |
| Whitener, Cox, & Maglich, 1998 | Public school | Foundational capabilities |

SCDNT, Self-Care Deficit Nursing Theory.

TABLE 12-2 Selected SCDNT Practice Models for the Twenty-First Century

| Author | Model | Practice Setting |
|---|---|---|
| Allison & McLaughlin-Renpenning, 2000 | A framework for specifying nursing outcomes | Variety of areas of nursing practice |
| Biggs, 2008b | Putting a practice model into practice: Orem's SCDNT | Variety of areas of nursing practice |
| Brooks, 2000 | Communication Model of Support | Variety of areas of nursing practice |
| Brooks, 2004 | Transtheoretical stages of change counseling framework | Nutrition management |
| Dennis, 2008 | Model for Dependent-Care | Dependent-care, self-care system of dependent-care agent |
| Fairchild, 2002 | Perioperative Nursing Practice Model (PNPM) | Variety of preoperative settings |
| Flues, 2008 | Practice Model for Interdisciplinary Collaboration in Case Management | Self-care systems, dependent-care systems |
| Grando, 2002 | Practice Model for a Comprehensive Nursing Rehab Program | Geriatrics nursing |
| Grando, 2005 | Psychiatric/Mental Health Advanced Practice Model | SCDNT |
| Hanucharunkul, 2000 | Self-Care Agency Model | Oncology nursing |
| Hirunchunha, 2000 | Self-Care Model for Caregivers | Home health for stroke patients |
| Isaramalai, 2000 | Diabetes Self-Management Model | Diabetes management programs |
| Isaramalai, Rakkamon, & Nontapet, 2008a | Practice Model for Thai Industrial System | Estimative, transitive, and productive stages of care operations; self-care capability; helping methods |
| Isaramalai, Rakkamon, & Nontapet, 2008b | Practice Model for Thai Occupational Health Care System | Estimative, transitive, and productive stages of care operations; self-care capability; helping methods |
| Kolbe-Alberdi, 2004 | Model for Preoperative Nursing Rounds | Variety of preoperative settings |
| Maneewa, 2000 | Supportive and Educative Model in Promotion of Self-Care | Oncology nursing |
| Nantachaipan, 2000 | Self-Care Agency Model | HIV/AIDS |
| Phuphaibul, 2000 | Causal Model of Dependent-Care Burden in Parents | Chronic illness in children |

HIV/AIDS, Human immunodeficiency virus/acquired immunodeficiency syndrome; *SCDNT*, Self-Care Deficit Nursing Theory.

Overview of Orem's Self-Care Deficit Nursing Theory

Nursing practice oriented by the SCDNT represents a caring approach that uses experiential and specialized knowledge (science) to design and produce nursing care (art). The body of knowledge that guides the art and science incorporates empirical and antecedent knowledge (Orem, 1995). Empirical knowledge is rooted in experience and addresses specific events and related conditions that have relevance for health and well-being. It is empirical knowledge that supports observations, interpretations of the meaning of those observations, and correlations of the meaning with potential courses of action. Antecedent knowledge includes previously mastered knowledge and identified fields of knowledge, conditions, and situations.

Orem (1995) identified eight fields of knowledge essential for understanding nursing practice. Seven of those emanate from previously developed fields of knowledge found in the sciences and other disciplines, including sociology, profession/occupation, jurisprudence, history, ethics, economics, and administration. The eighth, nursing science is knowledge about nursing practice created by nurses through scientific investigations that yield understanding of the field of nursing and provide foundations for nursing practice. In 2001, Orem characterized nursing science as composed of three nursing practice sciences and three foundational nursing sciences. The nursing practice sciences “define and explain three practice fields in nursing” (Orem, 2001, p. 175). The foundational nursing sciences “supply the foundations for understanding and for making required observations, judgments, and decisions in nursing practice situations” (Orem, 2001, p. 177).

Practice knowledge is systematized, validated, and conducive to dynamic processes. Its dynamic quality leads the user to acceptance and owning of the theory (Orem, 1988). Allison (1988) noted the dynamic quality of the SCDNT and commented that the theory always keeps the nurse in an action mode. Orem (1988) emphasized that today's nurses must be scholars within the developing theory. In doing so, nurses are committed to an awareness of the relationship between what they know and what they do. From this awareness comes a healthy sense of professionalism.

Critical Thinking in Nursing Practice with Orem's Theory

SCDNT-based critical thinking emanates from four structured cognitive operations: diagnostic, prescriptive, regulatory, and control. Each operation fulfills a distinct phase in the use of the theory. Sequencing of the phases may vary throughout the process in order to reassess and continue to prescribe and regulate the nursing system for the best interest of self-care.

The operations are intended to be collaborative and to provide the self-care agent or dependent-care agent input into the decision making. Examples of the four cognitive operations are found in this chapter's discussion of the nursing care for two clients. Table 12-3 outlines the critical thinking requirements for SCDNT-based decision making. Critical thinking exercises are featured at the end of this chapter.

TABLE 12-3 Critical Thinking with Orem**DIAGNOSTIC OPERATIONS**

| | |
|---|---|
| Establish therapeutic relationship | <p>Enter into and maintain relationship.</p> <p>Contract to collaborate in identifying and analyzing existing/potential therapeutic self-care demands.</p> <p>Assess for basic conditioning factors.</p> <p>Review existing/projected universal, developmental, and health deviation requisites.</p> <p>Estimate value and expected changes in value of each requisite.</p> <p>Consider interaction between basic conditioning factors and requisites.</p> <p>Identify and describe self-care practices.</p> <p>State specific limitations and abilities related to practices.</p> <p>Make inferences about effect of limitations and abilities on engaging in self-care.</p> <p>Validate inferences through continued observation.</p> <p>Determine adequacy of knowledge, skills, and willingness to meet therapeutic self-care demands.</p> <p>Estimate potential for development of self-care agency.</p> |
| Diagnose self-care deficits (existing or projected) | <p>Make judgments about degree of ability to provide self-care. Inform client of presence or absence of self-care deficit.</p> |

PRESCRIPTIVE OPERATIONS

| | |
|--|--|
| Calculate ideal therapeutic self-care demand | <p>Review possible helping methods.</p> <p>Consider validity and reliability of each method in relationship to basic conditioning factors.</p> <p>Identify most appropriate methods.</p> <p>Review identified methods with client/family.</p> <p>Explain to client/family sets and sequences of actions required for selected methods.</p> |
| Design therapeutic self-care demands | <p>Consider time-specific relationships between requisites, economy of time and effort, and compatibility with personal and family life.</p> <p>Plan for adjustment in design as requisites change or new requisites emerge.</p> |
| Prioritize therapeutic self-care demands | <p>Prioritize in this order:</p> <p>First: Those essential for life processes</p> <p>Second: Those that prevent personal harm/injury or health deterioration</p> <p>Third: Those that maintain or promote health</p> <p>Fourth: Those that contribute to well-being</p> |
| Prescribe client role and nurse role | <p>Identify what client should do, should not do, and is willing to do.</p> <p>Determine potential for continued development of self-care agency.</p> |

REGULATORY OPERATIONS

| | |
|---|--|
| Design regulatory nursing system for prescribed therapeutic self-care demands | <p>Take into consideration basic conditioning factors of age, developmental state, health state, and health care system.</p> <p>Provide for effective regulation of health and developmental state by describing relationships among components of therapeutic self-care demands.</p> <p>Specify timing, amount of nurse-client contact, and reasons for contact.</p> <p>Identify actions of nurse, client, and others.</p> <p>Take into consideration positive or negative cooperation.</p> |
|---|--|

Continued

TABLE 12-3 Critical Thinking with Orem—cont'd

| | |
|--------------------------------|--|
| Plan for regulatory operations | Describe organization and timing of essential tasks/roles and responsibilities. Specify time, place, environmental conditions, equipment/supplies, and type and number of personnel necessary. |
| Production of regulatory care | Perform and regulate self-care tasks, or assist client in performing self-care tasks. Coordinate self-care task performance. Instigate accomplishment of self-care that is satisfying to client. Guide, direct, and support client in exercise of self-care agency. Stimulate client interest in self-care. Support and guide client learning. Support and guide client through experiences in meeting ongoing self-care requisites. Monitor and assist client to monitor self in self-care measures. |

CONTROL OPERATIONS

| | |
|--|---|
| Observe and appraise regulatory operations | Make judgments about quantity and quality of self-care, development of self-care agency, and nursing assistance. Judge effect of measures on well-being of client. Make or recommend adjustments in nursing care system. Determine whether: Regulatory operations are performed according to nursing system design Operations are in accord with client condition and environment for which they were prescribed Operations are still valid Regulation of client functioning has been achieved Developmental change is in progress and is adequate Client is adjusting to any decline in self-care ability |
|--|---|

Diagnostic Operations

The first phase, diagnostic operations (see Table 12-3), begins with establishing the nurse-client relationship and proceeds to contracting to work toward identifying and discussing current and potential therapeutic self-care demands. Basic conditioning factors are noted and considered in relationship to a thorough review of universal, developmental, and health deviation self-care requisites and related self-care actions. The projected value of requisites is estimated. An analysis of the assessment data results in a diagnosis concerning the type of self-care demands. Self-care agency is addressed through an assessment of self-care practices and the effects of related limitations and abilities. Personal characteristics such as intellect, skill performance, and willingness are evaluated. From these data, inferences about the adequacy and potential of self-care agency are made, validated, and treated as diagnostic of self-care agency. Finally, self-care deficits are diagnosed by reflecting on the adequacy of agency to meet specific requisites. In instances in which self-care agency is inadequate, a self-care deficit is stated.

Prescriptive Operations

In the prescriptive phase, ideal therapeutic self-care requisites for each self-care requisite are determined by reviewing possible helping methods, considering related basic conditioning factors, and identifying the most appropriate helping methods. Actions required for the therapeutic self-care demands are discussed with the client and are designed for maximal efficiency and compatibility. Priority is given to those therapeutic self-care demands that are the most essential to physiological processes. Client and nurse expectations are formalized and recognized as supportive of continued development of self-care agency.

Regulatory Operations

The prescriptions that evolve are used in the regulatory phase to design, plan, and produce the regulatory nursing system. Factors entering decisions about design include basic conditioning factors, effective regulation of health and developmental state, timing, assignment of actions, and degree of cooperation. Further planning specifies conditions for the regulatory operations such as frequency, equipment and supplies, and personnel needed. Throughout the production of regulatory care, there is emphasis on development of self-care agency by using helping methods that encourage learning, increase feelings of well-being, and stimulate interest in self-care.

Control Operations

Evaluation occurs in the control phase. The effectiveness of regulatory operations and client outcome is estimated. Regulatory operations are evaluated for correctness and appropriateness. Client outcome is appraised for regulation of functioning, developmental change, and adjustments to varying levels of self-care ability.

CASE HISTORY OF DEBBIE

Debbie is a 29-year-old woman who was recently admitted to the oncology nursing unit for evaluation after sensing pelvic "fullness" and noticing a watery, foul-smelling vaginal discharge. A Papanicolaou smear revealed class V cervical cancer. She was found to have a stage II squamous cell carcinoma of the cervix and underwent a radical hysterectomy with bilateral salpingo-oophorectomy.

Her health history revealed that physical examinations had been infrequent. She also reported that she had not performed breast self-examination. She is 5 feet, 4 inches tall and weighs 89 pounds. Her usual weight is about 110 pounds. She has smoked approximately two packs of cigarettes a day for the past 16 years. She is gravida 2, para 2. Her first pregnancy was at age 16, and her second was at age 18. Since that time, she has taken oral contraceptives on a regular basis.

Debbie completed the eighth grade. She is married and lives with her husband and her two children in her mother's home, which she describes as less than sanitary. Her husband is unemployed. She describes him as emotionally distant and abusive at times.

Continued

CASE HISTORY OF DEBBIE—cont'd

She has done well following surgery except for being unable to completely empty her urinary bladder. She is having continued postoperative pain and nausea. It will be necessary for her to perform intermittent self-catheterization at home. Her medications are (1) an antibiotic, (2) an analgesic as needed for pain, and (3) an antiemetic as needed for nausea. In addition, she will be receiving radiation therapy on an outpatient basis.

Debbie is extremely tearful. She expresses great concern over her future and the future of her two children. She believes that this illness is a punishment for her past life.

Nursing Care of Debbie with Orem's Theory**Goal for Theoretical Guidance**

The goal for the application of the SCDNT to the care of Debbie is to prescribe the type of nursing system appropriate to meet Debbie's self-care requisites. The system designed should provide the optimum effect in achieving regulation of Debbie's self-care agency and meeting her therapeutic self-care demands. A revised version of Laschinger's (1990) data collection and nursing system design tool is used for data analysis and critical thinking.

Diagnostic and Prescriptive Operations

Table 12-4 places the data from Debbie's case into the SCDNT framework. A review of Debbie's basic conditioning factors, shown in section A of Table 12-4, reveals a young woman caught up in what Sheehy (1976) calls "age 30 passage," a time to claim full adult status in society (p. 175). However, Debbie is lacking the characteristics necessary for the transition. The effects of early sociocultural factors (limited education, teenage pregnancies) are compounded by adult experiences—an insecure, intergenerational family system of limited resources living in the unacceptable environment of Debbie's mother's home. Debbie's past history and her present illness represent negative influences that impinge on her universal, developmental, and health deviation requisites. Essential universal self-care requisites (air, prevention of hazards, and prevention of harm), shown in section B of Table 12-4, have been threatened by a history of smoking, inadequate relationships, and psychological dependency. Debbie's advanced stage of cancer and recent surgery challenged her physiologically and psychologically. In section C of Table 12-4, it is clear that Debbie's failure to meet developmental self-care requisites places her at risk. The health deviation self-care requisites reflected in section D of Table 12-4 represent requisites influenced by Debbie's basic conditioning factors and developmental self-care requisites. Limited resources, developmental threats, and weak self-care agency surfaced in Debbie's own awareness and perception of her health deviation self-care requisites. She is expected to perform self-care and undergo extensive treatment although she lacks the knowledge, skills, and psychological security to do so.

The nurse encounters Debbie 1 day before discharge and is plagued by the weak self-care agency shown in Debbie's health care history: early sexual activity,

TABLE 12-4 Data Collection for Debbie**A. BASIC CONDITIONING FACTORS**

| Age (Years) | Gender | Developmental State | Health State | Sociocultural Orientation | Health Care System | Family System | Patterns of Living | Environment | Resources |
|-------------|--------|-----------------------------------|-----------------------------------|---|--|------------------------------------|------------------------------|-------------|--|
| 29 | Female | Early adulthood 30s transition | Acute phase of chronic illness | 8th grade education Teenage pregnancies No work | Diagnosis Surgery Treatment plan | Married Children at home (2) | Lives at mother's home | Unclean | Extremely limited Husband out of work |

B. UNIVERSAL SELF-CARE REQUISITES

| Air | Water | Food | Elimination |
|--|-------------------------------|--|--|
| 730-pack/year smoking history | No restrictions | No restrictions Weight: 89 lb Weight loss (19%) Nauseated Phenergan (25 mg rectally prn for nausea) | Urinary retention Intermittent self-catheterization |
| Activity/Rest | Solitude/Social Interaction | Prevention of Hazards | Promotion of Normalcy |
| Pain, nausea Percocet (1-2 tablets daily) | Tearful Expresses concerns | Husband abusive Keflex (500 mg po qid) | Dissatisfied with home environment Dependent on mother Radiation therapy |

Continued

TABLE 12-4 Data Collection for Debbie—cont'd**C. DEVELOPMENTAL SELF-CARE REQUISITES****Maintenance of Developmental Environment**

Teenage pregnancies (2)
 Oral contraceptives for 10 years
 Dependent on mother
 Husband emotionally distant

Prevention/Management of Conditions Threatening Normal Development

No breast self-examinations
 Infrequent physical examinations
 No hormone replacement therapy
 Educational deprivation
 Poor health
 Oppressive living conditions

D. HEALTH DEVIATION SELF-CARE REQUISITES**Seeking Medical Assistance When Health Status Altered**

Seeks medical attention infrequently for overt symptoms

Awareness/Management of Disease Process

Aware of disease
 No evidence of ability to understand/manage effects

Adherence to Medical Regimen

Will perform intermittent self-catheterization
 Will receive radiation therapy

Awareness of Potential Problems Associated with Regimen

No awareness of need for hormone replacement therapy
 No awareness of radiation side effects

Modification of Self-Image to Incorporate Changes in Health Status

Views illness as punishment for past life

Adjustment of Lifestyle to Accommodate Changes in Health Status and Medical Regimen

Concerned for future of self and children

a 730-pack/year smoking habit, and a relative deficit in managing developmental self-care requisites. The goal is to make a difference in Debbie's self-care agency. Using sections B, C, and D of Table 12-4, the nurse quickly identified the therapeutic self-care demands and stated these demands in the nursing system design (Table 12-5) for discharge. Four priority diagnoses are indicated with asterisks (see Table 12-5) and are discussed here. First priority is given to the therapeutic self-care demands related to the following: (1) elimination (provide care for eliminative process) and (2) adherence

TABLE 12-5 Nursing System Design for Debbie: Supportive-Educative

| Therapeutic Self-Care Demand | DIAGNOSTIC OPERATIONS | | PRESCRIPTIVE OPERATIONS |
|--|------------------------------|--|--|
| | Adequacy of Self-Care Agency | Nursing Diagnosis | Methods of Helping |
| AIR Maintain effective respiration | Inadequate | Potential for impaired respiratory status related to smoking | Guiding and directing |
| WATER At present, no problem | Adequate | Potential for fluid imbalance related to nausea | Teaching |
| FOOD Maintain sufficient food intake | Inadequate | Actual nutritional deficit related to nausea and cachexia of cancer | Providing physical support |
| ELIMINATION Provide care for eliminative process | Inadequate | Actual eliminative disturbance related to postoperative urinary retention* | Teaching |
| ACTIVITY/REST Maintain balance | Inadequate | Actual activity/rest imbalance related to pain and nausea | Providing physical and psychological support |
| SOLITUDE/SOCIAL INTERACTION Maintain balance | Inadequate | Potential for social isolation related to emotional distress and husband's distancing | Providing and maintaining environment that supports personal development |
| PREVENTION OF HAZARDS Prevent spouse abuse | Inadequate | Potential for personal injury related to abusive husband* | Guiding and directing |
| PROMOTION OF NORMALCY Improve living environment and lifestyle | Inadequate | Actual deficits in environment related to shared housing | Guiding and directing |
| MAINTAIN DEVELOPMENTAL ENVIRONMENT Support increased normalcy in environment | Inadequate | Actual delay in normal human development related to early parenthood, dependence on mother, and level of education | Guiding and directing Providing psychological support |

Continued

**TABLE 12-5 Nursing System Design for Debbie: Supportive-Educative—
cont'd**

| DIAGNOSTIC OPERATIONS | | | PRESCRIPTIVE OPERATIONS |
|--|------------------------------|---|--|
| Therapeutic Self-Care Demand | Adequacy of Self-Care Agency | Nursing Diagnosis | Methods of Helping |
| <p>PREVENT/MANAGE DEVELOPMENTAL THREATS</p> <p>Manage/decrease threats by receiving appropriate therapy</p> | Inadequate | Actual developmental deficit related to lifestyle and surgical loss of reproductive organs | Providing physical and psychological support |
| <p>MAINTENANCE OF HEALTH STATUS</p> <p>Promote health</p> | Inadequate | Potential for continued alterations in health status related to inadequate health-seeking behaviors, financial status, and knowledge deficits | Teaching Guiding and directing |
| <p>AWARENESS/MANAGEMENT OF DISEASE PROCESS</p> <p>Develop understanding of disease effects and management</p> | Inadequate | Potential for urinary tract infection related to intermittent self-catheterizations | Teaching Guiding and directing |
| <p>ADHERENCE TO MEDICAL REGIMEN</p> <p>Ensure adherence</p> | Inadequate | Potential for decreased adherence in self-catheterization and outpatient radiation therapy related to no apparent patient teaching* | Teaching |
| <p>AWARENESS OF POTENTIAL PROBLEMS</p> <p>Understand treatment plan</p> | Inadequate | Actual deficit in awareness of advisability of hormone replacement and management of radiation side effects related to no discharge planning | Teaching |
| <p>MODIFY SELF-IMAGE TO INCORPORATE CHANGED HEALTH STATUS</p> <p>Adjust to loss of reproductive ability and develop healthy view of etiology of illness</p> | Inadequate | Actual threats to self-image related to disease, treatment, and guilt feelings* | Providing psychological support |
| <p>ADJUST LIFESTYLE TO ACCOMMODATE HEALTH STATUS CHANGES AND MEDICAL REGIMEN</p> <p>Plan for future</p> | Inadequate | Actual self-deficit to planning for future needs related to resources | Guiding and directing |

*Priority diagnosis.

to medical regimen (ensure adherence) because elimination is essential for life processes. Prevention of spousal abuse takes second priority in that it will prevent harm/injury. Lowest priority goes to the therapeutic self-care demand for modifying self-image. Although self-image is important, low priority is assigned to self-image-related therapeutic self-care demands because they involve only contributing to well-being.

Regulatory and Control Operations

The supportive-educative nursing system design was intended to return control to Debbie and ultimately to strengthen her self-care agency. The design was supportive-educative because the prescribed helping methods were designed to support—not compensate for—Debbie's self-care ability, primarily through teaching and guiding. The regulatory operations assisted Debbie to perform her self-care within a unified system of care. The support and guidance promoted her interest in self-care and brought her unexpected satisfaction with attainment of specific universal and health deviation self-care requisites. There was a possibility that a partly compensatory system would evolve if Debbie were unsuccessful in learning and performing intermittent self-catheterization, and the nurse had to assume that action. However, control operations revealed effective regulations. For example, regulatory operations for intermittent self-catheterization provided for a self-catheterization every 8 hours until Debbie had less than 60 ml postvoid residual. A routine urinalysis revealed no evidence of urinary tract infection subsequent to the self-care actions.

CASE HISTORY OF MS. DAVILA

Ms. Davila, age 64, is under the care of a home health agency. Because of rheumatoid arthritis she has been mostly homebound for 6 years. The home health care was begun at the time of her diagnosis with type 2 diabetes mellitus 3 years ago. She is pleased to report that she has never been hospitalized—even for the birth of her two children. Since age 50 she has had her share of health problems, including osteoporosis, intense arthritic pain and impaired mobility, diabetes, anemia, and a weight problem. Recent laboratory reports showed the following results: triglycerides, 250 mg/dl; lactate dehydrogenase (LDH), 290 units/L; HbA1c, 15 g/dl; red blood cells (RBCs), 3.65 million/mm³. Her blood sugar is usually elevated, but her diabetes continues to be managed by diet alone. She is 5 feet tall and weighs 180 pounds. Weight has never been viewed as a liability in her Hispanic upbringing. Good times are always associated with eating.

Ms. Davila dropped out of high school to get married. Now, as a widow, she provides a home in the country for her son. Her daughter and grandchildren live in the nearby city. Although her husband left her a small retirement fund, she relies mostly on Social Security income and receives health care through Medicare.

Home care has met her needs well and has minimized expenses. Her largest bill each month is to the pharmacy for Tramadol 50 mg, calcium, and monthly vitamin B₁₂ injections. She looks forward to the home health aide's assistance twice a day and to the weekly visit of the registered nurse. These visits are a source of social contact, which she rarely has anymore (see Table 12-5).

Nursing Care of Ms. Davila with Orem's Theory

A complete data collection compiled from Ms. Davila's agency records and a home visit is shown in Table 12-6. Section A of Table 12-6 reveals that Ms. Davila has limited resources, has changed her lifestyle to accommodate chronic health problems, and receives home health care. In section B of Table 12-6, there are concerns for the universal self-care requisites of food (abnormal laboratory findings and nonadherence to diet) and activity/rest (pain and impaired mobility). Ms. Davila has become somewhat developmentally dependent (section C of Table 12-6). She requires assistance in food preparation, hygiene, and toileting. The relationship of her universal and developmental self-care requisites to her health deviation self-care requisites emerges clearly in section D of Table 12-6. Ms. Davila is nonadherent to her diet, has not modified her self-image to include dietary precautions, and seems to deny any diet-associated difficulties.

Diagnostic and Prescriptive Operations

Table 12-7 presents the nursing system design. The three priority diagnoses (denoted by asterisks) are classified as second priority because the therapeutic self-care demands are related to preventing health deterioration. In Ms. Davila's case, the SCDNT proposes a supportive-educative nursing system (with a partly compensatory component) that is designed to individualize her care. The individualization of the nursing system was accomplished through the overlay of basic conditioning factors and developmental self-care requisites (in sections A and C of Table 12-6) on the therapeutic self-care demands. The expected outcome is health status maintenance, health promotion, and prevention of further health deviations through strengthening self-care agency. The helping methods that are shown in Table 12-7 foster self-care. As noted, the nursing system design would benefit from the addition of a partly compensatory component to supplement patient agency related to food intake. For example, supervised, restricted eating times, although they would seem developmentally appropriate, would produce increased adherence to the American Diabetes Association (ADA) diet. If Ms. Davila becomes extremely nonadherent to her diet, the nursing system design will change to partly or fully compensatory in an effort to promote physiological functioning and prevent health deterioration.

Regulatory and Control Operations

The SCDNT has been found to be especially useful in cases in which multiple chronic illnesses and medically prescribed interventions existed, such as the case of Ms. Davila. The theory guided the operations away from disease to the strengths/weaknesses of the self-care agent. In section C of Table 12-6, it is evident that Ms. Davila does seek to prevent/manage conditions threatening her development, yet she requires assistance in this area. The most significant self-care deficits are related to food. Section D of Table 12-6 shows that almost one half of the health deviation self-care requisites involved food in some way.

The theory also guided the nurse to analyze the self-care agency from the perspective of the basic conditioning factors. Culturally we know it is common and

TABLE 12-6 Data Collection for Ms. Davila

A. BASIC CONDITIONING FACTORS

| Age (Years) | Gender | Developmental State | Health State | Sociocultural Orientation | Health Care System | Family System | Patterns of Living | Environment | Resources |
|-------------|--------|---------------------------|---|----------------------------------|--------------------|--|--|---|--|
| 64 | Female | Ego integrity vs. despair | Disability resulting from health conditioning | 10th grade education Hispanic | Home health care | Widow, son, daughter, several grand-children | Lives at home Son lives with her Leaves home only for physician appointments | Rural Items needed for ADLs in easy reach: shower chair and safety bars in bathroom, wheelchair ramp | Social Security income Medicare Son makes small contributions Refrigerator and pantry well supplied |

B. UNIVERSAL SELF-CARE REQUISITES

| Air | Water | Food | Elimination |
|--|--|--|--|
| Breathes without difficulty Skin warm, dry Normal color for client | Fluid intakes sufficient No edema Skin turgor normal for age | Triglycerides: 250 mg/dl LDH: 290 units/L RBC: 3.65 million/mm ³ Hb _{A1c} : 15 g/dl 2000-calorie ADA diet Does not adhere to diet Weight: 180 lb Height: 60 inches Calcium (1500 mg po daily) Vitamin B ₁₂ (IM every Monday) Blood glucose tests bid (usually between 90 and 120 mg/dl) | voids without difficulty Last BM 4/20, normal |

Continued

TABLE 12-6 Data Collection for Ms. Davila—cont'd

| Activity/Rest | Solitude/Social Interaction | Prevention of Hazards | Promotion of Normalcy |
|--|---|---|---|
| Requires frequent rest periods because of pain with ambulation Uses wheelchair at home Nalfon for joint pain (especially hands) Careless scheduling pain medication Pain not completely relieved | Isolated—homebound and decreased mobility related to pain Communicates with daughter by phone frequently Home health aide present 2 times/day Nurse visits once a week | Requires reminders Needs instructions on foot care Prefers to walk barefooted | Has good relationship with son and daughter |
| C. DEVELOPMENTAL SELF-CARE REQUISITES | | | |
| Maintenance of Developmental Environment | | Prevention/Management of Conditions Threatening Normal Development | |
| Able to feed self once meals are prepared for her Needs assistance bathing, grooming, toileting | | Discusses condition and medical regimen with home health nurse and aide and family | |
| D. HEALTH DEVIATION SELF-CARE REQUISITES | | | |
| Reports to home health nurse any changes in conditions: blood glucose level, pain, prescribed medications | | Aware of disease processes Not compliant with diet or prevention of hazards | |
| Adherence to Medical Regimen | | Awareness of Potential Problems Associated with Regimen | |
| Cooperates with medications Aware of medications and side effects Aware of medical regimen Does not follow ADA diet well | | Aware of side effects of medications Appears to deny problems associated with nonadherence to diet | |
| Modification of Self-Image to Incorporate Changes in Health Status | | Adjustment of Lifestyle to Accommodate Changes in Health Status and Medical Regimen | |
| Accepting of general health condition Has adapted to limitations in mobility Has not been able to include healthy eating habits and weight loss in her self-image | | Has adapted well to home health care services | |

*ADA, American Diabetes Association; ADLs, activities of daily living; Hb_{A1c} , hemoglobin; IM, intramuscular; LDH, lactate dehydrogenase; RBC, red blood cell count.

TABLE 12-7 Nursing System Design for Ms. Davila: Supportive-Educative

| Therapeutic Self-Care Demand | DIAGNOSTIC OPERATIONS | | PRESCRIPTIVE OPERATIONS |
|---|------------------------------|---|--|
| | Adequacy of Self-Care Agency | Nursing Diagnosis | Methods of Helping |
| AIR | Adequate | | |
| WATER | Adequate | | |
| FOOD Increase adherence to ADA diet | Inadequate | Potential for becoming insulin-dependent related to failure to control diet and weight* | Teaching Guiding and directing Providing psychological support |
| ELIMINATION | Adequate | | |
| ACTIVITY/REST Cope with/manage pain on ambulation | Inadequate | Ineffective pain control related to no real schedule for analgesic | Teaching Guiding and directing |
| SOLITUDE/SOCIAL INTERACTION Continue to maintain family, social, and home care contacts | Adequate | Potential for social isolation related to solitary living arrangements | Providing psychological support |
| PREVENTION OF HAZARDS Maintain safe ambulation | Inadequate | Potential for diabetic foot problems related to carelessness in using shoes Potential for falls and fractures related to rheumatoid arthritis, osteoporosis, and obesity | Teaching Guiding and directing Providing physical support |
| PROMOTION OF NORMALCY | Adequate | Potential for deterioration of health status related to any future discontinuing of home health service* | Guiding and directing |
| MAINTAIN DEVELOPMENTAL ENVIRONMENT Continue to receive home health care assistance | Inadequate | | Providing psychological support |

Continued

TABLE 12-7 Nursing System Design for Ms. Davila: Supportive-Educative—cont'd

| Therapeutic Self-Care Demand | DIAGNOSTIC OPERATIONS | | PREScriptive OPERATIONS |
|---|------------------------------|--|--|
| | Adequacy of Self-Care Agency | Nursing Diagnosis | Methods of Helping |
| PREVENT/MANAGE DEVELOPMENTAL THREATS Keep communication lines open and clear with providers | Adequate | Potential for misunderstandings related to mixed messages | Providing/maintaining environment that supports personal development |
| MAINTENANCE OF HEALTH STATUS AWARENESS/MANAGEMENT OF DISEASE PROCESS Increase understanding of interrelationships of disease processes, diet, and hazards | Adequate Inadequate | Potential for diabetic complications, falls, and decreased mobility related to three chronic health problems* | Teaching Guiding and directing Providing physical support Providing/maintaining environment that supports personal development |
| ADHERENCE TO MEDICAL REGIMEN Increase adherence to ADA diet Regulate administration of analgesic Continue routine medications | Inadequate | Nonadherence to ADA diet related to lifestyle, motivation, and knowledge deficits Inadequate pain relief related to timing of analgesic Self-care deficit related to inability to inject medications | Teaching Guiding and directing Providing psychological support Acting for or doing for another Teaching Guiding and directing |
| AWARENESS OF POTENTIAL PROBLEMS Gain better understanding of cause/prevention of problems | Inadequate | Potential for exacerbations and increased disability related to knowledge deficits concerning problems | Teaching Guiding and directing |
| MODIFY SELF-IMAGE TO INCORPORATE CHANGED HEALTH STATUS Attain ideal body weight | Inadequate | Inability to maintain ideal body weight related to lifestyle, motivation, and knowledge deficits | Providing psychological support Teaching Guiding and directing |
| ADJUST LIFESTYLE TO ACCOMMODATE HEALTH STATUS CHANGES AND MEDICAL REGIMEN Adjust eating habits | Inadequate | Inability to maintain ideal body weight related to cultural attitudes toward eating and weight gain and meal preparation by aide | Providing/maintaining environment that supports personal development |

*Priority diagnosis.

ADA, American Diabetes Association.

socially acceptable for a Hispanic woman to be overweight, center her needs on caring for her family, and become more sedentary and gain weight at this age. Thus although the nurse-developed supportive-educative system may appear to be a successful way to intervene, a closer look at the adequacy of the self-care agent and the potential for Ms. Davila to actually become motivated to alter her food-related habits should be taken. Are there motivators that will strengthen her agency? Is it possible to alter sociocultural views at this late time in her life?

The theory guidance provides an ample framework and fosters maintenance through the nursing system. However, it is evident that much of the responsibility for prevention and health promotion rests in Ms. Davila's hands. Thus in retrospect, it becomes imperative to further analyze her developmental self-care requisites (see section C of Table 12-6), prescribe and regulate helping methods that center on the maintenance of the appropriate developmental environment, and—at the same time—prescribe a system that is partly compensatory in the area of food requirements.

The extensive diagnostic operations in this case led to an important recognition: do not expect one type of nursing system design to fit all therapeutic self-care demands. Rather, plan at the beginning to supplement patient agency when the patient is faced with overbearing basic conditioning factors and/or problematic developmental self-care demands. This insight prevents wasted time, energy, and expense; is more reality-based; and places more responsibility on the nurse agency.

CRITICAL THINKING EXERCISES

1. You are assistant nurse manager for the inpatient medical unit, and the hospital where you work is revising the patient information booklet. You are to develop a succinct statement of the nursing framework (SCDNT) that guides care at the hospital. Develop a draft of the statement using the following outline provided by the vice president for patient care services. Remember, the pamphlet is for laypeople.
 - a. Overall goal of nursing
 - b. Five premises concerning the self-evident characteristics of human beings served
 - c. Three subtheories (self-care, self-care deficit, and nursing systems)
 - d. Nursing: helping methods
 - e. Attainment of therapeutic self-care requisites
2. You are perceived by your peers as a resource person on the use of the SCDNT. You have developed a program on the theory and have included it in the annual in-service program schedule. The suggested title is "Inherent Values in Utilizing the Self-Care Deficit Nursing Theory in Inpatient Settings." What are the six values you would address in the program?
3. Reflect on the case of Debbie and reconsider her basic conditioning factors. Which factor may have influenced her current health status? If that one factor could have been changed earlier in her life, what change in Debbie's self-care agency might have been possible?

Continued

CRITICAL THINKING EXERCISES—cont'd

4. Mr. and Mrs. Cowan, parents of a 27-year-old man who is receiving inpatient rehabilitation for extensive burns incurred in an offshore oil rig fire, have an appointment to discuss their son's nursing care with you. Their major complaint is: "We are paying more than \$1000 a day for his rehabilitation! Why don't the nurses do more for him? He is so unfortunate and needs all the help he can get here." Using the five-point outline given in question 1 and your understanding of the SCDNT, develop a reply to the parents.
5. You have been appointed to the cost-effectiveness department of a home health agency that is facing nursing fee reorganization. Use the SCDNT framework to design a fee structure to share with the administration that is valid and reliable. Explain how nursing system design and specific helping methods vary based on client resource needs and usage.
6. This summer you plan to attend your high school class reunion. The organizer has requested each graduate to develop a brief personal history to share with the class. Which of your basic conditioning factors are you most likely to keep secret? What universal self-care requisites do you think they would find interesting? Which developmental self-care requisite do you especially want to explain to the class? Have a great class reunion!

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Rogers' Science of Unitary Human Beings in Nursing Practice

Kaye Bultemeier

Nursing is both a science and an art. The uniqueness of nursing, like that of any other science, lies in the phenomenon central to its focus. Nurses' long-established concern with people and the world they live in is a natural forerunner of an organized abstract system encompassing people and their environments. The irreducible nature of individuals is different from the sum of the parts. The integralness of people and environment that coordinate with a multidimensional [later changed to pandimensional] universe of open systems points to a new paradigm: the identity of nursing as a science. The purpose of nurses is to promote health and well-being for all persons wherever they are. The art of nursing is the creative use of the science of nursing for human betterment.
(Rogers, 1990, p. 5)

History and Background

First introduced by Rogers in 1970, the Rogerian model is an abstract system of ideas from which to approach the nursing care of unitary human beings. Her ideas were revolutionary and challenged nursing to approach care from a wholistic and dynamic worldview.

Within the Science of Unitary Human Beings (SUHB), assumptions regarding the nature of nursing offer further elaboration. First, nursing science is an organized body of abstract scientific knowledge that develops from research and analysis. This science of nursing helps explain the human experience (Rogers, 1970). Second, Rogers contends that nursing is a learned profession and therefore must be based on solid scientific information. Third, Rogers' theoretical model places an emphasis on "the essentials, potentials, and possibilities that exist within the wholeness of life" (Cowling, 2001, p. 37). Fourth, formulated knowledge is to be used creatively for human betterment (Rogers, 1970). Additional theoretical understanding and elaboration is needed to assist in the understanding of the

abstract model introduced by Rogers. Within SUHB, the following are understood to be fundamental:

- Wholeness—the unified whole and not merely a sum of parts
- Unidirectionality—life process exists along an irreversible space time continuum

Overview of Rogers' Science of Unitary Human Beings

Within this model, human beings are conceptualized as dynamic, constantly evolving energy fields, rather than as homeostatic beings. Variation is expected and embraced within this homeodynamic perspective. The human field and the environmental field are constantly exchanging energy. There are no boundaries or barriers to inhibit energy flow between fields (Rogers, 1970). “The human being openly participates in energy transformation with the environment creating mutual change” (Leddy, 2004, p. 16). The following concepts are inherent to the model and provide additional clarity regarding the Rogerian SUHB.

Unitary Human Being

A unitary human being is “an irreducible, indivisible, pandimensional energy field identified by pattern and manifesting characteristics that are specific to the whole and which cannot be predicted from knowledge of the parts” (Rogers, 1992, p. 27). The life process of the unitary human being is one of wholeness and continuity as well as dynamic and creative change.

Environment

The environment is “an irreducible, pandimensional energy field identified by pattern and integral with the human field” (Rogers, 1992, p. 27). Manifestations emerge from this field and are perceived. Figure 13-1 is an illustration of the coexistence or integrality of the human/environmental fields.

Nursing

The focus of nursing is the care of people within their life process and the lived experience. According to Rogers (1970), “Professional practice in nursing seeks to promote symphonic interaction between human and environmental fields, to strengthen the integrity of the human field, and to direct and redirect patterning of the human and environment fields for realization of maximum health potential” (p. 122). The nurse participates knowingly with the patient and the goal of nursing is human betterment.

Health

The concepts of health and illness are understood as pattern manifestations. The manifestation of health emerges from the mutual, simultaneous patterning process of the human/environmental fields. Pattern manifestation is an expression of the process of life as defined by individuals and their cultures (Rogers, 1970). Therefore, what we know as health and illness are considered continuous expressions or manifestations of the life process in Rogers' framework.



FIGURE 13-1

Conceptualization of human/environmental energy field. (From Bultemeier, K. [1993]. Photographic inquiry of the phenomenon premenstrual syndrome within the Rogerian-derived theory of perceived dissonance. Unpublished doctoral dissertation, University of Tennessee–Knoxville.)

There are four major concepts of the framework. These concepts describe characteristics of manifestations of the person and environmental mutual process. The major concepts of the framework are as follows:

Pattern

Pattern identifies individuals and reflects their wholeness. Pattern is defined as the distinguishing characteristic of an energy field that is perceived as a single wave. Rogers (1986) clarifies that pattern is “an abstraction” that “gives identity to the field” (p. 5). Patterning “is the dynamic or active process of the life of the human being” (Alligood & Fawcett, 2004, p.11).

Energy Field

Energy is the “potential for process, movement, and change” (Leddy, 2003, p. 21). The energy field is the conceptual boundary of all that is, the living and the nonliving. The energy field “provides a way to perceive people and their environment as irreducible wholes” (Rogers, 1986, p. 4).

Pandimensionality

Pandimensionality is defined as “a nonlinear domain without spatial or temporal attributes” (Rogers, 1990, p. 7). The universe encompasses infinite dimensions, providing an understanding of nonlocality, acausality, and unpredictability (Butcher, 2006).

Openness

The human field and the environmental field are constantly in mutual process. There are no boundaries or barriers to inhibit energy flow between fields (Rogers, 1970). “The human being openly participates in energy transformation with the environment creating mutual change” (Leddy, 2004, p. 16).

The complexity, and yet simplicity, of these paradigm shifting ideas preceded current scientific understanding by several decades. Rogers used her extensive knowledge and diverse educational background to articulate a revolutionary way of viewing the human experience.

Homeodynamic Principles

Rogers’ principles of homeodynamics provide a way of describing, explaining, and envisaging a wide range of perceivable person/environment processes involving change and growth (Rogers, 1986, 1990, 1992). The principles are theoretical assertions that were first proposed by Rogers (1970) as “an ordered arrangement of rhythms characterizing both the human field and the environmental field that undergoes continuous dynamic metamorphosis in the human-environment process” (p. 101) and were later articulated by Rogers (1992) and Phillips (2010). The principles describe the nature of the human/environmental process as follows:

- Resonancy is the continuous change from lower- to higher-frequency wave patterns in the human/environmental fields.
- Helicy is the continuous, innovative, unpredictable, increasing diversity of human/environmental patterns.
- Integrality is the continuous, mutual, continuous human/environmental field process (Rogers, 1992).

Theories for Practice

The Rogerian model provides the abstract philosophical framework from which to view the unitary human being and the environmental field. Though SUHB served as a framework for hundreds of research projects over the past 50 years, recent works have clarified application of SUHB for nursing practice. Rogers states that the nature of nursing is based on theoretical knowledge that guides nursing practice (1970). Barrett’s theory of power (1990b, 1998, 2000, 2010), Butcher’s pattern portrait (2006), and Cowling’s unitary pattern appreciation (1990, 1997, 2001, 2004, 2005) have proposed practice methods for the visionary work of Martha Rogers that guide both research and practice. Emerging from Rogers’ model are many theories that explain human phenomena and direct nursing practice. Cowling (2004) observes, “Research and practice are ‘theory-in-action,’ and practice informs research and theory building” (p. 206). The Rogerian model, with its implicit assumptions, provides broad principles that conceptually direct theory development (Figure 13-2). Theory emerges from each of the principles and unites the art with the science (Allgood, 2002). Some of the midrange theories that have emerged from the SUHB and provide understanding and guidance in the practice of nursing based on Rogers’ homeodynamic framework include the Theory of Perceived Dissonance derived by Bultemeier (1997) from the Rogerian model, which provides a theoretical

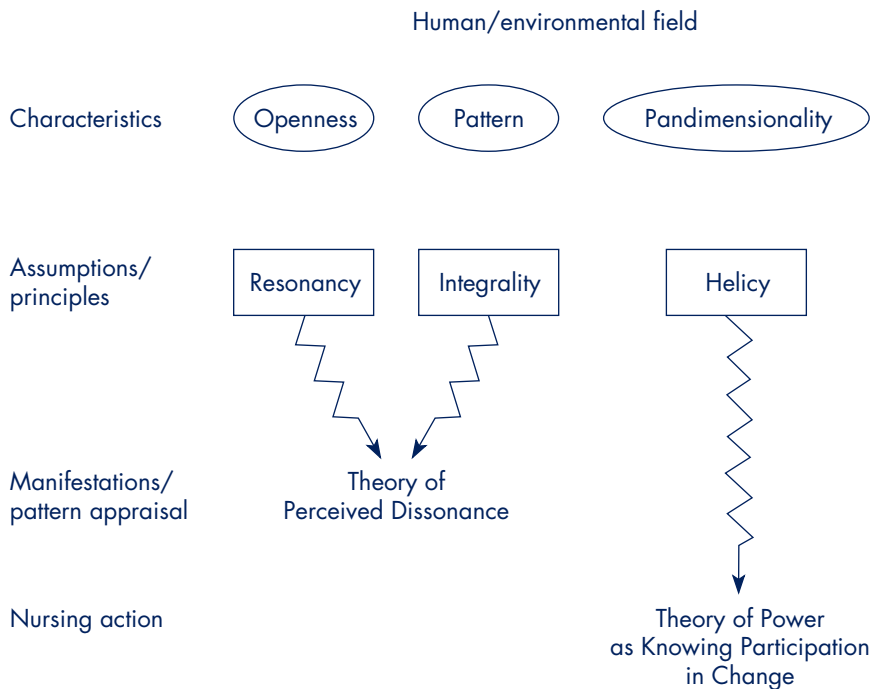


FIGURE 13-2

Two derived theories.

perspective for exploring situations of varying resonancy as manifested in health care concerns. This theory emerges from the principles of resonancy and integrality and proposes that resonancy is altered periodically and rhythmically during the evolution of energy fields. The perception of dissonance during the rhythmical evolution of the human/environmental field is proposed. During episodes of varying resonancy, the human/environmental field manifestations may be perceived as nonharmonic and as uncomfortable or unsettling to the person; thus the person may view himself or herself as out of harmony, or ill (see Figures 13-1 and 13-2).

Theory of Power as Knowing Participation in Change

The theory proposed by Barrett (1986, 2010), Power as Knowing Participation in Change, emerges from the principle of helicy within the Rogerian model (see Figure 13-2). The theory proposes that as knowledge increases, so does the capacity to participate knowingly. Furthermore, the theory proposes the capacity of human beings to pattern their human/environmental fields. Barrett (2010) explains, "Following the testing and research of the theory and measurement instrument, a practice methodology was developed and the health patterning practice model was initiated" (p. 47). Patterning manifests via the nurse and client patterning process. Barrett (2000) describes power as being aware of what one is choosing to do, feeling free to do it, and doing it. She identifies power as a relative state characterized by the momentary continuously changing pattern. Power is a relative trait characterized

by “the more consistent organization of the human and environmental field pattern” (Barrett, 1986, p. 174). She specifies that as the person is knowledgeable of his or her pattern manifestations, meaningful participation in the patterning process occurs. Barrett’s theory is used widely by nurses around the world. And in 2010, the volume 23, number 1 issue of *Nursing Science Quarterly* celebrated Barrett’s power theory and Rogers’ SUHB. Barrett (2010) told her story of the development of her power theory in that special issue also pointing out “what’s new and what’s next” (p. 47).

Theory of Self-Transcendence

The Theory of Self-Transcendence by Gulliver (2007) describes the process occurring at the end-of-life. The theory proposes continuously fluctuating imagery boundaries over past, present, and future. With self-transcendence the boundaries become less distinct. The theory further articulates the infinite possibilities for this transition.

Critical Thinking in SUHB Nursing Practice

Critical thinking is a process of conceptualizing, applying, analyzing, synthesizing, and evaluating information gathered from or generated by observation, experience, reflection, reason, and communication as a guide to belief and action. Within Rogers’ model, a critical thinking process was developed that specifies three components: pattern appraisal, mutual patterning, and evaluation (Barrett, 2000; Cowling, 1990, 2004). The activities associated with these components are occurring simultaneously and continuously throughout the care of the client. This is a simultaneous, integral, and constantly evolving process. The life process possesses its own unity and is inseparable from the environment.

Pattern Appraisal

Pattern appraisal requires the identification of pattern manifestations that reflect the whole. Pattern appraisal is integral to the provision of care to unitary human beings. Table 13-1 outlines the critical thinking of the nurse and the self-reflection by the client. Nursing within Rogers’ model focuses on the manifestations that emerge from the mutual human/environmental field process. The meeting of the art and science of nursing is vital to the entire process of caring for the client from a Rogerian framework. Pattern appraisal is a comprehensive assessment that incorporates cognitive input, sensory input, intuition, and language. Intuitive knowledge is gained from both the client and the nurse. The nurse accompanies the client in focusing on personal patterns and rhythms. Identification of emerging pattern manifestations throughout the provision of care allows for a departure from the linear cause-and-effect approach and uses an evolutionary approach. The nurse and client gain awareness of rhythmical fluctuations and their associated manifestations. A change in pattern of the human field and the environmental field is propagated by waves. The manifestations of field patterning that emerge are perceivable events (Rogers, 1992). The identification of patterns that characterize a phenomenon provides knowledge and understanding of the human experience and provides the basis for the care, which results (Rogers, 1970).

TABLE 13-1 Critical Thinking in Rogers' Model

| NURSE | CLIENT |
|---|---|
| Pattern Appraisal | Self-Reflection |
| Comprehensive assessment of: <ol style="list-style-type: none"> 1. Human field patterns of communication, exchange, rhythms, dissonance, harmony 2. Environmental field patterns of communication, rhythms, dissonance, harmony | Nutrition Work/leisure activities Exercise Sleep-wake cycles Relationships |
| Intuitive Reflection | Discomfort/Pain |
| Validate appraisal: <ol style="list-style-type: none"> 1. With self 2. With client 3. With others | Fears/hopes Dreams |
| Mutual Patterning of Human and Environmental Field | Patterning Activities |
| Sharing knowledge Offering choices Empowering client Fostering patterning Music, art, humor, language | Meditation Imagery Journaling Modifying surroundings, color, temperature, sounds, touch, music, art, humor |
| Evaluation | Personal Appraisal |
| Ongoing pattern appraisal | Areas for dissonance |
| Identify dissonance/harmony | Areas of harmony |
| Validate appraisal with client | Patterning activities |

Patterning “is the dynamic or active process of the life of the human being” that is “accessible to the senses” (Allgood & Fawcett, 2004, p. 11). Pattern information encompasses “phenomena that are categorized as physical/psychological, mental/emotional, social/cultural, and spiritual/mystical” (Cowling, 2005, p. 95). Wholistic pattern appraisal tools are necessary for application of the Rogerian model to the provision of nursing care to the unitary human being.

The nurse incorporates information gained from traditional measurement tools used to care for patients into the wholistic pattern appraisal. All conventional information gained such as vital signs, lab results, biopsy reports, and radiographic reports are integrated into the pattern appraisal and acknowledged as manifestations of the whole. Nurses are asked to incorporate knowledge gained from the use of their senses for the wholistic pattern appraisal. Consequently sight, smell, touch, hearing, and taste all contribute information of emergent patterns. Knowledge gained is via cognitive, sensory, intuitive understanding as well as language. Pattern appraisal includes perceivable rhythms of sleep/wake, mood, pain, movement, and nutrition. Patterning activities are based on probabilistic outcomes as they emerge

from the appraisal of pattern evolution. Emergent human environmental rhythms and patterns are manifestations of the whole; that is, the mutual process of human beings and their environment.

Cowling (2005) provides direction for nurses to study unitary human phenomena such as he has developed for nursing of despairing women. His guidelines assist the assessment and care process. He contends that all pattern appreciation must include the features of being synoptic—viewing together what normally is viewed apart, participatory and collaborative and transformative or reaching for the essence. Butcher (1998) identified additional pattern appraisal methods that include Human Field Motion Tool, Index of Field Energy, Human Field Image Metaphor Scale, Person-Environment Participation Scale, Perceived Field Motion Scale, and the Human Field Rhythms scale.

An important component of the appraisal process involves the work of the client to center and reflect on his or her personal pattern and on the pattern of those with whom he or she shares life. Bultemeier (1997) introduced the use of photographs and written narrative to assist in pattern identification. Pattern appraisal includes multiple lifestyle rhythms, such as nutrition, work, exercise, pain, anger, depression, sleep-wake cycles, and safety. A method for categorizing rhythmicities is by the use of criteria developed by Kim and Moritz (1982). These rhythms include the following: (1) exchanging (eating, elimination, breathing, giving, and receiving); (2) communication (verbal and nonverbal); and (3) relating (spacing, touching, eye contact, belonging, and referencing). During the appraisal, special attention is given to rhythms of pain and discomfort or to areas about which the client is uncomfortable or concerned (Cowling, 1990). Wholistic pattern appraisal methods and practice applications such as the following continue to be developed and refined for human betterment:

- Barrett (1990a,b, 1998, 2000, 2010): Health Patterning
- Butcher (1998, 2006): Pattern Portrait
- Cowling (1990, 1997, 2005): Pattern Appreciation
- Cowling and Swartout (2011): Life Patterning for Healing Praxis
- Greene and Greene (2012): Guided Imagery
- Gueldner, Michel, Bramlett, et al. (2005): the Well-being Picture Scale
- Johnston (1994): Human Field Image Metaphor Scale
- Malinski (2012): Unitary Rhythm of Dying-Grieving
- Willis and Griffith (2010) and Willis & Grace (2011): Healing Patterns
- Wright (2010): Power and Trust

The nurse integrates the feeling or sensing level of knowing, which is often described as intuitive or instinctual into the appraisal process. The intuitive knowledge is best realized through reflection, which assists in pattern appraisal. The nurse realizes that manifestations are not static but are partial perceptions of the synthesis of the past, present, and future. These perceptions provide the basis for reflection and intuitive knowing, which then further expands the appraisal. The manifestations, patterns, and rhythms are an indication of evolutionary emergence of the human field. Pattern appraisal, rhythm identification, and reflection provide the content for appraisal validation with the client. The emergent knowledge provides direction for nursing patterning activities. Maintenance and promotion of health,

prevention of disease, nursing diagnosis, intervention, and rehabilitation comprise the scope of nursing (Rogers, 1970).

The unitary human being and the environment are one. Rogers' theoretical model places an emphasis on "the essentials, potentials, and possibilities that exist within the wholeness of life" (Cowling, 2001, p. 37). Knowledge is used creatively for human betterment (Rogers, 1970). Nursing knowledge provides tools for emergent artistic application as the nurse cares for the unitary human being (Allgood, 2002; Rogers, 1992). Nursing is the creative use of nursing knowledge in the care of unitary human beings. Nursing practice accompanies unitary human beings in their health patterning. Therefore, clients define what health is for them and nurses assist their movement toward that goal.

Mutual Patterning

Once the client and nurse have consensus with respect to the appraisal, nursing action centers on mutual patterning of the human/environmental field. "Voluntary mutual patterning" is defined as the continuous process whereby the nurse assists clients to freely choose, with awareness, ways to participate in their well-being" (Barrett, 1998, p. 136). The goal of nursing is promoting symphonic rhythms of the human and environmental field. This is done to "strengthen the coherence and integrity of the human field and to direct and redirect patterning of the human and environmental fields" (Rogers, 1970, p. 122). Patterning activities in practice may be focused on areas identified as dissonant and described as pain, discomfort, or anxiety. Through mutual patterning of the nurse and the client, manifestations of pattern awareness and power emerge, evidence of Barrett's knowing participation in change theory.

Mutual patterning emerges from the pattern appraisal and relates to areas of mutually emerging goals. Barrett (1990a, 1998, 2010) identifies components of power that are fundamental to change in the patterning processes: awareness, choice, freedom, and involvement. From the inseparable components of power comes what Barrett (2010) calls a "Power Profile" (p. 49). The power profile indicates "the changing nature of the human and environmental field patterning" (p. 49) as follows:

- *Nature* of the awareness of experiences
- *Type* of choices that are made
- *Degree* to which freedom to act intentionally is operating
- *Manner* of involvement in creating specific changes (Barrett, 2010, p. 49)

Knowledge of the power profile and various options for patterning are shared with the client. The appraisal guides the knowledge shared, including specific information relating to options. The nurse ensures that the client has adequate knowledge of the appraisal and the various options for patterning. The sharing of the appraisal empowers client participation in the patterning process and choices. Various therapeutic patterning activities are discussed by the client and the nurse. Patterning activities instill hope and are individualized. Modifications are made as needed to accommodate patterning activities to the individual.

The client is empowered in the process of patterning (Barrett, 2010; Cowling, 2004). Power is characterized by continuously changing pattern. Power can be conceptualized as harmonious rhythmicity and as consistent integration of the

human/environmental field pattern. Cowling (1990) proposes the “goal of patterning is substantive change in health dynamic and change in the direction of health as defined by the client” (p. 51). The nurse’s goal is to assist the client to reach the health potential and foster harmonious patterns, thereby reducing the perception of dissonance.

Barrett (2010) defines patterning as the continuous process whereby the nurse, with the client, patterns the environmental field to promote harmony related to the health event. Rogers (1970) contends that “change proceeds by the continuous patterning of both [person] and environment by resonating waves” (p. 102). Change is specific to energy fields and is perceived through manifestations. Increasing diversity of field patterning characterizes the process of change (Rogers, 1970). Each human possesses rhythmicities of individual uniqueness. The goal is harmonious rhythmicities and human betterment.

Human and Environmental Field Patterning

All treatments and interactions are patterning activities as they are integral to the human/environmental field process. Practice modalities concern human life patterning and reflect the wholeness of the unitary human being in “continuous innovative change with the universe” (Barrett, 1990b, p. 35). The health-related change modalities allow for change; they do not require it. Nurses currently assist clients in the use of meditation, music, art, imagery, visualization, and therapeutic touch with a primary focus of patterning of the human field. Additional practice modalities based on motion, sound, light and color, humor, relaxation, nutrition, affirmation, art and nature, bibliotherapy, and journal keeping are all potentials for patterning. The nurse remembers that the human/environmental field is one without boundaries. “Human energy fields are integral with environmental energy fields; both fields change together toward greater diversity in field patterning” (Yarcheski, Mahon, & Yarcheski, 2004, p. 73). Awareness centers on perception of the human field, as it manifests the human/environmental field process. Centering is vital to all modalities for the nurse and the client. With centering, the client focuses on his or her core or energy field. Centering may be perceivable as a harmonious field manifestation. All manifestations, including those called *illness*, emerge from the mutual human/environmental field process. Patterning activities assist the client to move to and focus on emergent patterns.

Manifestations emerge from the human/environmental field process. The environment, with its healing quality, or lack of dissonance, is a vital component of patterning. Wholeness implies concern with the totality of the human/environmental field manifestation. The key is integrality—energy patterns flowing through energy patterns. The nurse works with the client in the context of the client’s family, community, and cultural group. The nurse’s concern for unitary human beings incorporates other nurses and health care providers, as well as the family, in the patterning. The nurse recognizes that pattern manifestations as perceived in the attitudes, intentions, and feelings of those with whom the client works are integral to the person/environmental field manifestation. Color, light, sound, and smell are manifestations of the environmental field. Harmony of the fields proposes increased potential for change (Davidson, 2001).

Evaluation

Evaluation is ongoing and simultaneous with appraisal and patterning. Emphasis is placed on identifying perceptions of desire for change. The evaluation process is ongoing and fluid as the nurse reflects on his or her intuitive knowing. Evaluation provides insight as the nurse integrates the pattern appraisal into all components of the nurse/unitary human process of care. The perceptions are then shared with the client and family/friends. Further mutual patterning is guided by the perceptions that emerge. This simultaneous process continues as long as the nurse-client relationship continues.

Analysis and Synthesis

The Rogerian model provides a challenging and innovative means of planning and implementing client care. The abstract ideas presented in Rogers' model are fertile for fostering theoretical conceptualizations and applications in patient care. The concept of unitary human beings and wholistic approaches offer opportunities for nurses to design and implement innovative healing environments. Creative modalities are continually being designed and implemented for pattern appraisal and patterning processes.

CASE HISTORY OF DEBBIE

Debbie is a 29-year-old woman who was recently admitted to the oncology nursing unit for evaluation after sensing pelvic "fullness" and noticing a watery, foul-smelling vaginal discharge. A Papanicolaou smear revealed class V cervical cancer. She was found to have a stage II squamous cell carcinoma of the cervix and underwent a radical hysterectomy with bilateral salpingo-oophorectomy.

Her past health history revealed that physical examinations had been infrequent. She also reported that she had not performed breast self-examination. She is 5 feet, 4 inches tall and weighs 89 pounds. Her usual weight is about 110 pounds. She has smoked approximately two packs of cigarettes a day for the past 16 years. She is gravida 2, para 2. Her first pregnancy was at age 16, and her second was at age 18. Since that time, she has taken oral contraceptives on a regular basis.

Debbie completed the eighth grade. She is married and lives with her husband and her two children in her mother's home, which she describes as less than sanitary. Her husband is unemployed. She describes him as emotionally distant and abusive at times.

She has done well following surgery except for being unable to completely empty her urinary bladder. She is having continued postoperative pain and nausea. It will be necessary for her to perform intermittent self-catheterization at home. Her medications are (1) an antibiotic, (2) an analgesic as needed for pain, and (3) an antiemetic as needed for nausea. In addition, she will be receiving radiation therapy on an outpatient basis.

Debbie is extremely tearful. She expresses great concern over her future and the future of her two children. She believes that this illness is a punishment for her past life.

Care of Debbie with Rogers' Model

Consistent with the Rogerian model, the process of caring for Debbie centers on the mutual process of pattern appraisal, mutual patterning, and reappraisal.

Pattern Appraisal

This appraisal is grouped into exchanging patterns, communication patterns, and relating patterns. The visible human pattern manifests dissonance in elimination (difficulty urinating), pain, extreme underweight, and cancer. The manifestations of vital signs, pathology reports, and lab reports become integral with the pattern appraisal. Dissonance is noted in the progression of the disease and in her pain. Appraisal of Debbie's sleep patterns, her nutritional status, and her perceptions of self and of healthful or harmonious existence is needed. The history is integral to the pattern appraisal. Debbie has a pattern of smoking, which has been associated with less-than-optimal health manifestation. This visible rhythmical pattern is a manifestation of evolution toward dissonance. In addition, Debbie has a pattern manifestation that has been labeled *cervical cancer*. This emergent pattern manifests as dissonant.

Communication patterns manifest as dissonant as Debbie has a low educational level, which is relevant as patterning activities are introduced. Sensory data add to the pattern appraisal. Through language, Debbie identifies a perception of dissonance with her husband and with her environment, which she describes as "unsanitary." Communication dissonance manifests as being withdrawn and emotionally distant from her husband. Relating dissonance is manifested as unclean environment. Providing care within the Rogerian model emphasizes the self-articulation of personal pattern manifestations and self-knowledge.

Relating manifestations are identified as anxious or being withdrawn is integral to the appraisal. Using Power as knowing participation in change to guide the care the nurse dialogues with Debbie and her family to answer questions and give guidance related to potential issues, which may emerge. The entire family becomes the center of the phenomenon and patterning activities involve all. The pattern appraisal is ongoing. Debbie is encouraged to use verbal and intuitive capacity to access manifestations. Sensory data are gained through language, feelings, and perceptions. The nurse has reported that Debbie has a manifestation of fear. Debbie reports the fear of inability to manage her life since the onset of this illness, and the nurse senses this manifestation of fear. Debbie's self-knowledge links the illness to her personal belief of being punished for past mistakes. History and focusing on the relative present to explore the pattern of punishment are imperative. It is important that the nurse appraise the environment of the hospital and of the others who share her existence. Debbie reports fear, a manifestation of dissonance.

Time with the nurse is needed to foster this comprehensive appraisal of Mary. During this entire process the nurse must rely heavily on personal intuition and insight regarding the pattern that is emergent with Debbie. All of the knowledge gained forms the unitary pattern of Debbie. The ongoing pattern appraisal is shared with the client. Emphasis can be placed on areas in which dissonance and harmony

are noted in the personal and environmental field manifestations. Consensus needs to be reached with Debbie before and while patterning activities are suggested and implemented.

Mutual Patterning

Dissonance can be perceived in many aspects of Debbie's appraisal. Environmental harmony is lacking, as is noted in Debbie's perception of it as unsanitary. In addition, dissonance is perceived with respect to her relationship with her husband. Personal dissonance is noted in the manifestations of cancer, weight loss, pain, nausea, and tobacco use. This dissonance is also conceptualized as fear in Debbie's words and in the emotional distance that she feels. The pattern appraisal is shared with the client. Emphasis is placed on areas in which dissonance and harmony are noted in the personal and environmental field manifestations. Consensus is reached with Debbie before patterning activities can be suggested and implemented.

Many patterning modalities can be introduced. The process is mutual between the nurse and the client. Surgery is a patterning activity. Manifestations will evolve from the surgical intervention and will require reconceptualization and validation with the patient. Medications are patterning modalities. Debbie is receiving medications. Decisions are made in conjunction with Debbie regarding the use of the medications and the patterning that emerges with the introduction of these modalities. Personal knowledge regarding the surgery and the medications empowers Debbie to be integral in the selection of modalities. Debbie possesses freedom and involvement in the selection of modalities. Possible options include therapeutic touch, humor, meditation, visualization, and imagery. Debbie is assessed regarding her ability to understand and select different patterning modalities. Therapeutic touch is introduced to Debbie. The touch is introduced and incorporated into the management of pain manifestations. Touch, in combination with medications, provides patterning that Debbie can direct. The nurse introduces the process of touch to Debbie's husband and teaches him how to incorporate touch into his wife's care. This option would be acceptable only if Debbie feels safe being touched by her spouse. Another option is to teach Debbie how to center her energy and channel her energy to the area in pain. Patterning directed at the manifestation of fear is introduced. Options that include imagery, music, light, and meditation are discussed. Fear manifests as apprehension of self-catheterization. Emphasis is placed on having Debbie direct how, where, when, and by whom the self-catheterization will be taught.

Evaluation

Establishing a rhythm to the catheterization schedule that is harmonious with Debbie's life reduces dissonance. Patterning of nutrition and catheterization based on the pattern appraisal assists in empowering Debbie to learn self-catheterization. A rhythm that is harmonious with Debbie and her energy field rhythm evolves. Specific actions of the nurse with respect to language and knowledge about the catheterization process empower Debbie to direct this phase of her treatment.

CASE HISTORY OF MARY

Mary is a 53-year-old woman who is in endstage leukemia. She has had two failed bone marrow transplants and three rounds of chemotherapy. She is moving into hospice home care, and the family and Mary become your client. Mary is the mother of four children: 25, 23, 20, and 17. One child lives at home.

Pattern appraisal includes:

Mary—frail, quiet, almost translucent in appearance, resting comfortably in hospital bed in living room, nasal O₂ in place

Tom—husband, quiet, pacing

Home—clean, orderly, many personal articles, large window facing north and looking into the yard. Noise level low. Dog sleeping on floor.

Nursing Care of Mary with Rogers' Model

Nursing care for Mary is guided by the components of Gulliver's Theory of Self-Transcendence. Self-transcendence at the end of life is a process of merging of the past, present, and future. Nursing care for Mary offers the opportunity to incorporate a variety of patterning activities. Patterning activities will be directed by the knowledge gained during the appraisal. As Mary nears and prepares for the end of her life, many patterning concerns must be addressed for peaceful closure to her life and the change to another energy form.

Pattern Appraisal

The visible rhythmical pattern is a manifestation of peace (Mary) and a human environmental manifestation of anxiety in husband. The pattern is one of movement toward transcendence and death for Mary and many unknowns for Tom and Mary. Using Power as knowing participation in change to guide the care the nurse dialogues with Mary and Tom to answer questions and give guidance related to potential issues, which may emerge. The entire family becomes the center of the phenomenon and care incorporates all. The unknown and preparation for loss is the focus. The pattern appraisal is ongoing. Mary is verbal and intuitive. She readily shares with others the story of her journey with cancer. A sense of sadness and communion with others is perceived.

Dissonance is noted in the progression of the disease, in her pain. Harmony is noted in her relationship with her husband and family and with her sense of how she has progressed through this disease process. Mary has a great deal of knowledge about herself and about the disease.

Sensory data are gained through language, feelings, and perceptions. The nurse perceives that much attention to sensory information is needed. Mary has a great deal to share about her feelings regarding the disease and her thoughts and fears. Dissonance is perceived through her acknowledgment of fear and apprehension regarding her future. It is known that pain is a major component of end of life. Therefore, the pattern appraisal (using all senses) to access the level of comfort of

Mary is vital. Pain often manifests as a perceived dissonance. Use of touch to assess and care for Mary is vital to the mutual patterning of Mary and Tom during this transition.

This same appraisal tool can be given to Tom as he cares for her. Evaluation is ongoing and integral to pattern appraisal and not a separate component. Mary and Tom are offered ways to ease pain, discuss fears and concerns and encouraged to pattern their environmental field in ways that are conducive to peace and comfort manifestations. Language provides a valuable addition to the pattern appraisal of Mary and Tom.

Appraisal of Mary's sleep patterns, her nutritional status, and her perceptions of self and of healthful or harmonious existence is needed. This appraisal can be grouped into exchanging patterns, communication patterns, and relating patterns, as discussed previously. Time with the nurse is needed to foster this comprehensive appraisal of Mary. During this entire process the nurse relies heavily on personal intuition and insight regarding the pattern that is emergent with Mary. All of the knowledge gained forms the unitary pattern of Mary.

Dissonance is perceived in many aspects of Mary and Tom's appraisal. Personal dissonance is noted in the manifestations of cancer, weight loss, pain, and nausea for Mary. Dissonance is recognized as fear in Mary and Tom as they discuss Mary's care since she is home.

Mutual Patterning

Many patterning modalities can be discussed. The process is mutual between the nurse and the client. Mary is receiving medications. Decisions are made in conjunction with Mary regarding the use of the medications. Personal knowledge regarding the medications empowers Mary to be integral in the selection of modalities. Mary possesses freedom and involvement in the selection of modalities. Possible options include therapeutic touch, humor, meditation, visualization, and imagery. Therapeutic touch can be introduced to Mary. The touch is introduced and incorporated into the management of pain manifestations. Touch, in combination with medications, is patterning that Mary can direct. The nurse may introduce the process of touch to Tom and teach him how to incorporate touch into his wife's care. Another option would be to teach Mary how to center her energy and channel her energy to the area in pain. Patterning directed at the integration of past, present, and future is offered to foster self-transcendence. Options that include journaling, imagery, music, light, and meditation can be discussed. A rhythm that is harmonious with Mary and her energy field rhythm will evolve. The entire family is involved in power as knowing participation in change. Language and the use of language are explored to determine what patterning Mary would prefer.

Evaluation

The appraisal process again is ongoing and integrated throughout the care. Specific emphasis is placed on emergent patterns of dissonance or harmony that are evident.

Manifestations of pain, fear, and tension with family members are appraised. A summary of the pattern appraisal is shared with Mary, and mutual patterning is modified or instituted as indicated based on the evaluation.

Options regarding how her physical space is oriented, decorated, and located are explored in the patterning of Mary. She and her family are given latitude in bringing personal effects, artwork, children's drawings, and photographs. The bed is turned to face the window at Mary's request. A favorite rocker and a bright rug for the floor are brought into the room. Mary elects to place a beautiful cloth over her bedside table and has her small weaving loom placed in the room. The room radiates a sense of peace, and the feeling of the illness is lost. According to Rogers (1992), dying is moving beyond the pattern visible to human perception. Death is a transformation of energy (Rogers, 1970). At death, the human field ceases to exist and identity as a living human being is gone. The process of dying is a period of transition in which the integrity of the human field as such diminishes and dies (Rogers, 1970). As the pattern of cancer evolves for Mary, manifestations of pain increase and the reality of impending death emerges. Nursing care revolves around the introduction of modalities to assist Mary and her family as the human/environmental field evolves.

CRITICAL THINKING EXERCISES

1. Keep a journal for 3 days. Using Table 13-1 as a guide, conduct a comprehensive pattern appraisal of yourself in each of the areas. You may include photos or historical events as a source of pattern appraisal. Note your harmonious and dissonant rhythms.
2. Conduct a comprehensive pattern appraisal of your home environment. Focus on manifestations that are perceived as harmonious and those that seem dissonant. Record your observations in your journal. Compare these rhythms with those from the appraisal in question.
3. Identify a patient and introduce at least one patterning modality and record pattern appraisal evolution as the patterning activity is introduced. Follow the process of pattern appraisal, mutual patterning, and evaluation.
4. Select a patient for a comprehensive pattern appraisal, including discussion with family members. Develop a comprehensive appraisal and review the appraisal with the patient.
5. Introduce a nursing plan for the person selected in question 4 following the steps outlined in Theory of Knowing Participation in Change (awareness, choice, freedom, and involvement).
6. Reflect on your learning through experiences in questions 4 and 5 and write a summary.

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Roy's Adaptation Model in Nursing Practice

Kenneth D. Phillips and Robin Harris

Adaptation is viewed as the process and outcome whereby thinking and feeling persons, as individuals or in groups, use conscious awareness and choice to create human and environmental integration.
(Callista Roy, 2008, p. 138)

Human beings incessantly respond to myriad internal and external environmental stimuli. A stimulus is any entity that provokes a response (Andrews & Roy, 1991a) and that serves as the point of interaction between the person and the environment (Roy & Andrews, 1999). Environmental stimuli either threaten or enhance an individual's ability to adapt. As an example, loving, supportive behaviors from a parent enhance a child's ability to successfully adapt, whereas a hostile, abusive parent poses a threat to a child's adaptation.

Nursing plays a vital role in assisting individuals who are sick or well to respond to a variety of new stressors, move toward optimal well-being, and improve the quality of their lives through adaptation. The Roy Adaptation Model (Roy & Andrews, 1991) provides an effective framework for addressing the adaptive needs of individuals, families, and groups.

As noted in Chapter 1, nursing's most pressing question is the following: "What is the nature of the knowledge that is needed for the practice of nursing?" Nurses practicing within the Roy Adaptation Model seek the following:

- Greater knowledge of factors that either promote or hinder adaptation
- Better methods and tools for assessing adaptation level
- Specific nursing interventions that either promote or hinder adaptation
- Effective methods for evaluating adaptation as an outcome of nursing care

History and Background

Sister Callista Roy, a Sister of Saint Joseph of Carondelet, developed the Roy Adaptation Model (RAM) in 1964 in response to a challenge by her professor, Dorothy E. Johnson. Since that time, the RAM has been reconceptualized for use in the twenty-first century. The development of the model has been a dynamic process. The preliminary ideas of this conceptual framework were first published in an article titled *Adaptation: A Conceptual Framework for Nursing* (Roy, 1970). The RAM continues to be refined. The RAM is presented in its most complete and recent form in *The Roy Adaptation Model* (Roy & Andrews, 1999). Nurses in the United States, in Canada, and around the world practice nursing from the perspective of RAM. The RAM has stimulated other scholars to publish books of their own about adaptation nursing (Rambo, 1984; Randell, Poush Tedrow, & Van Landingham, 1982; Welsh & Clochesy, 1990), has been implemented in numerous hospitals and other health care settings, and has been applied to diverse populations, adaptive needs, and developmental stages (Fawcett, 2005; Phillips, 2006).

Overview of Roy's Adaptation Model

The RAM provides a useful framework for providing nursing care for persons in health and in acute, chronic, and terminal illness. The RAM views the person as an adaptive system in constant interaction with an internal and external environment. The environment is the source of a variety of stimuli that either threaten or promote the person's unique wholeness. The person's major task is to maintain integrity in the face of these environmental stimuli. Integrity is "the degree of wholeness achieved by adapting to changes in needs" (Roy & Andrews, 1999, p. 102). Roy, drawing on the work of Helson (1964), categorizes these types of stimuli as focal, contextual, or residual. The first type of stimulus, focal, is defined as the internal or external stimulus most immediately challenging the person's adaptation. The focal stimulus is the phenomenon that attracts the most of one's attention. Contextual stimuli are all other stimuli existing in a situation that strengthen the effect of the focal stimulus. Residual stimuli are any other phenomena arising from a person's internal or external environment that may affect the focal stimulus but whose effects are unclear (Roy & Andrews, 1999). The three types of stimuli act together and influence the adaptation level, which is a person's "ability to respond positively in a situation" (Andrews & Roy, 1991a, p. 10). A person's adaptation level may be described as integrated, compensatory, or compromised (Roy & Andrews, 1999).

A person does not respond passively to environmental stimuli; the adaptation level is modulated by a person's coping mechanisms and control processes. Roy categorizes the coping mechanisms into either the regulator or the cognator subsystem. The coping mechanisms of the regulator subsystem occur through neural, chemical, and endocrine processes. The coping mechanisms of the cognator subsystem occur through cognitive-emotive processes. Roy has identified two control processes that coincide with the regulator and cognator subsystems when a person

responds to a stimulus. The control processes identified by Roy are the stabilizer subsystem and the innovator subsystem. The stabilizer subsystem refers to “the established structures, values, and daily activities whereby participants accomplish the primary purpose of the group and contribute to common purposes of society” (Roy & Andrews, 1999, p. 47). The innovator subsystem refers to cognitive and emotional strategies that allow a person to change to higher levels of potential (Roy & Andrews, 1999).

Although direct observation of the processes of the regulator and cognator subsystems is not possible, Roy proposes that the behavioral responses of these two subsystems can be observed in any of the four adaptive modes: physiological, self-concept, role function, and interdependence adaptive modes. Roy and her associates describe the function of the adaptive modes in the Theory of the Person as an Adaptive System (Andrews & Roy, 1991a).

Roy's Theory of the Person as an Adaptive System postulates that the four adaptive modes are interrelated through perception. Either an adaptive response or an ineffective response in one mode influences adaptation in the other modes.

The physiological adaptive mode refers to the “way a person responds as a physical being to stimuli from the environment” (Andrews & Roy, 1991a, p. 15). The five physiological needs of this mode are oxygenation, nutrition, elimination, activity and rest, and protection. Four complex processes that mediate the regulatory activity of this mode are senses, fluids and electrolytes, neurological function, and endocrine function. Physiological integrity is the adaptive response of this adaptive mode (Andrews & Roy, 1991a, 1991c).

The self-concept adaptive mode refers to psychological and spiritual characteristics of the person (Andrews, 1991b; Andrews & Roy, 1991a; Roy & Andrews, 1999). A person's self-concept consists of all the beliefs and feelings that one has formed about oneself. The self-concept is formed both from internal perceptions and from the perceptions of others. The self-concept changes over time and guides one's actions. The self-concept incorporates two components: the physical self and the personal self. The physical self incorporates body sensation and body image (Buck, 1991b). The personal self incorporates self-consistency, self-ideal, and moral-ethical-spiritual self (Buck, 1991a). Psychic integrity is the goal of the self-concept mode (Andrews, 1991b; Andrews & Roy, 1991a).

The interdependence adaptive mode refers to coping mechanisms arising from close relationships that result in “the giving and receiving of love, respect, and value” (Andrews & Roy, 1991a, p. 17). In general, these contributive and receptive behaviors occur between the person and the most significant other or between the person and his or her support system. Affectional adequacy is the goal of the interdependence adaptive mode (Roy & Andrews, 1999; Tedrow, 1991).

The role function adaptive mode refers to the primary, secondary, or tertiary roles the person performs in society. According to Andrews and Roy (1991a), “A role, as the functioning unit of society, is defined as a set of expectations about how a person occupying one position behaves toward a person occupying another position” (p. 16). Social integrity is the goal of the role function mode (Andrews, 1991a; Nuwayhid, 1991; Roy & Andrews, 1999).

Adaptive or ineffective responses result from these coping mechanisms. Adaptive responses promote the integrity of the person and the goals of adaptation. The major task of a person is to adapt to environmental stimuli to achieve survival, growth, development, and mastery. Ineffective responses neither promote integrity nor contribute to the goals of adaptation (Andrews & Roy, 1991a).

As described earlier, adaptation is accomplished through two main coping subsystems: regulator and cognator. The mechanisms of regulator and cognator have not been explicated by Roy because these mechanisms cannot be directly observed and remain largely unknown. However, the behaviors of regulator and cognator are manifested indirectly and can be observed and measured in the four adaptive modes (Roy, 1981).

Roy and Andrews (1999) define health as “a state and a process of being and becoming an integrated and whole person” (p. 31). Health is a reflection of how successfully an individual has adapted to environmental stimuli. The goal of nursing therefore is to help a person achieve adaptation by helping the person survive, grow, reproduce, and master. Adaptation leads to optimum health and well-being, to the highest quality of life possible, and to death with dignity (Andrews & Roy, 1991a). Adaptation enables the person to find meaning and purpose in life and to become an integrated whole.

Critical Thinking in Nursing Practice with Roy’s Model

The nursing process is a goal-oriented, problem-solving approach to guide the provision of comprehensive, competent nursing care to a person or groups of persons. According to Andrews and Roy (1991b), the nursing process “relates directly to the view of the person as an adaptive system” (p. 27). Roy has conceptualized the nursing process to comprise the following six simultaneous, ongoing, and dynamic steps (Roy & Andrews, 1999):

1. Assessment of behavior
2. Assessment of stimuli
3. Nursing diagnosis
4. Goal setting
5. Intervention
6. Evaluation

Each of these phases of the nursing process is discussed within the RAM. The goal of nursing in the RAM is to promote adaptation in each of the four adaptive modes (Roy & Andrews, 1999).

The nursing process alone is limited in promoting critical thinking; however, nursing theory serves as a guide for nursing care. Nursing theory directs the practitioner toward important aspects of assessing, planning, goal setting, implementation, and evaluation. Furthermore, practice within a model allows the practitioner to ignore irrelevant considerations and to selectively choose among a variety of nursing strategies. Another way of saying this is that nursing theory promotes critical thinking. Table 14-1 illustrates how the RAM guides the nurse through the critical thinking process.

TABLE 14-1 Critical Thinking in the Roy Adaptation Model

| Phases of Process | Physiological Adaptive Mode | Interdependence Adaptive Mode | Self-Concept Adaptive Mode | Role Function Adaptive Mode |
|------------------------|--|---|--|--|
| Assessment of behavior | Oxygenation Nutrition Elimination Activity and rest Protection Senses Fluids and electrolytes Neurological function Endocrine function | Significant other Giving Receiving Support system Giving Receiving | Physical self Body sensation Body image Personal self Self-consistency Self-ideal Moral-ethical-spiritual self | Instrumental Primary role Secondary roles Tertiary roles Expressive Primary role Secondary roles Tertiary roles |
| Assessment of stimuli | Focal stimulus Contextual stimuli Residual stimuli | Focal stimulus Contextual stimuli Residual stimuli | Focal stimulus Contextual stimuli Residual stimuli | Focal stimulus Contextual stimuli Residual stimuli |
| Nursing diagnosis | Statement of behaviors with most relevant stimuli | Statement of behaviors with most relevant stimuli | Statement of behaviors with most relevant stimuli | Statement of behaviors with most relevant stimuli |
| Goal setting | Behavior Change expected Time frame | Behavior Change expected Time frame | Behavior Change expected Time frame | Behavior Change expected Time frame |
| Intervention | Management of stimuli Alter Increase Decrease Remove Maintain | Management of stimuli Alter Increase Decrease Remove Maintain | Management of stimuli Alter Increase Decrease Remove Maintain | Management of stimuli Alter Increase Decrease Remove Maintain |
| Evaluation | Observation of behaviors after interventions have been completed to see if goals have been obtained | Observation of behaviors after interventions have been completed to see if goals have been obtained | Observation of behaviors after interventions have been completed to see if goals have been obtained | Observation of behaviors after interventions have been completed to see if goals have been obtained |

Assessment of Behavior

From Roy's perspective, behavior is an action or a reaction to a stimulus. A behavior may be observable or nonobservable. An example of an observable behavior is pulse rate; a nonobservable behavior is a feeling experienced by the person and reported to the nurse. Exploration of behaviors manifested in the four adaptive modes allows the nurse to achieve an understanding of the current adaptation level and to plan interventions that will promote adaptation. At the beginning of the

nurse-client relationship, a thorough assessment of behavior must be performed (Roy & Andrews, 1999) and the assessment must be ongoing. Table 14-1 presents categories of behaviors that are assessed in each of the adaptive modes.

Assessment of Stimuli

A stimulus is any change in the internal or external environment that induces a response in the adaptive system. Stimuli that arise from the environment can be classified as focal, contextual, or residual. In this level of assessment, the nurse analyzes subjective and objective behaviors and looks more deeply for possible causes of a particular set of behaviors (Roy & Andrews, 1999).

Nursing Diagnosis

A nurse's education and experience enable him or her to make an expert judgment regarding health care and adaptive needs of the client. This judgment is expressed in a diagnostic statement that indicates an actual or a potential problem related to adaptation. The diagnostic statement specifies the behaviors that led to the diagnosis and a judgment regarding stimuli that threaten or promote adaptation (Roy & Andrews, 1999). The RAM defines nursing diagnosis "as a judgment process resulting in statements conveying the adaptation status of the human adaptive system" (Roy & Andrews, 1999, p. 77).

Goal Setting

Goal setting focuses on promoting adaptive behaviors. Together the nurse and the client agree on clear statements about desired behavioral outcomes of nursing care. The outcome statement should reflect a single adaptive behavior, be realistic, and be measurable. The goal statement should include the behavior to be changed, the change expected, and the time frame in which the change in behavior should occur (Roy & Andrews, 1999).

Intervention

According to Andrews and Roy (1991b), "Intervention focuses on the manner in which goals are attained" (p. 44). A nursing intervention is any action taken by a professional nurse that he or she believes will promote adaptive behavior by a client. Nursing interventions arise from a solid knowledge base and are aimed at the focal stimulus whenever possible (Andrews & Roy, 1991b). Intervention is any nursing approach that is intended "to promote adaptation by changing stimuli or strengthening adaptive processes" (Roy & Andrews, 1999, p. 86).

Evaluation

In the RAM, evaluation consists of one question: "Has the person moved toward adaptation?" Evaluation requires that analysis and judgment be made to determine whether those behavioral changes stated in the goal statement have, or have not, been achieved by the recipient of nursing care (Andrews & Roy, 1991b). In the evaluation phase, the nurse judges the effectiveness of the nursing interventions that have been implemented and determines to what degree the mutually agreed upon goals have been achieved (Roy & Andrews, 1999).

CASE HISTORY OF DEBBIE

Debbie is a 29-year-old woman who was recently admitted to the oncology nursing unit for evaluation after sensing pelvic “fullness” and noticing a watery, foul-smelling vaginal discharge. A Papanicolaou smear revealed class V cervical cancer. She was found to have a stage II squamous cell carcinoma of the cervix and underwent a radical hysterectomy with bilateral salpingo-oophorectomy.

Her health history revealed that physical examinations had been infrequent. She also reported that she had not performed breast self-examination. She is 5 feet, 4 inches tall and weighs 89 pounds. Her usual weight is about 110 pounds. She has smoked approximately two packs of cigarettes a day for the past 16 years. She is gravida 2, para 2. Her first pregnancy was at age 16, and her second was at age 18. Since that time, she has taken oral contraceptives on a regular basis.

Debbie completed the eighth grade. She is married and lives with her husband and her two children in her mother's home, which she describes as less than sanitary. Her husband is unemployed. She describes him as emotionally distant and abusive at times.

She has done well following surgery except for being unable to completely empty her urinary bladder. She is having continued postoperative pain and nausea. It will be necessary for her to perform intermittent self-catheterization at home. Her medications are (1) an antibiotic, (2) an analgesic as needed for pain, and (3) an antiemetic as needed for nausea. In addition, she will be receiving radiation therapy on an outpatient basis.

Debbie is extremely tearful. She expresses great concern over her future and the future of her two children. She believes that this illness is a punishment for her past life.

Nursing Care of Debbie with Roy's Model

Physiological Adaptive Mode

Debbie's health problems are complex. It is impossible to develop interventions for all of her health problems within the space of this chapter; therefore, representative examples are presented.

Assessment of Behavior

Postoperatively, Debbie has been unable to completely empty her urinary bladder. She states that she is numb and unable to tell when she needs to void. Catheterization for residual urine revealed that she was retaining 300 ml of urine after voiding. It will be necessary for her to perform intermittent self-catheterization at home. Unsanitary conditions at Debbie's home place her at high risk for developing a urinary tract infection. She states that she is scared about performing self-catheterization.

Assessment of Stimuli

In this phase of the nursing process, the nurse searches for stimuli responsible for the observed behavior. After stimuli have been identified, they are classified as focal, contextual, or residual.

The focal stimulus for Debbie's urinary retention is the disease process. Contextual stimuli include tissue trauma resulting from surgery and radiation therapy. Debbie verified anxiety as a residual stimulus.

Infection is a potential problem. The focal stimulus is the need for intermittent self-catheterization. Contextual stimuli include altered skin integrity related to surgical incision, poor understanding of aseptic principles, and unsanitary conditions at Debbie's home.

Nursing Diagnosis

From the assessment of behaviors and the assessment of stimuli, the following nursing diagnoses were made:

- Altered elimination: urinary retention related to surgical trauma, radiation therapy, and anxiety
- Potential for infection related to intermittent self-catheterization, altered skin integrity related to surgical incision, poor understanding of aseptic principles, and unsanitary conditions at Debbie's home

Goal Setting

Goals were set mutually between the nurse and the client for each of the nursing diagnoses. The goals were the following:

- Complete urinary elimination every 4 hours as evidenced by correct demonstration of the procedure for intermittent self-catheterization
- Continued absence of signs of infection of the surgical incision and urinary tract

Intervention

To help Debbie attain these goals, the following nursing interventions were implemented:

- *Altered elimination: urinary retention related to surgical trauma, radiation therapy, and anxiety*

Debbie was taught the importance of performing intermittent self-catheterization every 4 hours to prevent damage to the urinary bladder and kidney. She was taught to assess her abdomen for bladder distention and the proper procedure for intermittent self-catheterization. She was instructed to keep a record of the exact time and amount of voiding and catheterizations. In addition, Debbie was taught relaxation techniques to facilitate voiding so that it would not be necessary for her to catheterize herself as often.

- *Potential for infection related to intermittent self-catheterization, altered skin integrity related to surgical incision, poor understanding of aseptic principles, and unsanitary conditions at Debbie's home*

Debbie was taught the importance of washing hands before touching the surgical incision or doing incision care. Following a demonstration of incision care by

the nursing staff, Debbie was asked to perform a return demonstration. After the intermittent self-catheterization procedure was explained and demonstrated, Debbie performed a return demonstration with good technique.

Evaluation

Evaluation of Debbie's adaptive level was performed each shift. Significant findings included the following:

- It will be necessary for Debbie to perform intermittent self-catheterization at home. She was able to state the importance of performing intermittent self-catheterization on a regular basis. She performed a return demonstration of intermittent self-catheterization before discharge, and she was able to adequately adhere to aseptic principles during the procedure. She accurately recorded the times and amount for each voiding and catheterization.
- Debbie was able to list the signs and symptoms of a wound and a urinary tract infection and to state appropriate steps to take if symptoms occur (i.e., notify physician or nurse practitioner). She was able to discuss the importance of maintaining adequate oral fluid intake. Debbie was given a thermometer and instructed in its use. She correctly demonstrated taking a temperature.

Interdependence Adaptive Mode: Assessment of Behavior

Significant Other

Debbie's most significant other is her husband. She describes her husband as emotionally distant and abusive at times. He has been at the bedside since Debbie was admitted to the hospital. He appears worried. In addition to these findings, it would be important to determine how Debbie and her husband give and receive love, value, and respect and how they express nurturing and caring behaviors to each other.

Support System

Debbie's support system includes her mother and her two children. Debbie and her family live in her mother's home. It is important to know how Debbie and her support system give and receive love, value, and respect and how they express nurturing and caring behaviors to each other.

Assessment of Stimuli

Assessment of stimuli within the interdependence adaptive mode reveals that Debbie's relationship needs with her husband are not being met. It is encouraging that her husband is displaying nurturing, caring behaviors while Debbie is in the hospital. Further evaluation of Debbie's self-esteem would be warranted. Debbie and her husband were married at an early age. Their knowledge regarding building friendships and relationships may be limited. It would be important to assess modes of communication as well. The developmental stage for Debbie and her husband is that of young adults. In this stage, the individual becomes independent and establishes his or her own family. Debbie and her family live with her mother. This may

be creating a stress on interdependence. Debbie acknowledges that she and her husband have very little time alone.

The focal stimulus in the interdependence adaptive mode is an emotionally distant relationship with her husband. Contextual stimuli are the following:

- Debbie and her husband were married at an early age following an unplanned pregnancy.
- They exhibit ineffective communication skills.
- They live with her mother.
- They have very little time alone.

Nursing Diagnosis

The following nursing diagnoses of interdependence adaptive needs were made:

- Affectional inadequacy related to emotionally distant relationship, marriage at an early age following an unplanned pregnancy, ineffective communication skills, living with a parent, and having very little time alone
- Potential change in support system dynamics related to potential role changes and changes in health status

Goal Setting

To help Debbie with these adaptive needs, she and the nurse agreed on the following goals:

- Increased affectional adequacy between Debbie and her husband by discharge as manifested by verbalization of and a need for increased communication between Debbie and her husband
- Support system dynamics to remain stable during Debbie's recovery period

Intervention

To help Debbie attain these goals, the following nursing interventions were implemented:

- *Affectional inadequacy related to emotionally distant relationship, marriage at an early age following an unplanned pregnancy, ineffective communication skills, living with a parent, and having very little time alone*

Assessment of interdependence was begun while performing other routine care. Debbie was asked the following questions:

- Can you tell me about your relationship with your husband?
- Do you consider it a good relationship?
- What do you think would make it a good relationship?
- How does your husband express to you that he loves you?
- How do you express to your husband that you love him?
- How do you and your husband talk about things important to you?

Debbie's husband has been with her much of the time she has been hospitalized, and he seemed worried. Her husband was encouraged to massage Debbie's back when she was experiencing pain or to just hold her hand when she became tearful.

- *Potential change in support system dynamics related to potential role changes and changes in health status*

With Debbie's permission, time was allocated to discuss important aspects of relationship building. Both Debbie and her husband were agreeable. Professional family counseling services were obtained for Debbie's family through the hospital's parish nursing ministry.

Evaluation

Debbie was pleased that her husband was talking to her more frequently, and she enjoyed the caring behaviors in which he was participating. They began their counseling sessions before Debbie's discharge. They both resolved to spend more time alone. They both felt the counseling was worthwhile and wanted to continue the sessions after discharge.

Self-Concept Adaptive Mode

Assessment of Behavior

Debbie is extremely tearful. She expresses great concern over her future and the future of her children. Exploration of Debbie's tearfulness revealed that she was afraid of dying. She believes that this illness is a punishment for her past behavior. Debbie and her husband were married at a very young age after Debbie became pregnant with their first child.

Debbie has not asked the nurse any questions about sexuality. Her hesitancy to introduce the subject may be related to her cultural background. In this case, the nurse introduces the topic. Salient findings include the following:

- Debbie recently learned of a diagnosis of cervical cancer.
- She has undergone a recent radical hysterectomy.
- She is receiving radiation therapy in the hospital, and the need for this therapy will continue at home.
- Debbie has a lack of information about the effect of cervical cancer, radical hysterectomy, and radiation therapy on sexuality.
- Debbie has unresolved guilt related to unplanned premarital pregnancy.

Assessment of Stimuli

Debbie is a young adult, is married, and has two young children. Debbie has an eighth-grade education. She is in an emotionally distant, sometimes abusive relationship. Being diagnosed with cervical cancer at an early age has resulted in a maturational crisis for Debbie. This is complicated by the fact that several of her relatives have died of cancer. It is important for the nurse to assess coping strategies. One coping strategy that is mentioned is that Debbie is frequently tearful; crying is therapeutic.

Nursing Diagnosis

The following nursing diagnoses were made:

- Fear and anxiety of dying related to medical diagnosis and witnessing other family members' deaths as a result of cancer
- Spiritual distress related to severe life-threatening illness and unresolved guilt related to unplanned premarital pregnancy

- Sexual dysfunction related to the disease process; recent radical hysterectomy; need for radiation therapy at home; loss of childbearing capacity; weakness; fatigue; pain; anxiety; hormonal changes; and a lack of information about the effect of cervical cancer, radical hysterectomy, and chemotherapy on sexuality
- Grieving related to body image disturbance, loss of self-ideal, changes in roles, and potential for premature death

Goal Setting

To help Debbie achieve adaptation in the self-concept adaptive mode, the following goals were mutually set:

- Decreased fear and anxiety of dying as evidenced by less tearfulness, relaxed facial expression, relaxed body movements, verbalization of new coping strategies, and fewer verbalizations of fear and anxiety
- Decreased spiritual distress as evidenced by verbalization of positive feelings about self, verbalization about the value and meaning of her life, and less tearfulness
- Resumed sexual relationship that is satisfying to both partners as evidenced by verbalization of self as sexually capable and acceptable, verbalization of alternative methods of sexual expression during the first 6 weeks following surgery, and verbalization of when to be able to resume vaginal intercourse
- Progression through the grieving process as evidenced by verbalization of feelings regarding body image, self-ideal, changes in roles, and potential for premature death

Intervention

The following nursing interventions were implemented to help achieve these goals in the self-concept adaptive mode:

- *Fear and anxiety of dying related to medical diagnosis and witnessing other family members' deaths as a result of cancer*

Although Debbie's prognosis appeared good, she remained fearful of dying. Time was taken to sit with Debbie, to make eye contact, and to actively listen to her, especially when she began crying.

Debbie was asked to share an extremely difficult experience she had encountered in the past. She was asked how she coped with that experience. Once her present coping strategies were assessed, new coping strategies were suggested.

Debbie was encouraged to express her feelings openly. After allowing Debbie adequate time to express her feelings, truthful and realistic hope based on Debbie's medical history was offered. A cancer support group met each Tuesday in the hospital where Debbie was a patient. Debbie was given a schedule of the meeting times and topics. She and her husband were encouraged to attend the cancer support group meetings.

- *Spiritual distress related to severe life-threatening illness and unresolved guilt related to unplanned premarital pregnancy*

Debbie was encouraged to express her feelings openly about her illness. It was suggested that times of illness are good times to renew spiritual ties. Debbie was

supported in positive aspects of her life (e.g., being a good mother). At Debbie's request, the parish nursing ministry was consulted and a chaplain was asked to visit Debbie.

- *Sexual dysfunction related to the disease process; recent radical hysterectomy; need for radiation therapy at home; loss of childbearing capacity; weakness; fatigue; pain; anxiety; hormonal changes; and a lack of information about the effect of cervical cancer, radical hysterectomy, and chemotherapy on sexuality*

A complete sexual assessment was conducted to evaluate the perceived adequacy of Debbie's sexual relationship and to elicit concerns or issues about sexuality before her diagnosis with cervical cancer. Private conversation with Debbie was initiated to gain an understanding of her sexual concerns resulting from her therapy and her beliefs about the effects of radical hysterectomy in regard to sexual functioning. Debbie was instructed regarding possible changes in sexual functioning, such as a temporary loss of vaginal sensation for up to several months, vaginal dryness, and dyspareunia resulting from vaginal dryness. Because vaginal intercourse would not be possible for up to 6 weeks, alternate forms of sexual expression were discussed. To facilitate communication and sexual expression between Debbie and her husband, long periods of uninterrupted privacy were provided.

- *Grieving related to body image disturbance, loss of self-ideal, changes in roles, and potential for premature death*

Debbie's perceptions regarding the effect of the diagnosis of cervical cancer on her body image, self-ideal, roles, and her future were explored. Debbie was encouraged to verbally acknowledge the losses that she was experiencing. She was observed to determine which stage of the grief process she was currently experiencing (denial, anger, bargaining, depression, or acceptance) (Kübler-Ross, 1969). The grieving process was explained to Debbie and to her family, and they were assured that grieving is a normal process. Family members were encouraged to allow Debbie to cry when she needed to cry and to talk about her fears and feelings of grief. The nursing staff offered realistic reassurance about Debbie's prognosis. Debbie was encouraged to attend the cancer support group so that she could talk to others who better understood her grief.

Evaluation

Debbie's behavior changed before discharge. At the cancer support group Debbie met Marie, a survivor of cervical cancer. After meeting Marie, Debbie became more hopeful that she could conquer cancer. Less tearful, Debbie appeared more relaxed. Debbie verbalized a good understanding of the sexual changes that would occur and ways to help her adapt to these changes.

Role Function Adaptive Mode

Assessment of Behavior

Assessment in the role function adaptive mode requires the nurse to identify primary, secondary, and tertiary roles. When these roles have been identified, the nurse looks for instrumental and expressive behaviors related to each of these roles. An instrumental behavior is an actual physical act performed by the individual that helps achieve the goal of mastery of a primary, secondary, or tertiary role. An

expressive behavior is the attitude or feeling a person holds about a primary, secondary, or tertiary role.

Assessment of behaviors in the role function adaptive mode revealed that Debbie loves her husband very much and wants things to be better for them. She is a conscientious mother. She is a dutiful daughter who assists her mother as needed. She enjoys helping elders in her community because it makes her feel good to help others when they need it. She has been diagnosed with cervical cancer, has undergone a radical hysterectomy, and is being treated with radiation therapy.

Assessment of Stimuli

The focal stimulus in the role function adaptive mode is the fear of not being able to care for herself or her children in the future. Contextual stimuli include severe illness, radiation therapy, weakness, fatigue, and increased dependency on others.

Nursing Diagnosis

The following nursing diagnoses were made:

- Ineffective primary role transition related to severe illness, radiation therapy, weakness, fatigue, and increased dependency on others
- Ineffective secondary role transition related to fear of not being able to care for herself or her children in the future

Goal Setting

To help Debbie achieve adaptation in the role function adaptive mode, the following goals were mutually set:

- Effective primary role transition as manifested by less weakness, less fatigue, willingness to allow others to help her when she needs assistance, and desire to resume self-care activities as she becomes able
- Effective secondary role transition as manifested by fewer verbalizations of anxiety over her ability to care for herself and her children in the future

Intervention

The following nursing interventions were implemented to help achieve these goals in the role function adaptive mode:

- *Ineffective primary role transition related to severe illness, radiation therapy, weakness, fatigue, and increased dependency on others*

Debbie was monitored for factors that would hinder her from performing self-care activities. A daily routine was established that incorporated periods of activity and periods of rest. Measures were implemented to promote rest (e.g., activity restrictions, minimal noise, restricted visitation, a morning and afternoon nap time, assistance with personal care, needed items close to her bed, back massage, progressive relaxation, guided imagery, soft music). However, maximum independence was encouraged. Family members were instructed regarding the importance of maintaining independence. Debbie was given positive reinforcement for successful accomplishment of self-care behaviors.

Debbie was praised for her performance of her primary, secondary, and tertiary roles. Resumption of these roles was discussed with Debbie. Debbie was asked to identify her support system. She felt that at home she had adequate support for performing her roles. She was encouraged to rely on her support system for help when needed in maintaining these roles.

- *Ineffective secondary role transition related to fear of not being able to care for herself or her children in the future*

A thorough assessment was performed to gain an understanding of Debbie's fears and misconceptions about the effects of cancer, radical hysterectomy, and radiation therapy on bodily functioning, her lifestyle, and her ability to perform roles. Debbie verbalized a fear of dying and leaving her children. Interventions to instill hope were implemented. For instance, Debbie was given realistic assurance about her expected prognosis.

Evaluation

Debbie's husband was exhibiting supportive behaviors in the hospital. Debbie's mother was at home to help Debbie when she arrived. As Debbie's energy level increased, she became less anxious about her future. Before discharge, Debbie became increasingly anxious to return home to her children.

CASE HISTORY OF DAVID

David is a 48-year-old white who experienced an acute MI 3 weeks ago. He is a successful vice-president at a large international company, where he has worked for 15 years and was promoted to his current position 3 years ago. He enjoys his work, but it requires late night and weekend hours. David is married to Janice, his college sweetheart, and they have two children, 18-year old Kevin and 16-year old Kimberly.

David was awakened 4:00 AM with severe, crushing chest pain. His wife was awakened and recognized the symptoms of a heart attack and called 911. On arrival to the local emergency department, David was diaphoretic, hypotensive, and having multiple episodes of nonsustained ventricular tachycardia. An electrocardiogram (ECG) showed ST elevation in the anterior leads, signifying an anterior myocardial ischemia. David was taken emergently to the cardiac catheterization lab and underwent successful placement of a drug-eluting stent to the left anterior descending artery for a 95% proximal stenosis. An echocardiogram showed an ejection fraction (EF) of 30% (normal 55% to 70%) with hypokinesis of the anterior wall. David was placed on medications to manage his coronary disease and cardiomyopathy.

Prior to his heart attack, David had been working long hours. He has a strong family history of coronary disease and heart attacks in male relatives prior to age 55. To decrease his risk of heart disease, David had been exercising regularly and

Continued

CASE HISTORY OF DAVID—cont'd

trying to follow a heart-healthy diet for several months prior to his heart attack. David enjoys exercising and is worried that he will not be able to work out as he had previously.

After hospital discharge following his heart attack, David had increased fatigue and shortness of breath. He was readmitted to the hospital 1 week ago with acute congestive heart failure (CHF). He was treated with intravenous (IV) diuretics for his CHF. His home furosemide (Lasix) dose was increased to prevent decompensated heart failure. He has continued to experience fatigue and shortness of breath with activity. He has been more sedentary due to these symptoms. He has also required assistance with daily activities, such as showering, due to fatigue and lightheadedness and dizziness. David has had intermittent mild hypotension that he attributes to his medications. David expected to recover from his heart attack and return to work in a few weeks. He is frustrated with his activity limitations and his need for assistance with basic activities.

David has lost several relatives to heart disease. He is worried about his risk of dying and leaving behind his wife and children. He and his wife have talked about his health and the effect on the family. His wife has not worked for several years because she stayed at home to raise their children. David expressed concern and guilt that his wife may have to return to work to support the family if he is unable to return to work. He is very worried that he will not be able to return to his job. He is a self-described “workaholic” who enjoys his job and is anxious to return to his work.

Nursing Care of David with Roy’s Model***Assessment of Behavior***

David is a 48-year-old who suffered an anterior wall myocardial infarction (MI) 3 weeks ago. Prior to his MI, he was active and exercised regularly. He is a successful and respected professional in his company and in his community. He has experienced increased fatigue, shortness of breath, and lightheadedness/dizziness due to hypotension since his MI. He was admitted to the hospital last week for congestive heart failure. David is frustrated that he has limited activity tolerance due to fatigue and shortness of breath with activity. David is frustrated that he has not been able to return to his previous level of activity for his personal and professional life.

Assessment of Stimuli

Assessment of stimuli revealed the focal stimulus for David’s decreased activity tolerance was reduced left ventricular function from anterior wall MI. Contextual stimuli contributing to the decreased activity tolerance are fatigue, shortness of breath with activity, and symptomatic hypotension.

Nursing Diagnosis

The following nursing diagnoses were made in the physiological adaptive mode:

- Altered perfusion due to decreased cardiac output and hypotension
- Knowledge deficit of heart failure due to ischemic heart disease

Goal Setting

The following goals were mutually established:

- Increase understanding of symptoms associated with decreased cardiac output related to myocardial infarction
- Increase understanding of ischemic heart disease and living with chronic heart failure condition

Intervention

So that David could achieve his goal to improve his activity and level of understanding of ischemic heart disease, the following interventions were implemented:

- *Altered perfusion due to decreased cardiac output and hypotension*

David was instructed to keep a home daily weight, blood pressure, and heart rate log to document hypotension and evidence of fluid retention associated with worsening heart failure. Understanding of ischemic heart disease and signs/symptoms associated with worsening heart failure will allow David to communicate changes of his condition to his health care provider for appropriate follow-up and management of his condition. This will also allow David to take an active role in his own care and management of his health condition.

- *Knowledge deficit of heart failure due to ischemic heart disease*

The nurse met with David and his wife to discuss David's heart condition. The nurse discussed David's MI and the alteration in left ventricular systolic function that occurred as a result of his MI. The importance of taking his medications as prescribed to manage his heart failure and prevent further reduction in cardiac function was reviewed with David and his wife.

Evaluation

David became more active in his care and felt more in control by keeping a daily log. By keeping this log, he was able to recognize a trend of low blood pressure readings in the evening hours that were associated with times when he was feeling more fatigued. David discussed this with his physician, who was able to adjust his medication regimen to avoid medication-related hypotension in the evening hours.

Interdependence Adaptive Mode

Assessment of Behavior

David has been active throughout his life. He has always been independent and is not used to needing or asking for any assistance with activity. Asking his wife for assistance makes David feel uncomfortable and anxious. He is concerned about returning to his previous level of function in his personal and professional life.

Assessment of Stimuli

The focal stimulus for David's anxiety is the left ventricular dysfunction from MI. Contextual stimuli are the anxiety and dependence on family members regarding his reduced functional capacity following MI.

Nursing Diagnosis

The following nursing diagnosis of the interdependence adaptive needs was made:

- Anxiety related to decreased activity tolerance and need for assistance with activities of daily living (ADLs)

Goal Setting

The following goals were mutually set:

- Improve activity tolerance and increase physical activity and decrease dependency for ADLs

Intervention

To help David achieve his goal, the following nursing interventions were implemented:

- *Anxiety related to decreased activity tolerance and need for assistance with ADLs*

David was advised to plan his activities throughout the day to avoid overexertion and increased fatigue. He was encouraged to rest between activities as needed and increase his activity gradually. David was instructed to begin walking 5 minutes daily and increase walking by 3 to 5 minutes daily to a goal of 30 minutes daily.

Evaluation

David was able to increase his daily activity without becoming overly fatigued. David planned periods of rest after activities such as showering or shaving. Over time, David was gradually able to complete his ADLs independently. David began walking each day for 3 to 5 minutes followed by a rest period. He increased his walking time gradually and was walking for 10 minutes a day by the end of the first week and for 30 minutes a day by the end of the first month.

Self-Concept Adaptive Mode**Assessment of Behavior**

David verbalized that he has lost several relatives to heart disease and that he is worried about his risk of dying and leaving behind his wife and children. David expresses that he has a strong spiritual faith and that his primary concern is for his wife and children's well-being. As part of David's history, his nurse learned that his father died of sudden cardiac death outside the hospital at the age of 43 when David was just 13 years old.

Assessment of Stimuli

The focal stimulus in this mode is David's anxiety about death. Contextual stimuli are the MI that he has experienced, the death of his father at an early age, and the well-being of his wife and children.

Nursing Diagnosis

The following nursing diagnosis of the self-concept adaptive mode was made:

- Anxiety related to risk of dying from heart disease

Goal Setting

The following goals were set mutually:

- Anxiety about impending death will decrease.
- Verbalizations of hope about the future will increase

Intervention

A first step with David is to explore what he knows about his heart disease and prognosis. This provides the opportunity to provide additional education about his condition and to correct misunderstandings that he may have. Ask about his specific fears of dying. Although it seems counterintuitive, talking about one's fear of dying helps to decrease anxiety. The nurse should provide an empathetic understanding of David's fears and let him know that impending doom is one of the hallmark psychosocial responses to an MI. David should be encouraged to talk with his wife and spiritual counselors about his concerns. David has lost several relatives to heart disease, which may fuel his anxiety about death. The nurse can explore similarities and differences between his relatives' heart disease and his own heart disease. For instance, knowing how long ago his relatives died may be a key factor in relieving his anxiety. The nurse can talk about new and more effective treatments that are available. Knowing his coping styles will facilitate interventions to reduce his anxiety. As an example, in a very brief intervention during routine care, David's nurse can help move him from emotional coping to a more active problem-solving coping style while still providing emotional care. His nurse can give him control over his environment by encouraging him to make decisions about his treatment and care. The nurse can encourage him to increase his activity as he is able. His nurse can instill hope during routine encounters by providing David with information about self-care strategies that he can use to help with his recovery.

Evaluation

David will slowly take more responsibility for his own ADLs and begin to increase his activity by sitting in a chair and steadily increasing ambulation while in the hospital. In the hospital the nurse should look for signs of decreasing death anxiety such as verbalizations about the future. At home he can begin a structured exercise program that progressively returns him to his normal activities.

Role Function Adaptive Mode

Assessment of Behavior

David's primary role is that of a middle-aged adult male. His secondary roles include husband, father, son, brother, and friend. He is an executive. He is concerned about his job and that his professional future could change due to his heart disease.

Assessment of Stimuli

The focal stimulus is reduced left ventricular function from anterior wall MI. Contextual stimuli are the potential for change in employment status and financial effect on his family.

Nursing Diagnosis

The following nursing diagnosis related to role function is:

- Potential for role change related to change in work status from health condition

Goal Setting

The following goals were mutually set:

- Effective primary role transition as evidenced by verbalization of feelings with spouse and family
- Effective secondary role transition as evidenced by review of job duties with employer

Intervention

David was encouraged to discuss his concerns with his spouse and children for open communication about his job status and effect on the family's future. David was also encouraged to discuss his job and responsibilities with his employer.

Evaluation

David and his family developed good communication about his concerns over his responsibilities to his family as the provider and to his employer. David's teenage children volunteered to get part-time jobs after school to help with their financial expenses. David talked to his employer, who was willing to adjust his work schedule and work responsibilities so that David would have shorter work hours and less stress. After 3 months David was able to return to his job full-time.

CRITICAL THINKING EXERCISES

1. In caring for David as his nurse you also identify that Janice, his wife, is under increased stress from caring for David and is not taking care of herself. She confided to you that she is fatigued and her blood pressure has been elevated. Using Roy's model, identify appropriate nursing interventions for Janice for each of the four adaptive modes.
2. The North Carolina Lottery has just notified you that your ticket is worth \$30 million. Consider your adaptation to such a change in your life and use Roy's two-level assessment (assessment of behaviors and assessment of stimuli) to assess your response:
 - a. List possible behaviors for each of the four adaptive modes.
 - b. Identify focal, contextual, and residual stimuli for each of the four adaptive modes.
3. Your closest friend has been diagnosed with breast cancer. Following surgery and chemotherapy she learned that the cancer has metastasized. She is single and has a daughter who is 6 years old.

CRITICAL THINKING EXERCISES—cont'd

- a. Identify her adaptive needs in the physiological adaptive mode. What interventions would you provide?
 - b. Consider her possible adaptive needs in the self-concept mode. What possible interventions would you discuss with her?
 - c. What would be her needs in the interdependence adaptive mode? What possible interventions would you discuss with her?
 - d. Identify her adaptive needs in the role function adaptive mode. List an intervention you could offer to provide.
4. Your friend was just discharged from the hospital following mitral valve replacement surgery for severe mitral valve disease. He is retired and has lived alone since his wife died several years ago. His daughter lives nearby and helps with your friend's care. She wants your friend to move in with her, but he wants to continue to live in his own home. Your friend's daughter calls you to ask your opinion on allowing your friend to continue to live in his own home. You go by to visit your friend and his daughter at his home.
- a. What would be his adaptive needs in the physiological adaptive mode? What interventions would you provide?
 - b. What would be his adaptive needs in the self-concept adaptive mode? What interventions would you provide?
 - c. What would be his adaptive needs in the interdependence adaptive mode? What interventions would you provide?
 - d. What would be his adaptive needs in the role function adaptive mode? What interventions would you provide?

Focusing on the two cases presented in this chapter, Debbie and David, what advanced practice monitoring is indicated for their care? Consider what you would include in the monitoring when the care for both of these patients is structured according to the adaptation model.

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Orlando's Nursing Process Theory in Nursing Practice

*Barbara A. May**

Ida Jean Orlando Pelletier, a nursing leader and theorist, passed away on November 28, 2007. She discovered, as she preferred to say, her middle-range, research-based theory, Deliberative Nursing Process, in the 1950's and described it in her first book. (Potter, 2008, p. 3)

History and Background

In the 1950s, governmental grants became available for studies integrating mental health concepts into nursing curricula. Yale University received such a National Institute of Mental Health grant and Ida Orlando became project investigator. Whereas nursing theories were most often developed deductively in the 1950s, Orlando was the first to develop theory inductively in an empirical study of nursing practice. For 3 years she observed and recorded what she saw and heard in interactions between patients and nurses (Orlando, 1989; Pelletier, 1976).

After examining 2000 records, Orlando was able to categorize them as “good” and “bad” nursing. Orlando asked nurses with dissimilar views, experience, and education to place each record into one of the categories she had initially identified. All the nurses agreed with Orlando’s categorization. Orlando believed that if they all agreed, then the record’s anecdotal content contained “what made good and bad nursing happen” (Pelletier, 1976, p. 22).

According to Orlando, “In the records judged as good the nurse’s focus was on the patient’s immediate verbal and nonverbal behavior from the beginning through the end of the contact; whereas in those judged bad, the nurse’s focus was on a prescribed activity or something that had nothing to do with the patient’s behavior”

*The chapter author and editor acknowledge the scholarship of Norma Jean Schmieding, who contributed this chapter in earlier editions of this text.

(Pelletier, 1976, p. 23). When good nursing occurred, the nurse listened to what was happening and identified the patient's distress. The nurse understood why the patient was distressed and recognized that without the nurse's help, the patient's distress was not relieved. Orlando concluded, "that the function of professional nursing is to find out and meet the patient's immediate needs for HELP" (Pelletier, 1976, p. 24). This original work published in 1961 became the basis for Orlando's deliberative nursing theory (republished in 1990 by the National League for Nursing).

Orlando conducted research at McLean Hospital in Belmont, Massachusetts, and was funded with a Mental Health Public Service grant. In the second study, she assessed the relevance of earlier formulations, educated and evaluated nurses in the use of her formulations, and tested the validity of the theory formulations. Based on this research, her original formulations were validated and showed significant research results. She also extended her theory to include the entire nursing practice system (Orlando, 1972).

Orlando's theory is appealing because it clearly describes what nurses consider good nursing and she proposed its value for the twenty-first century (Orlando, 1987). Many theory scholars have published descriptions and analyses of her work (Alligood & Tomey, 2010; Fawcett, 2005; George, 2011; Meleis, 2007; Parker, 2006). The theory has been discussed in articles related to its use in research (Haggerty, 1987; Olson & Hanchett, 1997; Reid-Ponte, 1992). In addition, Orlando's theory has been used for and by both clinical and administrative practice in two acute-care hospitals (Schmieding, 1984), in operating rooms (Rosenthal, 1996), in a psychiatric hospital (Potter & Bockenbauer, 2000), in nursing management (Laurent, 2000), and in a long-term care facility (Faust, 2002). Orlando's work has been translated into six languages. A Web page on Orlando's theory, developed by Schmieding, is updated periodically and contains extensive references (www.uri.edu/nursing/schmieding/orlando).

Overview of Orlando's Nursing Process Theory

Various theorists have categorized Orlando's theory differently. Woolridge, Skipper, and Leonard (1968) classified it as a prescriptive theory. Others including Barnum (1998) and Crane (1980) described it as an interaction theory, and Fawcett (1993) classified it as a middle-range predictive theory. Orlando's theory is a reflective practice theory that is based on discovering and resolving problematic situations. If the problem is not discovered, it cannot be solved. The centrality of the patient is ever-present when using Orlando's theory (Schmieding, 1983). Orlando described her theory as a *nursing process theory* rather than *effective nursing care theory* (Orlando-Pelletier, 1990).

Framework of the Theory

As a reflective practice theory, Orlando's theory contains concepts that are interrelated but are described separately. These five interrelated concepts are addressed within the problematic framework derived from Schmieding's (1983, 1987) analysis of Orlando's theory using the writings of John Dewey (1933, 1938) and Thomas Kuhn (1970). The five concepts are the following:

1. Professional nursing function—organizing principle
2. Patient's presenting behavior—problematic situation

3. Immediate reaction—internal response
4. Deliberative nursing process—reflective inquiry
5. Improvement—resolution

Professional Nursing Function: Organizing Principle

Orlando believed that without the authority derived from a distinct function of nursing, nurses' practice could not be autonomous. From her research, she conceptualized the nurse's unique function as "finding out and meeting the patient's immediate needs for help" (Orlando, 1972, p. 20), which constitutes the theory's organizing principle. Thus the patient is the focal point of the nurse's function. Orlando states, "Nursing...is responsive to individuals who suffer or anticipate a sense of helplessness; it is focused on the process of care in an immediate experience; it is concerned with providing direct assistance to individuals in whatever setting they are found, for the purpose of avoiding, relieving, diminishing, or curing the individual's sense of helplessness" (Orlando, 1972, p. 12).

According to Orlando (1961), "Need is situationally defined as a requirement of the patient which, if supplied, relieves or diminishes his immediate distress or improves his immediate sense of adequacy or well-being" (p. 5). It is the nurse's responsibility to meet the patient's immediate needs for help either by supplying it directly or by calling in the services of others. The central core of the nurse's practice is to understand what is happening between the patient and the nurse, which provides the framework for the help the nurse gives the patient (Orlando, 1961).

At the first nurse-patient contact, the nurse does not know whether the patient is in need of help. However, information is available through assessment to achieve an accurate understanding of the patient's presenting behavior and to determine if the patient is in need of help. This is not as easy as it appears. Orlando (1961) asserts, "First, the nurse must take the initiative in helping the patient express the specific meaning of his behavior in order to ascertain his distress. Second, she must help the patient explore the distress in order to ascertain the help he requires for his [immediate] need [for help] to be met" (p. 26).

If the patient is in need and the need is fulfilled, the nursing function has been fulfilled. Orlando (1972) states, "The product of meeting the patient's immediate need for help is... 'improvement' in the immediate verbal and nonverbal behavior of the patient. This observable change allows the nurse to believe or disbelieve that her activity relieved, prevented, or diminished the patient's sense of helplessness" (p. 21).

The distinct function clarifies the nurse's role and guides the assessment by directing it to the patient's immediate needs for help in the immediate situation. The function remains the same regardless of the patient's diagnosis, treatment, or age or whether the patient is hospitalized or at home (Orlando, 1972).

The Patient's Presenting Behavior: Problematic Situation

Orlando focuses almost exclusively on understanding the complexities of problematic situations. Nursing practice comprises frequent patient-nurse contacts in which the patient manifests verbal and nonverbal behavior. Behaviors can be manifested in verbal forms (e.g., requests, comments, complaints, questions, moaning, crying, wheezing), in nonverbal forms (e.g., skin color, silence,

clenching fist, reddened face), or in physical forms (e.g., respirations, blood pressure). These situations disrupt the equilibrium and are cues that get the nurse's attention. It is unclear, however, whether the patient is experiencing a need for help. From her research, Orlando formulated the following statement to guide the nurse's observation: "The presenting behavior of the patient, regardless of the form in which it appears, may be a plea for help" (Orlando, 1961, p. 40). However, the need for help may not be what it appears to be. Therefore, the initial behavior is not reliable for determining the meaning of the behavior or the help, if any, that the patient requires. Nonetheless, a nurse often makes assumptions or inferences about what help the patient needs and acts on the basis of these assumptions without first exploring the observation with the patient.

Orlando specifies that both the patient and the nurse participate in the exploratory process to identify the problem as well as the solution. Therefore, the nurse-patient situation is a dynamic process; each is affected by the behavior of the other. The interaction is unique for each situation. The patient's behavior stimulates the nurse's immediate reaction and becomes the starting point of the assessment.

Immediate Reaction: Internal Response

The problematic situation, in the form of the patient's presenting behavior, triggers an automatic immediate reaction in the nurse that is both cognitive and affective. The reaction comprises the nurse's perceptions, the thoughts about the perceptions, and the feelings evoked from the thoughts; they cannot be controlled. The reaction occurs in an automatic, almost instantaneous sequence (Orlando, 1972). The nurse's past experiences and knowledge combine with the nurse's understanding of the immediate situation to produce the nurse's unique reaction.

In any person's process of action, four distinct items occur sequentially. Orlando (1972) notes:

These separate items reside within an individual and at any given moment occur in the following automatic, sometimes instantaneous, sequence: (1) the person perceives with any one of his five sense organs an object or objects; (2) the perceptions stimulate automatic thought; (3) each thought stimulates an automatic feeling; and (4) then the person acts (p. 25).

The interaction of these items is called the *nursing process*. The first three items cannot be observed; only the action can. The action is what the person says verbally or conveys nonverbally.

The nurse's immediate reaction is unique for each situation. What the nurse perceives, thinks, or feels reflects his or her individuality. The automatic thoughts come from the nurse's interpretation or meaning attached to the perception. It may or may not be correct from the patient's point of view (Orlando, 1961). Regardless of the extent of the nurse's accuracy, the perceptions that evoked the thoughts are communications from the patient and represent the raw data for the nurse to use in assessing the patient's behavior (Orlando, 1961). In 1972, Orlando renamed the deliberative nursing process the *disciplined nursing process*; however, for consistency, the *deliberative nursing process* term will continue to be used throughout this chapter.

Deliberative Nursing Process: Reflective Inquiry

Orlando's (1961) deliberative nursing process views the nurse-patient situation as a dynamic whole. The nurse's behavior affects the patient, and the nurse is affected by the patient's behavior. Understanding the patient's behavior is a complex process in which observations and thoughts are used in a serial responsive way to get the facts. To be successful, the nurse's focus must be on the patient rather than on an assumption about the nature of the patient's problem and on arbitrary decisions about actions to be undertaken.

To understand this process, Orlando (1972) describes the components of a person's action process. In a person-to-person encounter, each person experiences an immediate reaction that contains the person's perception of the other person's behavior, the thought about this perception, and the feelings associated with the thought. Unless the content of a person's reaction is openly disclosed, it remains a secret from the other person. For example, if a nurse makes a statement to the patient and does not disclose what perceptions, thoughts, or feelings led to his or her action, the patient remains unaware of it because it was not expressed. Orlando (1972) notes this action process often functions in secret.

Although it is at first difficult to separate perceptions, thoughts, and feelings from one another, this separation will help a nurse visualize how one aspect of the reaction affects other aspects (Orlando, 1961). In 1972, Orlando developed specific guidelines that specify a person's use of the content or his or her reaction in a deliberative way. They include the following: "(a) in a situation a person verbally states to the other person any or all of the items of his or her immediate reaction; (b) the stated item must be expressed as self-designated; and (c) the person asks the other person to verify or correct the item verbally expressed" (Schmieding, 1993, p. 24). The deliberative nursing process is described as follows: "Whatever the nurse perceives about the patient with any one of the five sense organs and thinks and feels about the perception must, at least in part, be verbally expressed as self-designated to the patient and then asked about" (Schmieding, 1993, p. 25).

According to Orlando (1961), "The nurse does not assume that any aspect of her reaction to the patient is correct, helpful or appropriate until she checks the validity of it in exploration with the patient" (p. 56). The nurse will find it more efficient to learn the nature of the patient's immediate need for help by first exploring and understanding the meaning of the patient's perception. The patient is more likely to agree with the correctness of the perception and often explains its meaning to the nurse. Efficiency is important because the longer it takes to determine the patient's immediate need for help, the more distressed the patient becomes (Orlando, 1961).

The nurse's automatic thoughts can also be used, but this approach is less efficient. However, if exploring perceptions is not successful, the nurse uses his or her thoughts to try to understand the nature of the patient's distress. Orlando (1961) cautions that the nurse's thoughts may not be valid. When using thoughts, the nurse must describe the perception from which the thought was derived and ask the patient whether it is valid. Orlando (1961) cautions that nurses are likely to assume that their thoughts are correct, unless they tentatively formulate them as a question. When the nurse states his or her thoughts as a tentative possibility, the patient is

more likely to respond with his or her own negative reaction—for example: “I saw you close your eyes when I started to change your colostomy bag. I thought you might be frightened about having to learn how to do this yourself. Could that be so or not?” (Schmieding, 1993, p. 26). When nurses express their reactions, it minimizes the opportunity for nurses to make private interpretations about patients.

Feelings, either positive or negative, originate from the thought about the perception. Feelings can also be used, but the nurse must state the perception that evoked the thought from which the feeling was derived. An example of this approach is the following question: “I get annoyed when you keep asking for the urinal because I don’t think you really need it. Am I right or not?” The patient might respond, “Yes, but I’m afraid I might get short of breath and then I wouldn’t be able to call for the nurse.” If nurses do not resolve their feelings with the patient, these same feelings occur each time they are in contact with the patient. In addition, these unexpressed feelings may be apparent in the nurse’s verbal or nonverbal behavior.

Regardless of what aspect of his or her reaction the nurse uses, the patient is affected by the action; therefore, “the nurse initiates a process of exploration to ascertain how the patient is affected by what she says or does. Only in this way can she be clearly aware of how and whether her actions are helping the patient” (Orlando, 1961, p. 67).

When nurses express their immediate actions to patients in a deliberative way, they are more likely to meet patients’ immediate needs for help because when nurses use the deliberative nursing process patients are more likely to use it also. Therefore, both nurses and patients have a better understanding of how each is experiencing the immediate situation (Orlando, 1972). If this is not done, patients remain distressed because the communication between them was unclear and the nurse’s response to the patient was automatic (Orlando, 1961).

Orlando (1961) noted that automatic personal responses contribute to situational conflicts. Thus it is important to understand them so that problems associated with their use can be avoided. Actions based on the nurse’s conclusion, without the patient’s participation, are often not helpful. Therefore, the nurse’s decisions are based on reasons other than the meaning of the patient’s behavior. Thus if actions are carried out automatically, even though they could be correct, they are ineffective in helping the patient because the patient was not involved (Orlando, 1961). A nurse’s past experiences are not sufficient as the basis for understanding the patient’s immediate behavior. Therefore, in each nurse-patient experience, a deliberative process of inquiry is required to prevent the use of automatic responses and arbitrary actions. When this occurs, the patient’s immediate behavior improves.

Improvement: Resolution

When a situation becomes clear, it loses its problematic character and a new equilibrium is established. When the patient’s immediate needs for help have been determined and met, there is improvement (Orlando, 1961). This change is observable in both the patient’s verbal and nonverbal behavior. This allows the nurse to conclude that the patient’s sense of helplessness has been relieved, prevented, or diminished (Orlando, 1972). If the patient’s behavior has not changed, the function of nursing has not been met and the nurse continues with the process until there is improvement.

According to Orlando (1961), it is not the nurse's activity that is evaluated. Rather, it is the results—namely, whether the nurse's action helped the patient communicate his or her need for help and whether that need was met. Schmieding (1993) explains:

Orlando's deliberative nursing process is *not* a linear process. . . . Rather the deliberative process is a "muddy," serial, back-and-forth process because it has elements of continuous reflection as the nurse attempts to understand the patient's meaning of the behavior and what help the patient needs from the nurse in order to be helped (p. 27).

Orlando's deliberative nursing process is an important and integral part of her theory. The theory's simplicity disguises the complexity of its use. Learning to use it requires its deliberate use, followed by a self-reflective analysis of one's action process. Practicing to separate one's perceptions, thoughts, and feelings allows nurses to analyze their practice to see whether they have incorporated all or part of their immediate reaction into the action they have taken with the patient. If this is done, the nurse will include the patient as a reciprocal partner in determining both the immediate need for help and the action that will best meet the patient's need, thus relieving the patient's distress.

Critical Thinking in Nursing Practice with Orlando's Theory

Each component of the nursing process depends on the previous component before the next step is taken (Barnum, 1998). Although it systematizes and standardizes an approach to nursing practice, it is linear in design and patients have minimal involvement in any element of the process. Nurses assess, determine a nursing diagnosis for each problem, establish goals and interventions, implement them, and evaluate the results. With the exception of assessment and implementation, other aspects of the nursing process are formulated without the patient's participation. Because patients have minimal involvement in the process, there is little opportunity for patients to agree or disagree with any aspect of the nursing process.

From an Orlando perspective, the espoused linear nursing process is fertile ground for basing assumptions. The diagnostic classifications attached to patients generally lack patient participation and can readily lead to patient labeling and stereotyping. The nursing process offers little, if any, encouragement for nurses to use, in their actions, their thoughts about the situation. Rather, nurses tend to withhold their thoughts without verifying or correcting them, thus operating as if the thoughts, assumptions, and inferences, conceived in their minds, are factual and justifiable as the basis for nursing action. Consequently, patients cannot confirm or refute these assumptions. However, these thoughts, if stated, might be useful—even critical—in patient assessment, plans, goals, and interventions. Subsequently, many nurses have not fully developed the critical thinking processes that would enhance their effectiveness.

Leaders in nursing recognized the need to incorporate a nonlinear process—critical thinking—into the nurse's practice. As with theories, nurses select the description of critical thinking that best matches their conception of what will help them most in using a nonlinear thinking approach in all aspects of their patient care.

How to think is more important than what to think, because there is no one right answer (Jones & Brown, 1993). Regardless of the thoughts, they can be used in understanding any aspect of the patient's behavior (Orlando, 1961). Consequently, critical thinking requires a reflective process that is patient-centered (Daly, 1998) and also enhances nurses' functioning in the complex health environment. In contrast to the nursing process, critical thinking is characterized as a "unique, cognitive thought process that is grounded in reflection" (Jones & Brown, 1993, p. 73). Kataoka-Yahiro and Saylor (1994) stress that attitudes toward critical thinking, knowledge fundamental to nursing practice, experience that leads to understanding complex situations, and cognitive competencies are needed for nursing judgment. Miller and Malcolm (1990) include similar criteria.

According to Dewey (1933), reflective thinking "involves (1) a state of doubt, hesitation, perplexity, mental difficulty, in which thinking originates; and (2) an act of searching, hunting, inquiring to find material that will resolve the doubt, settle and dispose of the perplexity" (p. 12). Dewey continues, "Any attempt to decide the matter by thinking will involve inquiring into other facts, whether brought to mind by memory, or by further observation, or by both" (pp. 13, 14). The facts to which Dewey refers are not in one's mind but are available only in observable data. Therefore, Dewey emphasizes that conclusions must be based on existing evidence. In other words, both the problem and its solution require observable evidence. Thus critical thinking counteracts the tendency to base conclusions on assumptions.

In Orlando's theory, ascertaining the patient's immediate need for help emphasizes the importance Orlando gives to the first step of the critical thinking process. If the problem is inaccurately identified, the development of goals, strategies, and other components of the nursing process will not be effective because they are based on a faulty foundation. In all aspects of the nursing process, Orlando's theory places high priority on patient involvement. In essence, the nurse and patient are partners in the process. Orlando's theory also emphasizes that patient improvement is determined by positive changes in both the verbal and the nonverbal behavior of the patient, which from Dewey's perspective is the basis of evidence (Dewey, 1938).

Thus critical thinking is an integral part of Orlando's theory. Her work, a derivative of Dewey's (1938) *Theory of Inquiry*, contains the basic elements of reflective inquiry (Schmieding, 1986). Orlando's work reflects her assumption that the nurse's mind is the most important tool and that the reflective process is recognized as critical in all phases of the deliberative nursing process used with patients. Our thoughts propel our actions, and therefore understanding the process by which we think is critical in any nursing situation. Each situation evokes in the nurse an immediate reaction that comprises the present situation, previous knowledge and theories, past nursing, and other work experiences. These elements combine to make the nurse's reaction unique for each situation. Within the nurse's reactions are tentative assumptions and inferences that the nurse will use to seek further evidence to refute or confirm them. This can be determined only by returning to the original source, namely, the patient.

In understanding and using the elements of the nurse's immediate reaction in a deliberative exploratory process, the nurse discovers, from the patient, information about the present situation. The nurse involves the patient in exploring alternative

possibilities about the help the patient needs and exercises judgment while ascertaining with the patient whether the patient is capable of doing each intervention alone. If not, the nurse helps the patient as needed or performs the intervention on the patient's behalf. Nurses using Orlando's deliberative nursing process incorporate reflective elements of critical thinking into all phases of their practice.

National and International Use of Orlando's Theory

The use of Orlando's Deliberative Nursing Process Theory has been permeated nationally and internationally. Nurses, both in nursing schools and in practice, are increasingly using Orlando's theory. Hospitals, long-term care facilities, and community health agencies are also using Orlando's theory. More recently, nurse administrators, leaders in practice, and individual practice nurses use Orlando's theory.

New Hampshire Hospital nurses have used Orlando's theory for many years. Bockenbauer (Potter & Bockenbauer, 2000) has worked with staff in developing their deliberative nursing process skills. Potter and Dawson (2001) used contracts and safety agreements to help psychiatric patients. Potter (2004) applied Orlando's theory in groups and nursing students, and in developing research based on her theory.

Previously and increasingly, nurses in administration and leadership roles are using Orlando's theory. Schmieding used Orlando's theory simultaneously in both practice and administration within several hospitals in the early 1970s. In 1984, Schmieding reported the advantages of adopting Orlando's theory throughout a nursing department. Its use increases effectiveness in meeting patient needs, improves staff nurses' decision making, and more easily determines nursing versus nonnursing functions. Schmieding (1987) discusses "how specific types of actions facilitate or thwart problem identification" (pp. 431-440).

With few exceptions, most nursing theorists focus on management of patients. Astute nurses recognize that managers and leaders are not the same. Orlando's "dynamic leadership-follower relationship model" (Laurent, 2000, p. 85) is based on the dynamic nurse-patient relationship theory. According to Laurent, Orlando advocates exploration to identify patients' immediate needs for help. Laurent proposed a leadership theory using Orlando's theory.

Orlando's theory was used in an extended care facility in which one older adult woman was constantly calling for staff and another was constantly removing her oxygen (Faust, 2002). Using Orlando's theory, Faust's staff was able to determine what the women were thinking as well as the reasons for their actions. Faust noted that the use of research-based evidence to guide interventions with patients experiencing stressful behaviors leads to positive outcomes.

Valentine (2005) used Laurent's (2000) nursing leadership theory that was based on Orlando's work for development of nursing leadership ideas for the new nurse. She identifies patients' distress and their immediate needs for help. Interaction between managers and new nurses can develop basic leadership principles by interactions with established nurse leaders. Finally, Bauer and McBride (2002) have used Orlando's theory to treat people with bipolar disorders. They report the use of various evidenced-based data for interventions.

Orlando's work has resonated with nurses in many countries. The purpose of the work of Johansson, Blomquist, Nilsson, and colleagues (1996-1998) was to support reflective thinking. Orlando's nursing theory was used because it was inductively developed. In England, Price (2003) examined the understanding and origin of practice problems and the concern for reflective practice. Price used Schmieding's (1999) inquiry process for decision making based on a back-and-forth gathering of information as well as collaboration with others to make decisions. And in Australia, instructors at the University of Southern Queensland developed a management course using Schmieding's (1999) reflective framework for administration. Primomo (2000) provides an overview of the work in Japan and references published information about Japan's preparation for care of growing numbers of elderly people. The purpose was to identify universal theories and practice in two different cultures. Primomo reported on the research work of Schmieding and Kokuyama (1995) that was cross-cultural and comparative. Also, other authors noted research and practice in Japan using Orlando's theory (Kawamura, Shijiki, & Mastsuo, 2004; Kobayshi, 1998; Kumata & Goto, 1984). In Germany, Mischo-Kelling and Wittneben, (1995) included a section on Orlando's theory that highlighted Orlando's focus on problematic situations. The situations and the investigation of the patient's immediate need for help were found to be essential in determining patient needs. Finally, a descriptive exploratory study was conducted through the Brazilian online databases that identified five elements. Orlando's theory was used for practicing the response to customers whose face surgery was canceled.

In a national conference with three nursing theories, one of which was Orlando's theory, nurses shared how to integrate theory and practice. Orlando's reflective tools were developed in two separate steps. Also, teachers were trained in reflective thinking (Selanders, Schmieding, & Hartweg, 1995). Toniolli and Pagliuca (2002) reviewed published articles containing Orlando's theory. The applicability of the theory was verified.

CASE HISTORY OF DEBBIE

Debbie is a 29-year-old woman who was recently admitted to the oncology nursing unit for evaluation after sensing pelvic "fullness" and noticing a watery, foul-smelling vaginal discharge. A Papanicolaou smear revealed class V cervical cancer. She was found to have a stage II squamous cell carcinoma of the cervix and underwent a radical hysterectomy with bilateral salpingo-oophorectomy.

Her past health history revealed that physical examinations had been infrequent. She also reported that she had not performed breast self-examination. She is 5 feet, 4 inches tall and weighs 89 pounds. Her usual weight is about 110 pounds. She has smoked approximately two packs of cigarettes a day for the past 16 years. She is gravida 2, para 2. Her first pregnancy was at age 16, and her second was at age 18. Since that time, she has taken oral contraceptives on a regular basis.

Debbie completed the eighth grade. She is married and lives with her husband and her two children in her mother's home, which she describes as less than sanitary. Her husband is unemployed. She describes him as emotionally distant and abusive at times.

CASE HISTORY OF DEBBIE—cont'd

She has done well following surgery except for being unable to completely empty her urinary bladder. She is having continued postoperative pain and nausea. It will be necessary for her to perform intermittent self-catheterization at home. Her medications are (1) an antibiotic, (2) an analgesic as needed for pain, and (3) an antiemetic as needed for nausea. In addition, she will be receiving radiation therapy on an outpatient basis.

Debbie is extremely tearful. She expresses great concern over her future and the future of her two children. She believes that this illness is a punishment for her past life.

Nursing Care of Debbie with Orlando's Theory

Since the information presented about Debbie constitutes indirect information rather than direct observation, the nursing care of Debbie with Orlando's theory is guided by Orlando's description of this type of information. Often nurses make decisions using indirect information about a patient. Indirect observations may originate from comments made about a patient by colleagues—nurses, physicians, and other health care workers—and from such documents as progress reports, records, and nurses' notes (Orlando, 1961). Comments and written material about the patient are second-hand information because they are not obtained in the nurse's presence of the patient. Direct information comes from nurses' observations of patients through direct contact with them. The following description of the care of Debbie illustrates the use of Orlando's theory in practice. The description assumes that routine care activities are being done with and for the patient.

Debbie's nurse is Bill, who graduated with a baccalaureate nursing degree 2 years ago. Bill will use words that are easy for Debbie to understand. Determining what indirect information Bill would use first in "real life" would depend on Bill's observing whether Debbie had either verbal or physical presenting behaviors that indicated a need for immediate exploration. For example, is Debbie crying, avoiding looking at Bill, or demonstrating evidence of physical trauma? When meeting Debbie, Bill introduces himself by his full name and tells her his type of position. He asks Debbie what she prefers to be called. Before Bill communicates anything else, he asks Debbie if she has any questions, concerns, or things she would like to ask or tell him. If Debbie does not raise any questions or concerns, Bill tells Debbie how long he will be her nurse. He explains that a staff nurse's responsibilities are to provide physical care as needed, explain anything that is new to her, and talk with her about any of her questions or concerns. He emphasizes that any question or concern is not too small or too unusual to discuss with the nurse. Because of Bill's explicit explanation of what nurses provide, Debbie has a more comprehensive idea of how she can be a more sophisticated user of the nurse's service.

Bill informs Debbie that he will ask her some questions about her record to understand her needs better and to help her with anything that she thinks is important to her or her family. If Debbie does not raise any issues, Bill might say, "I read in

your chart that you had major surgery. Is there anything you think I should know about this so I can be more helpful to you?” Debbie’s verbal or nonverbal behavior would help Bill determine whether he needs to explore Debbie’s presenting behavior or to continue asking about information in the record.

The note on the chart about Debbie having pain and nausea is the next indirect issue that Bill explores. Bill informs Debbie, “In your record, I saw that you continue to have pain and nausea. I wonder—do you still have the same pain, or has it changed?” Bill would respond to Debbie based on his immediate reactions. Bill would also check to see if Debbie continued to have nausea or whether that had changed. His verbal question would be similar to the one about pain. It is critical that Bill explore both Debbie’s verbal and nonverbal behavior to determine her need for help as well as whether she was helped by their verbal exchange.

Bill states he saw in the chart that she had gone from 110 pounds to 89 pounds. He tells her that, if she is able, she should eat the kind of foods that would help her gain strength as well as help her body heal. Bill asks Debbie what type of food she likes and tells her he can ask the dietitian to talk with her. He would say, “Debbie, would it be okay with you if I ask the dietitian to see you, or would you prefer that I not?” If Debbie replied negatively, Bill would explore contents of his immediate reaction to understand her negative reply. This would help Bill deduce that Debbie’s basis was erroneous and conclude with her agreeing to see the dietitian. Orlando (1961) notes that by also stating a negative when asking a question, the patient is more likely to respond negatively.

After completing this area of investigation, Bill proceeds with additional data in the chart. He says, “It was noted in your chart that you were concerned about your children. It didn’t state what your concerns were. Do you still have concerns?” If Debbie says she does, Bill would ask, “What type of concerns do you have?” If Debbie stated some concerns, Bill would explore further to have a clearer understanding of what type of help Debbie might need. This would help Bill determine whether Debbie’s concerns were related to areas with which nurses could help her; if not, as with the dietitian, Bill would say, “From what you say, I think it would be helpful for you to talk with the social worker. Would you like me to have one see you, or not?” Depending on Debbie’s reply, Bill would explore Debbie’s presenting behavior to determine whether Debbie was no longer in need of immediate help with this by asking, “I think you are satisfied with these plans. Am I right, or not?”

Another area Bill would explore pertains to Debbie’s self-catheterization. He might say, “Debbie, I saw in your chart that you will be putting a tube into your bladder to drain your urine. I’d like to know if you have started to do this.” If Debbie states that she has, Bill would ask, “Do you think you are learning how to do this more easily, or not?” Depending on Debbie’s response, Bill would proceed with the next indirect information in the chart.

Although other information is in the chart, the last area Bill explores in this interaction with Debbie is about the statement in the chart that notes Debbie thinks her illness is a punishment for her past life. Bill brings this up by saying, “Another item in your record said you thought your illness was a punishment.

Is that what you think now, or not?” Bill responds according to Debbie’s response. If it remains a source of distress to Debbie, Bill would use the content of his immediate reaction, such as “Debbie, I know there are various people, such as ministers, priests, and rabbis, from different religions that come to the hospital to see patients. Would you like to talk about this with anyone or not?” It may take more than one exploration with Debbie to determine whether this was a need for help. According to Orlando (1961), it is the nurse’s responsibility to provide what help the patient needs for his or her need to be met, either by the nurse or by the services of others.

These are examples of how a nurse using Orlando’s nursing process theory would approach the initial care of Debbie. Her theory emphasizes that nurses use whatever sources of patient information are available to determine whether the patient has an immediate need for help. In these examples, Bill states the information in a form that makes it easier for Debbie to respond, either positively or negatively. Certainly more areas of her care would need to be addressed. However, those addressed were clearly relevant to Debbie’s immediate concerns and her state of health. Those requiring additional exploration could be discovered as Bill continues using the theory in the process of caring for Debbie.

CASE HISTORY OF VUALL *

Vuall, a 57-year-old Vietnamese immigrant, has been in the United States for 5 years and lives with his family, which comprises his wife, three daughters ranging in age from 16 to 23, and a son, age 25. Also living within the household are three members who are considered an extended family. Except for Vuall (who prefers to be called Vu), all members of the family speak English. Vu works part-time as a laborer. Recently, Vu tested positive on the Mantoux skin test and was diagnosed as having noninfectious tuberculosis (TB). He either has an active, noninfectious case or has been exposed to TB. Vu does not have pulmonary symptoms; however, his lymph nodes are enlarged. He is being treated at an occupational health clinic with the basic four frontline drugs. In addition to receiving care at the clinic for his TB, Vu also has been seen in the clinic for other health issues. These visits with physicians have not been very satisfying to Vu and his family. Vu has been treated for 4 months for TB and for 2 years for diabetes. Several nurses at the clinic say he is angry and that they find it difficult to care for him. When Vu sees his physician, some of the staff members are reluctant to be with him because he does not speak English.

Direct observation therapy for patients with TB is commonly used to ensure that patients adhere to their treatment regimen. Therefore the patient and the health care worker agree on a place for the health care worker to observe the patient taking the prescribed medications and to assess for possible side effects. Mary has been involved in the care of Vu since his first visit to the clinic.

*Martha Brown is acknowledged for contributing to the development of this case.

Nursing Care of Vuall with Orlando's Theory

Several examples of situations with Vu illustrate how a nurse using Orlando's theory would provide deliberative nursing care. The nurse's name is Mary, and she previously completed a course explaining the use of Orlando's nursing process theory.

Many of the clients who come to this clinic do not speak English. Therefore, observing such nonverbal behaviors as facial expression, eye contact, and types of body posture is of great importance with these patients. Orlando (1961) emphasizes the need to use the data in the immediate experience to explore its meaning. The physical behaviors are data that can be used to understand the patient's immediate needs for help.

Example 1

Observation

Mary was told that Vu was really "mad," but no one knew why. Mary thought to herself, "I'll listen to what the staff says, but I'll find out for myself what's going on rather than accepting the staff's conclusion about Vu."

Mary described that when she went to see Vu, his daughter Holly was there. When the physician's examination was finished, Mary told Holly that Vu had to return for an appointment to have his eyes checked. She talked with Holly about the best time for an appointment. Instead of giving the appointment card to Holly, Mary handed it to Vu. He took the card and then frowned. Mary thought, "This is where the mad part that the staff had previously talked about comes from." However, Mary explored the meaning of his facial expression by asking, "Holly, your father is really frowning. Is he upset about something?" Holly replied, "Oh, no. He's just trying to read what you wrote. He doesn't want people to think he can't read." Mary laughed and thought, "Mad, huh! Pretty simple to check out what you observe, but so many times nurses don't do it." Vu left the clinic with a smile on his face.

Analysis

Mary listens to the indirect data from the staff that include an assumption about Vu. However, Mary does not base her actions with Vu on the staff's interpretation of his behavior. Rather, Mary relies on her own ability to discover whether Vu has unmet needs for help. She does this by exploring her perceptions with the patient through his daughter, the interpreter. Mary has developed a laser-sharp ability to use both obvious and subtle changes in the patient's behavior as cues that Vu might have an immediate need for help. When Mary explored her own perception first, from Orlando's (1961) perspective, she is most efficient. She also used both her perception and her thoughts about it to explore Vu's behavior. Mary states the perception that gave rise to her thought, again an important part of Orlando's theory. Although this may appear to be a small problem, it is the type of problem that can lead to nonadherence to the treatment regimen. Without Mary's exploration of this situation, she would not have uncovered the meaning of Vu's frown.

Example 2

Observation

A problematic situation involves Vu and his son, Do. The staff informed Mary that Vu's appointments in the past had ended with the doctor being frustrated. Mary was not present at this particular appointment, but she saw Vu after it was over. Mary approached Vu to tell him that the doctor wanted to see him again in several weeks. Mary knew from previous experience that Vu needed to have the appointment when someone from his family could accompany him. This is very important because both Vu and his family need to know what treatment or recommendations the doctor makes to ensure that Vu can adhere to the plan.

Accompanying him on this visit was his son, Do. Mary said to Do, "Because your father isn't able to understand English, would it be possible for you to go with him to the doctor's office?" Do replies to Mary that he could not go. Mary explored her perception as well as some of her thoughts by asking, "Is there some reason you can't go, like the time of day or day of the appointment?" Do repeated "no" and claimed that the doctor did not like him. Mary asks, "What is that all about?" Do says the doctor was concerned about Vu's "rung" and had shouted the word at him again and again. Do states that he did not understand what the doctor meant. Recognizing that a person whose first language is not English might have difficulty understanding such words as lung, Mary explored her thoughts. Pointing to her lung area and breathing deeply, she said slowly, "Was it lung?" He confirmed that it was. Do laughed and said that the doctor was speaking too quickly and that it sounded like "rung." He said, "If the doctor could slow down, I could understand better." Mary asked, "Do you think you could tell the doctor that?" Do agreed but asked that Mary also tell the doctor to slow down for him. Mary said, "I will tell the doctor's nurse about our conversation, and I will ask the nurse to tell the doctor that it would help you if the doctor would talk more slowly."

Analysis

On the surface this appears to be a simple problem. However, because Mary explored her perceptions and thoughts with Do, he will be able to go to the appointment and participate in the process between his father and the doctor. In this situation both Vu and Do were helped. In addition, Do might be able to use the information Mary discussed with him in other areas of his life.

Example 3

Observation

Vu had his initial eye examination with the doctor, who wanted him to return for a follow-up appointment in 1 year. When Mary asked, "Was another eye appointment scheduled for you?" Vu began to talk loudly in Vietnamese but he had a smile on his face and a twinkle in his eyes. Mary asked his daughter Holly, "Your father is smiling but talking loudly. What is that all about?" Holly said, "He complains about the doctor's office because they say they will make an appointment, but they never do." Mary explored by saying, "Would it help you keep the appointment if I made the appointment for you?" Both Vu and Holly agreed and showed relief by expressing many thanks and smiling. Mary did not stop with this. She took the initiative

to speak with the scheduler at the doctor's office and requested that Vu's next appointment be made at the time of his visit rather than having someone call for Vu.

Analysis

This is another case in which Mary, using a deliberative process, explores Vu's facial expression and his loud talking with his daughter to determine what Vu was saying. Because Vu has diabetes, it is critical that he has regular eye examinations. Not only will it benefit Vu, but also, by taking preventive actions, it will help avoid additional health care costs. The nurse's use of Orlando's deliberative process is helpful to patients and rewarding to the nurse who uses it.

CRITICAL THINKING EXERCISES

1. Make a list of the behaviors you have seen when patients were identified as hostile or uncooperative. Reflect on times you have heard nurses refer to patients in those terms and consider what may have led to the labeling. Now, use a deliberative process approach to reconsider the patient's behaviors. If the meaning of the behavior had been explored using Orlando's process, what might have been the outcome? Would it be the help the patient needed?
2. Consider assumptions (thoughts, not facts) you had about a patient you cared for recently. Assess the observable evidence to support or refute your assumptions. Describe a plan to involve the patient in your assessment of each assumption.
3. Reflect on a case in your own practice when you made an erroneous assumption (leap). What deliberative action would you take to avoid repeating that leap in the future? What question might have prevented the leap in that case?
4. List patient procedures you routinely perform in your area of practice. Consider your interaction with patients in each procedure and identify the evidence needed to evaluate your effectiveness.
5. Explore the use of the five basic steps of the deliberative process with a patient in your practice and note the outcomes. Reflect on the experience and the outcomes. What did you learn about the patient's situation using the deliberative process? How was that patient understanding used in their care? How did this exercise modify your style of practice?

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Modeling and Role-Modeling Theory in Nursing Practice

Margaret E. Erickson

Modeling and Role-Modeling is based on the philosophy that all humans have the desire to live healthy, happy lives, to find meaning and purpose in their lives, and to become the most that they can be. This holds true across the lifespan. When we use strategies that focus on the strengths of our clients, help them become more fully alive (even as they approach physical death), and to live their lives to the fullest, then we are truly helping them grow, heal, and transcend. We help them discover the essence of their being, to find or reclaim their soul.
(Erickson, 2001, p. 309)

History and Background

The Modeling and Role-Modeling (MRM) paradigm, conceived by Helen Erickson in the late 1950s, was an outcome of her exposure to the work of her father-in-law, Milton H. Erickson, coupled with her own experiences as a professional nurse. During the late 1940s and the 1950s, M. Erickson, MD, developed an international reputation for his unorthodox methods, views on human nature, and clinical results (Rossi & O’Ryan, 1985, 1992; Rossi, O’Ryan, & Sharp, 1983). H. Erickson states that she repeatedly asked him to tell her “what to do and how to do it” (H. Erickson, personal communication, February 2000). She hoped for protocols, treatment recommendations, and quick fixes, but instead she was told that she must model the client’s world and plan strategies within that context. M. Erickson, MD, advised that each human has a unique view of the world and needs to maintain his or her role in unique ways and that the practice of health care professionals was to help clients succeed in living quality lives and growing to the maximum of their potential.

Over a period of approximately 16 years, H. Erickson came to understand the wisdom of her father-in-law’s advice. As a result, by the mid-1970s, she had

conceived and developed a practice framework that she called *Modeling and Role-Modeling*. She began to label and articulate the theoretical components during her baccalaureate completion and master's study at the University of Michigan (1972-1976). Refinement of the concepts and their linkages continued as she worked with and was challenged by two colleagues, Mary Ann Swain and Evelyn Tomlin.

H. Erickson's first independent research study occurred during graduate school. Under Swain's supervision, a study was designed to test the Adaptive Potential Assessment Model (APAM) (Erickson, 1976), which had been conceived, labeled, and articulated in the mid-1970s (Figure 16-1). Concurrently, Swain and Erickson collaborated on another project designed to test the effects of MRM nursing interventions with persons who had hypertension. This work led to a third study that explored the effects of using MRM with persons who had diabetes (Erickson & Swain, 1982). Tomlin joined the research team for this project.

During these years Erickson also expanded and tested the concept of self-care knowledge (Erickson, 1984, 1990) that was conceived during the 1960s and early 1970s. She presented numerous papers, consulted in various agencies, taught at the University of Michigan, and continued her independent practice. Tomlin continued to explore ways to apply MRM in practice and to teach the theory and paradigm to undergraduate students while Swain supervised Erickson's research, collaborated with her on further elaboration of the theory, and facilitated the administrative phase of Erickson's career.

Finally, innumerable requests for written materials from practicing nurses, students, and faculty mandated that the book *Modeling and Role-Modeling*:

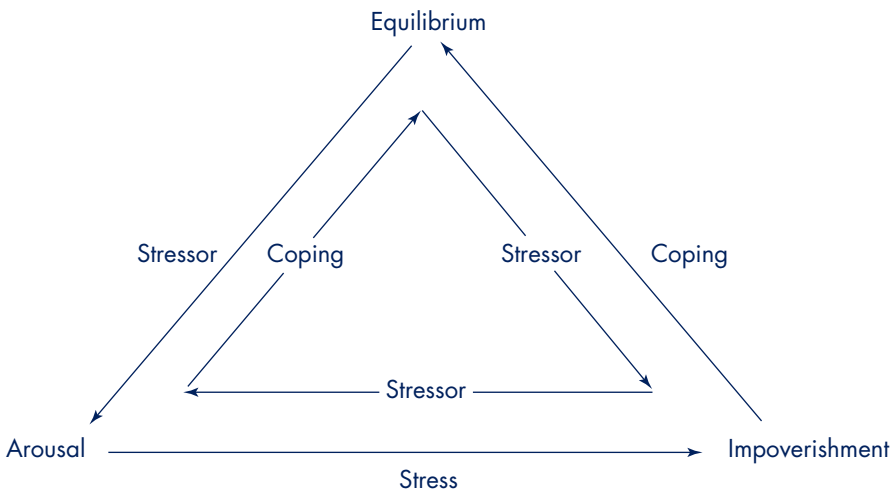


FIGURE 16-1

The dynamic relationship among the states of the Adaptive Potential Assessment Model (APAM). (From Erickson, H., Tomlin, E., & Swain, M. [1983]. *Modeling and role-modeling: A theory and paradigm for nursing*. Englewood Cliffs, NJ: Appleton & Lange, with permission from Helen Erickson, Austin, TX.)

A Theory and Paradigm for Nursing be written. After the book was published, it was used as a text at the University of Michigan. Undergraduates were taught the basic premises; several university hospital units adopted it as a guide for practice (Walsh, Vandenbosch, & Boehm, 1989); a modified assessment form was developed at the University of Michigan Medical Center (Campbell, Finch, Allport, et al., 1985); graduate students used it to guide their master's theses (Calvin, 1991; Finch, 1987; Hannon & McLaughlin, 1983; Smith, 1980; Walker, 1990); and doctoral students used it for their dissertations (Acton, 1993; Baas, 1992; Baldwin, 1996; Barnfather, 1987; Beltz, 1999; Benson, 2003; Boodley, 1986; Bowman, 1998; Bray, 2005; Chen, 1996; Clayton, 2001; Curl, 1992; Daniels, 1994; Darling-Fisher, 1987; Dildy, 1992; Erickson, 1996; Hertz, 1991; Holl, 1992; Hopkins, 1994; Irvin, 1993; Jensen, 1995; Keck, 1989; Kennedy, 1991; Kline, 1988; Landis, 1991; MacLean, 1987; Miller, 1994; Miller, 1986; Nash, 2004; Raudonis, 1991; Robinson, 1992; Rogers, 2003; Rosenow, 1991; Scheela, 1991; Sofhauser, 1996; Straub, 1993; Weber, 1995). These studies helped identify and support many of the theoretical concepts and proposed midrange theories.

The Society for the Advancement of Modeling and Role-Modeling

In 1986, a website (www.mrmnursingtheory.org) was established by a cohort of students, faculty, and practitioners, and national biennial conferences were initiated. The first conference was co-sponsored by the University of Michigan in Ann Arbor in 1986, followed by the University of South Carolina at Hilton Head in 1988, and the University of Texas at Austin in 1990. National conferences continue to be held biennially. The Society for the Advancement of Modeling and Role-Modeling was established in 1986.

Schools and health care organizations—including, but not limited to Metro State University in St. Paul, Minnesota; State University of New York at Buffalo; University of Tennessee at Knoxville; Capital University, Columbus, Ohio; St. Catherine's Hospital in Minneapolis, Minnesota; Lamar University, Joanne Gay Dishman Department of Nursing, Beaumont, Texas; the University of Texas at Austin, Galveston, and Brownsville; and others—have adopted and use MRM as the bases for either parts or all of their nursing curricula. In addition, health care agencies throughout the country such as the University Health System in Knoxville, Tennessee, or Salina Regional Health Center, Salina, Kansas, have applied MRM to implement and guide holistic nursing practice (Alligood, 2011; Perese, 2002).

Continued research has provided support for several of the middle-range theories proposed in MRM. The three states of the APAM model have been tested and found to be independent of one another and predictors for stress (Barnfather, 1990; Barnfather, Swain, & Erickson, 1989a,b; Erickson & Swain, 1982, 1990). Relationships have been shown between the following: stress and needs status (Barnfather, 1990, 1993); needs status and developmental residual and hope (as developmental residual) (Curl, 1992); burden and affiliated-individuation in caretakers of persons with Alzheimer's disease (Acton, 1993); needs satisfaction (Leidy, 1994); needs and affiliated-individuation (Acton & Miller, 1996); stress

and affiliated-individuation (Irvin & Acton, 1996); perceived support, control, and well-being in the elderly (Chen, 1996); and stress, psychological resources, and physical well-being (Leidy, 1989, 1990).

Several studies also have been conducted to explore perceived enactment of autonomy (PEA) in the elderly (Hertz & Baas, 2006), PEA and self-care, and holistic health in the elderly (Anschutz, 2000; Anschutz & Hertz, 2002); PEA and related socioeconomic factors among noninstitutionalized elders (Hwang & Lin, 2004); and PEA, self-care resources, among seniors (Matsui & Capezuti, 2008).

Other studies have provided support for linkages between role-modeled interventions and outcomes (Acton, 1993; Acton, Irvin, Jensen, et al., 1997; Erickson, 1996, 2006; Erickson, Thomlin, & Swain, 1983; Hertz, 1991; Holl, 1992; Hopkins, 1994; Irvin, 1993; Jensen, 1995; Keck, 1989; Kennedy, 1991; Kline, 1988; Scheela, 1991).

Instruments have been developed to enhance application of MRM in practice and research. Tools include those designed to measure the following: needs status (Leidy, 1994); developmental residual (Darling-Fisher & Leidy, 1988); the APAM stress states using content analysis (Hopkins, 1994); self-care resources of cardiac patients (Baas, 1992, 2011); denial in postcoronary patients (Robinson, 1992); perceived enactment of autonomy in the elderly (Hertz, 1991); family experience with eating disorders (Folse, 2007); patients' adjustment to implanted cardiac devices (Beery, Baas, Mathews, et al., 2005); and the bonding-attachment process within the context of needs satisfaction in teenage mothers (Erickson, 1996).

This theory also can be applied in all settings and with all populations. MRM has been used to provide a theoretical foundation for exploration and examination of how persons ages 85 and older manage their health (Beltz, 1999), quality care of diverse older adults (Hertz, 2008); urinary incontinence and assessment of the Bladder Health Program among rural elders (Liang, 2008, 2011); to achieve greater understanding of families' experience through prolonged periods of suffering and their evolution toward spiritual identity (Clayton, 2001); caring for people living with advanced cancer (Haylock, 2010); finding meaning in life (Clayton, Erickson, & Rogers, 2006; Erickson, 2006); living with mental health disorders (Hagglund, 2009; Sung & Yu, 2006); mentoring students (Lamb, 2005); and coping with stress (Benson, 2006). Benson's application of MRM was supportive and provided insight into the subsequent use of APAM in small groups (Benson, 2003, 2011). MRM also has provided a foundation for exploration of how patients adjust to implanted cardiac devices (Beery, Baas, & Henthorn, 2007).

Researchers have used this holistic nursing theory and paradigm to explore the following situations: lived experiences and perceptions of hope of elementary children in urban areas (Baldwin, 1996); the experience and perceptions of mothers using child health services in South Africa (Jonker, 2012); the meaning of encouragement and its connection to the inner-spirit perceived by caregivers of the cognitively impaired (Miller, 1994); the evaluation of holistic peer education and support group programs aimed at facilitating self-care resources in adolescents (Nash, 2004, 2007); the experiential meaning of well-being for employed mothers (Weber, 1995); the relationship between psychosocial attributes, self-care resources, basic needs satisfaction, and measures of cognitive and psychological health of

adolescents (Bray, 2005); psychosocial aspects of heart failure management (Baas & Conway, 2004); and self-care resources and activity as predictors of quality of life in persons with post-myocardial infarction (Baas, 2004). In addition, holistic healing for women with breast cancer through a mind, body, and spirit self-empowerment program (Kinney, Rodgers, Nash, et al., 2003); morbid obesity (Lombardo & Roof, 2005); patient's perceptions regarding nurse-client interactions (Rogers, 2003), the relationship between basic need satisfaction and emotional eating (Cleary & Crafti, 2007; Timmerman & Acton, 2001) has been studied using MRM.

Finally, research has been conducted to further explore major constructs or philosophical assumptions in the MRM theory. Baas, Beery, Allen, and colleagues (2004) studied self-care knowledge in patients with heart failure and transplant; Baldwin (2004) studied self-care for clients in early menopause; Baldwin and Herr (2004) studied the effect of self-care on treatment of interstitial cystitis; Baldwin, Hibbeln, Herr, and colleagues explored self-care as defined by members of an Amish community (2002); and Beery, Baas, Fowler, & Allen (2002) studied spirituality in persons with heart failure.

Overview of Modeling and Role-Modeling

Modeling and Role-Modeling (Erickson, et al., 1983 [reprinted in 2002]), conceived within the context of numerous philosophical assumptions, was labeled and articulated by Erickson synthesizing several concepts from established theories. Concepts were drawn from the works of Maslow (1968, 1970), Bowlby (1969, 1973, 1980), Erikson (1963), Engel (1962, 1968), and Selye (1974) to create a new theory that described relations among needs, loss, grief, adaptation, developmental processes, growth, and well-being of the holistic person (Figure 16-2). The practice paradigm was derived from integrating philosophical assumptions with theoretical underpinnings.

Philosophical Assumptions and Constructs

Holism

Humans consist of cognitive, biophysical, social, and psychological subsystems permeated by genetic predispositions and a spiritual drive (Figure 16-3). The ongoing interaction of these multiple components creates a dynamic, holistic system that is greater than a sum of the parts (Erickson, Tomlin, & Swain, 2005). Health, which is affected by these dynamic interactions, is a perception of well-being, as perceived by the client. Although physical status influences perceptions of health, persons can perceive a high level of well-being even as they take their last breath. Therefore, health can be defined as a dynamic, eudaemonistic sense of well-being (Erickson, et al., 2005) associated with self-fulfillment and transcendence beyond the objective reality of the moment (Erickson, 2001).

Affiliated-Individuation

Essential to a person's sense of well-being is the need for *affiliated-individuation* (AI). AI, coined by Erickson, is defined as "the need to be dependent on support systems while simultaneously maintaining independence from these support systems (Erickson, et al., 1983, p. 252). AI is usually first recognized, and accepted

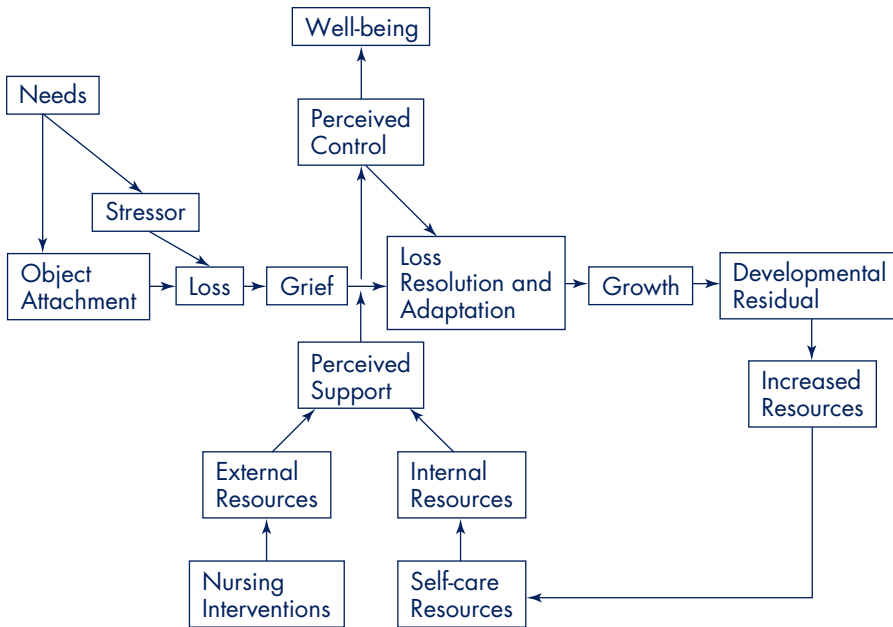


FIGURE 16-2

Relationships among the constructs of the Modeling and Role-Modeling (MRM) theory. (From Erickson, M. E. [1996]. *Relationships among support, needs satisfaction, and maternal attachment in adolescent mothers*. Doctoral dissertation: University of Texas–Austin, with permission from Margaret Erickson, Austin, TX.)

as normal, during the stage of autonomy as a toddler explores the world but reconnects regularly with his or her care provider. Although AI is a lifelong need for all people, it is commonly not recognized as acceptable behavior as people get older and are expected to be independent.

Need Satisfaction, Growth, and Development

Humans are in a continual state of change and have inherent drives that motivate behavior. These include a drive for needs satisfaction, adaptation, and growth sequential development. According to Erickson and colleagues (2005), “Growth is defined as the changes in body, mind, and spirit that occur over time” (p. 46) and facilitates an individual’s development. Development is defined as “the holistic synthesis of the growth-produced...differentiations in a person’s body, ideas, social relations, and so forth” (Erickson, et al., 1983, p. 47). When individuals are given necessary information, adequate emotional support, and are empowered in making satisfactory decisions, growth and subsequent development occur and health is enhanced.

Internal and External Resources

According to the MRM paradigm, the nurse facilitates an interactive, interpersonal relationship with the client. During this process the nurse assists the client in

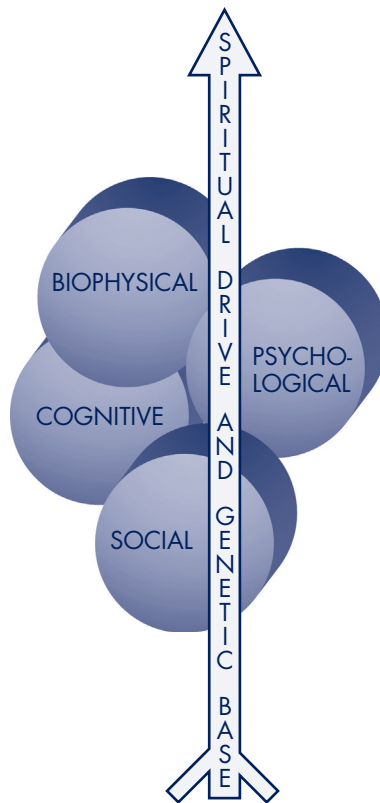


FIGURE 16-3

Relationships among the human subsystems, genetic predispositions, and spiritual drive. (From Erickson, H., Tomlin, E., & Swain, M. [1983]. *Modeling and role-modeling: A theory and paradigm for nursing*. Englewood Cliffs, NJ: Appleton & Lange, with permission from Helen Erickson, Austin, TX.)

identifying, developing, and mobilizing internal and external resources—resources needed to cope with life’s stressors, to grow and heal. Essential to this process is the nurse’s unconditional acceptance of the client. Erickson and colleagues (1983) argue that “[b]eing accepted as a unique, worthwhile, important individual—with no strings attached—is imperative if the individual is to be facilitated in developing his or her own potential” (p. 49).

Modeling

In a supportive and caring environment, a nurse attempts to understand “the client’s personal model of his or her world and to appreciate its value and significance for the client from the client’s perspective” (Erickson, et al., 1983, p. 49). The act of developing an image and understanding of the clients’ worldviews from within their perspectives and framework is called *modeling*. “The way an individual communicates, thinks, feels, acts, and reacts—all of these factors comprise the individual’s *model of his or her world*” (Erickson, et al., 1983, p. 84).

Role-Modeling

After the client's world has been modeled, the nurse facilitates and nurtures the individual "in attaining, maintaining, or promoting health through purposeful interventions" (Erickson, et al., 1983, p. 254). This is known as *role-modeling*. In role-modeling the client's world, the nurse plans interventions that do the following:

- Identify mutual nurse-client goals
- Promote client strengths, control, and positive orientation
- Build trust

These interventions are aimed at helping the client "achieve an optimal state of perceived health and contentment" (Erickson, et al., 1983, p. 49).

Self-Care Knowledge, Self-Care Resources, Self-Care Actions

Nursing interventions are designed based on the belief that all individuals at some level understand what has interfered with their growth and development and altered their health status. Accordingly, people also know what they need to improve and optimize their state of health, facilitate their growth and development, and maximize their quality of life and well-being. This inherent knowledge is called *self-care knowledge*. Individuals also have internal and external self-care resources. *Internal self-care resources* (or *self-strengths*) refer to all of the "internal resources that an individual can use to promote health and growth" (Erickson, et al., 1983, p. 128). These strengths are defined by the perceptions of both the nurse and the client and can include attitudes, endurance, patterns, or whatever else is perceived to be a personal strength and resource of that individual. *External self-care resources* include the client's social network and support systems. The social network is a set of individuals with whom the client is socially acquainted, and support systems are a set of individuals who are perceived to support, energize, and provide resources for the client.

Development and utilization of self-care knowledge and self-care resources is known as *self-care action*. "Through self-care action the individual mobilizes internal resources and acquires additional resources that will help the individual gain, maintain, and promote an optimal level of holistic health" (Erickson, et al., 1983, p. 49).

Finally, an individual's potential for mobilizing resources and achieving a state of coping is directly related to his or her level of needs satisfaction (Erickson, et al., 1983). Individuals who have a high level of needs satisfaction have a greater ability to positively cope with life's stressors and to achieve a state of equilibrium. However, individuals who have a high level of unmet needs have less ability to mobilize resources and are at risk when confronted with stressors.

Nursing interventions are designed to facilitate clients in using self-care actions that will help them meet their physiological, psychological, social, cognitive, and spiritual needs. Repeated needs satisfaction results in growth; continued growth produces healthy developmental residual. Fundamental to this theory is the understanding that an individual's needs are met only when the individual perceives that they are met.

Theoretical Underpinnings

Developmental processes are sequential tasks, strengths, and virtues that are associated with biological time periods (Figure 16-4). Each stage has a central focus

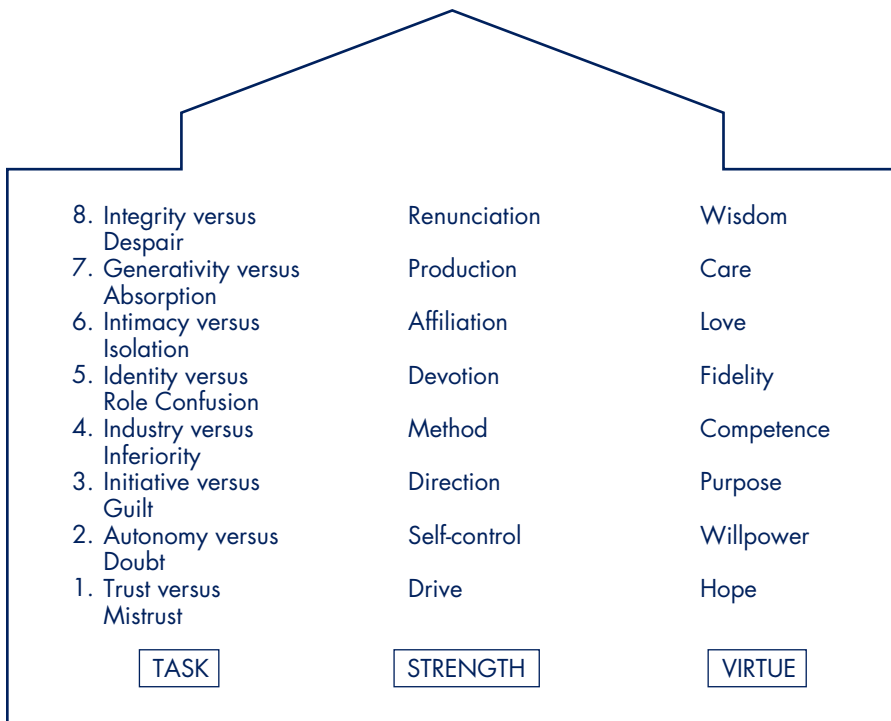


FIGURE 16-4

Erikson's developmental tasks, strengths, and virtues. (From Erickson, H., Tomlin, E., & Swain, M. [1983]. *Modeling and role-modeling: A theory and paradigm for nursing*. Englewood Cliffs, NJ: Appleton & Lange, with permission from Helen Erickson, Austin, TX.)

and related life task to be accomplished. The manner in which this task is completed will determine what type of developmental residual results. Residual from stage one serves as a resource (or hindrance) for task resolution of stage two, and so forth across the life span. Because of the epigenetic nature of the developmental processes, people are constantly reworking earlier stages. One's ability to resolve developmental tasks in a healthy manner (and to rework earlier acquired residual) is dependent on resources accrued from having one's needs met across the life span.

Need Satisfaction, Growth, and Development

Inherent needs, classified as survival, AI, or growth-related, emerge in a quasi-ordered manner. Lower-level needs must be satisfied to some degree before higher-level needs emerge (Figure 16-5). Minimal lower-level and mid-level needs satisfaction is necessary for survival; repeated needs satisfaction facilitates growth and development. Lower-level and mid-level needs deficits create tension and drive behaviors aimed at meeting those unmet needs; satisfaction of these needs dissipates the tension. Higher-level needs satisfaction creates tension and desire

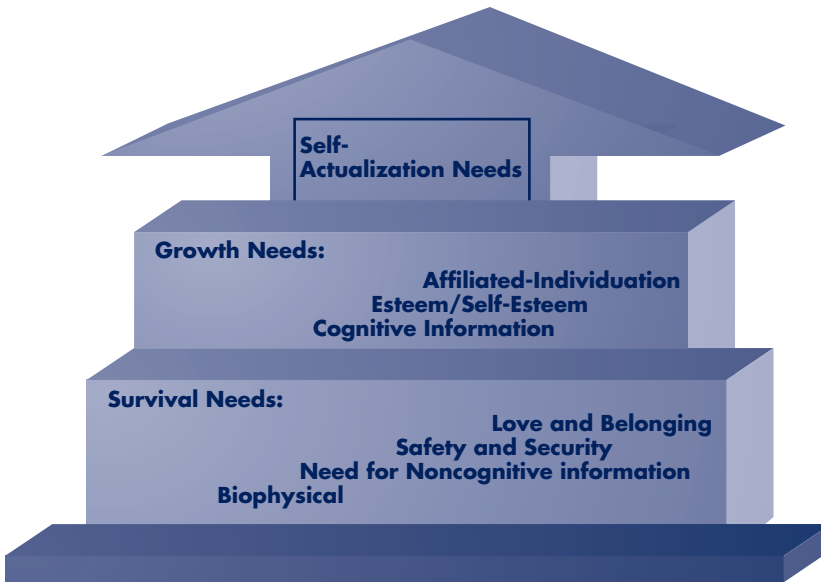


FIGURE 16-5

Needs across the life span. (Modified from Erickson, H., Tomlin, E., & Swain, M. [1983]. *Modeling and role-modeling: A theory and paradigm for nursing*. Englewood Cliffs, NJ: Appleton & Lange, with permission from Helen Erickson, Austin, TX.)

for additional growth experiences. People who repeatedly experience unmet needs during the early years of life develop a deficit motivation toward relationships. Those who repeatedly experience needs satisfaction during the early years of life develop a being motivation.

Unmet Needs as Stressors and Stress Responses

Unmet needs are *stressors*; stressors produce *stress responses*. Resolution of stress requires adequate resources; one's ability to mobilize adequate resources determines the outcome of the stress response. Stressors, stress responses, and resources may be within the same subsystem; however, they are not limited to a single subsystem. For example, an individual may experience an accident that can affect his or her physiological subsystem, or depending on the severity and the client's perception of the event, it may affect the client's physiological, emotional, cognitive, and spiritual subsystems.

Stress Response States: Arousal and Impoverishment

The two types of stress response states are *arousal* and *impoverishment*. When adequate resources are available and readily mobilized, arousal occurs (Figure 16-6). When inadequate (or diminished) resources are available, impoverishment occurs. Those in impoverishment are at greatest risk for continued stress, depletion of resources, and resulting illness, disease, and/or physical death than are those in arousal (see Figure 16-6).

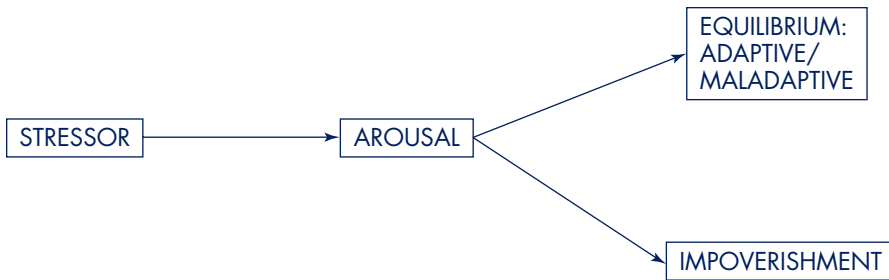


FIGURE 16-6

The Adaptive Potential Assessment Model (APAM). (From Erickson, H., Tomlin, E., & Swain, M. [1983]. *Modeling and role-modeling: A theory and paradigm for nursing*. Englewood Cliffs, NJ: Appleton & Lange, with permission from Helen Erickson, Austin, TX.)

BOX 16-1**Major Theoretical Linkages in Modeling and Role-Modeling**

1. There is a relationship between adaptive potential and needs satisfaction.
2. There is a relationship between developmental task resolution and needs satisfaction.
3. There is a relationship between developmental task resolution and developmental residual.
4. There is a relationship between developmental residual and self-care resources.
5. There is a relationship among basic needs satisfaction, object attachment, loss, grief, growth, and development.

From Erickson, H., Tomlin, E., & Swain, M. (1983). *Modeling and role-modeling: A theory and paradigm for nursing*. Englewood Cliffs, NJ: Appleton & Lange, with permission from Helen Erickson, Austin, TX.

Adaptation, Attachment Objects, Loss and Grief Response

Adaptation occurs as needs are met, stress responses are diminished, and new resources are built. Those objects that repeatedly meet needs become *attachment objects*. These objects change as people move through various developmental stages. When attachment occurs, loss of attachment objects will result in feelings of loss. Loss can be situational and developmental. Loss is real, threatened, or perceived. Examples of situational losses are the loss of a favored item, the perceived rejection by a loved one, or a major flooding of one's home. Developmental losses are phases of movement through the developmental sequence, such as weaning during infancy, going to school, or leaving home. When loss occurs—whether it is real, threatened, or perceived—people experience grief.

The grief process has sequential phases; movement through the grief process requires mobilization of resources. One's ability to mobilize adequate resources determines the outcome of the grief response. Inadequate resources and one's inability to deal with a loss result in morbid grief (Lindemann, 1942); morbid grief affects future developmental processes, as Box 16-1 illustrates. A synthesis of these multiple theories provided the bases for the MRM theory. Major theoretical linkages are shown in Box 16-1.

Critical Thinking in Nursing Practice with the Modeling and Role-Modeling Theory

The MRM practice paradigm is guided by five related nursing principles, intervention aims, and outcome goals for the nursing process (Table 16-1). There are interview guidelines that influence the type of data collected and specify the purpose of the data (Table 16-2). Table 16-3 illustrates the process for each phase of assessment. It discusses the data interpretation and analysis that lead to nursing impressions.

Data Collection, Interpretation, Analysis, Synthesis, and Application

Critical thinking occurs continually in the process as the following steps occur: data are collected, interpreted, analyzed, and synthesized; strategies are planned and used to facilitate growth and healing; and the caring process is evaluated to determine whether a healing process has been initiated. The primary source of information is the client; secondary sources include the family's view and the nurse's observations. Tertiary sources are all others, including medical information. The client's self-care knowledge is considered primary information and is the initial focus of the nursing assessment. As the nurse uses an unstructured interview to collect self-care

TABLE 16-1 Nursing Principles, Aims, and Goals

| Intervention Goal | Principle | Aim |
|--|--|--|
| 1. Develop a trusting and functional relationship between yourself and your client. | The nursing process requires that a trusting and functional relationship exist between the nurse and the client. | Build trust. |
| 2. Facilitate a self-projection that is futuristic and positive. | Affiliated-individuation is contingent on the individual perceiving that he or she has some control. | Promote client's positive orientation. |
| 3. Promote affiliated-individuation with the minimum degree of ambivalence possible. | Human development is dependent on the individual perceiving that he or she has some control over life while concurrently sensing a state of affiliation. | Promote client's control. |
| 4. Promote a dynamic, adaptive, and holistic state of health. | There is an innate drive toward holistic health that is facilitated by consistent and systematic nurturance. | Affirm and promote client's strengths. |
| 5. (a) Promote (and nurture) coping mechanisms that satisfy basic needs and permit growth needs satisfaction. (b) Facilitate congruent actual and chronological developmental stages. | Human growth is dependent on satisfaction of basic needs and is facilitated by growth needs satisfaction. | Set mutual goals that are health-directed. |

From Erickson, H., Tomlin, E., & Swain, M. (1983). *Modeling and role-modeling: A theory and paradigm for nursing*. Englewood Cliffs, NJ: Appleton & Lange, with permission from Helen Erickson, Austin, TX. Reprinted (1988, 1990, 1994, and 1999). Ann Arbor, MI: ETS.

knowledge (primary data), both verbal and nonverbal communications are noted. A continuous appraisal of congruence is determined when nonverbal messages indicate lack of congruence with verbal statements; the interviewer stores this information for further consideration (Erickson, 1990; Erickson, et al., 1983). Having clients share “their life story” is one way to obtain rich, detailed primary data.

Secondary data are collected from the family or significant others and, when needed, additional data (tertiary data) are collected from other sources, such as the medical record, physicians, or other health care providers. These data are interpreted individually and then integrated to determine congruency among the sources, differing views, and other information. The primary source of data (self-care knowledge) always serves as the primary focus of nursing care. When there are differences in views, information, and orientation among the data sources, the nurse accepts the responsibility of working with the secondary client after first addressing the needs of the primary client. The MRM nurse also provides leadership

TABLE 16-2 Interview Guidelines and Purpose for Data Collection

Category and Subcategories Purpose of Data Collection

DESCRIPTION OF THE SITUATION

- | | |
|---------------------------|---|
| 1. Overview of situation | 1. To develop an overview of client’s situation from his or her perspective |
| 2. Etiology | 2. To identify etiological factors involved |
| Stressors and distressors | |
| 3. Therapeutic needs | 3. To identify possible therapeutic interventions |

EXPECTATIONS

- | | |
|--------------|---|
| 1. Immediate | 1. To understand client’s personal orientation in terms of client’s expectations for present and future |
| 2. Long-term | |

RESOURCE POTENTIAL

- | | |
|--|--|
| 1. External Social network Support system Health care system | 1. To determine the nature of the external support system |
| 2. Internal Strengths Adaptive potential Feeling states Physiological data | 2. (a) To determine client’s strengths and virtues (b) To determine client’s current available internal resources |

GOALS AND LIFE TASKS

- | | |
|------------|---|
| 1. Current | 1. To determine current developmental status in order to understand client’s personal model and to use maximum communication skills |
| 2. Future | |
-

Modified from H. Erickson. (2001). From Erickson, H., Tomlin, E., & Swain, M. (1983). *Modeling and role-modeling: A theory and paradigm for nursing*. Englewood Cliffs, NJ: Appleton & Lange, with permission from Helen Erickson, Austin, TX. Reprinted (1988, 1990, 1994, and 1999). Ann Arbor, MI: ETS.

TABLE 16-3 Data Analysis Methods, Interpretation, and Nursing Impressions

| Assessment Phase | Nursing Interventions | Nursing Impressions |
|---------------------------------|--|---|
| Description | Write a paragraph on the relationship among the factors. Include comments that state client’s perceptions, identified stressors, distressors, perceptions of loss, congruency of this perception with that of secondary and tertiary resources, mind-body relationships, and associated subsystem. Identify possible therapeutic interventions, desire for information; include congruency with family and health care providers. | Basic need assets/deficits Growth need assets/deficits Attachment/loss status Affiliation status |
| Expectations | Write a paragraph regarding client’s positive orientation. Include expectations for immediate nurse-client relationship, projection of self into future, extent of projection and nature of projection, sense of self as worthwhile, valued person, role of self in future. | Self-futurity |
| Resource Potential: External | Write a paragraph on client-family relationship in their social network. State whether relationship is invigorating or draining; comment on availability of a significant other and mode of communication with other. Comment on perceived control in respect to others (i.e., ability to satisfy needs and resolve problems and dependency on others). Comment on past use of health care providers and perceptions of health care providers. | Affiliation Individuation Perceived control |
| Resource Potential: Internal | Write a paragraph on client’s strengths and virtues, which includes both universal and unique individual strengths and virtues. Describe feelings and patterns, length of time of feeling pattern. | Assets, APAM, developmental status, psychological, cognitive |
| Goals | Write a paragraph on planned goals, factors that facilitate, and barriers that inhibit. State chronological/current task. Note the type of cognitive processing used. | |

APAM, Adaptive Potential Assessment Model.
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for the interface between these three sources (primary, secondary, and tertiary) of information. That is, MRM nurses serve to facilitate better understanding of the client’s self-care knowledge and vice versa among other members of the team.

Although critical thinking is usually considered a scientific process, MRM practitioners also use critical thinking during the artistic phase of the caring process. That is, practitioners use critical thinking during the strategy implementation phase as well as during the previous phases of the process. Although specific strategies can be used to facilitate growth and healing, they are always applied within the context of the client’s worldview (Erickson, 2000, 2001; Erickson et al., 2005). That is the artistic aspect of MRM.

CASE HISTORY OF DEBBIE

Debbie is a 29-year-old woman who was recently admitted to the oncology nursing unit for evaluation after sensing pelvic “fullness” and noticing a watery, foul-smelling vaginal discharge. A Papanicolaou smear revealed class V cervical cancer. She was found to have a stage II squamous cell carcinoma of the cervix and underwent a radical hysterectomy with bilateral salpingo-oophorectomy.

Her past health history revealed that physical examinations had been infrequent. She also reported that she had not performed breast self-examination. She is 5 feet, 4 inches tall and weighs 89 pounds. Her usual weight is about 110 pounds. She has smoked approximately two packs of cigarettes a day for the past 16 years. She is gravida 2, para 2. Her first pregnancy was at age 16, and her second was at age 18. Since that time, she has taken oral contraceptives on a regular basis.

Debbie completed the eighth grade. She is married and lives with her husband and her two children in her mother’s home, which she describes as less than sanitary. Her husband is unemployed. She describes him as emotionally distant and abusive at times.

She has done well following surgery except for being unable to completely empty her urinary bladder. She is having continued postoperative pain and nausea. It will be necessary for her to perform intermittent self-catheterization at home. Her medications are (1) an antibiotic, (2) an analgesic as needed for pain, and (3) an antiemetic as needed for nausea. In addition, she will be receiving radiation therapy on an outpatient basis.

Debbie is extremely tearful. She expresses great concern over her future and the future of her two children. She believes that this illness is a punishment for her past life.

Nursing Care of Debbie with Modeling and Role-Modeling

Data Aggregation and Interpretation

Primary Data

Debbie’s self-care knowledge is not discussed. Therefore, the logical first step would be to return to Debbie and ask for her description of the situation, related factors, expectations, resources, and goals. These data would then be integrated with secondary and tertiary data to determine the appropriate course of action. However, because Debbie made “reported” comments, these can be integrated with obvious secondary and tertiary data.

Secondary and Tertiary Data

Description of the situation. According to the report, Debbie is distressed and depressed about her current life situation. Physically, she has just undergone major surgery and is experiencing postoperative pain, nausea, difficulty emptying her bladder, and a recent significant weight loss. No data are provided

regarding Debbie's ability to complete self-catheterization; her feelings about the multiple losses associated with her altered body image, need for self-catheterization, and inability to have children in the future; her discomfort associated with post-operative pain and nausea; and her fear of the future regarding her radiation treatment and the potential for recurrence of the cancer. Furthermore, no information is provided on personal or professional resources available to help her meet these needs.

Psychologically, Debbie is depressed and blames her current life situation on her past life transgressions. She believes that this illness is punishment for her past life. It is difficult to know if Debbie is referring to having been an adolescent mother, having smoked cigarettes since she was 16 years old, or other perceived transgressions. It would be important to ask her if she could share more information regarding this statement so that relevant data could be collected.

Debbie has experienced multiple losses recently and over the past several years that have resulted in needs deficits related to unmet love and belonging needs. As an adolescent mother, Debbie had little time to care for herself. At a time in her life when she needed to focus on who she was and on meeting her own needs, her resources were directed toward the care of two small children. This conflict of interest might have resulted in feelings of loss and related unmet needs (Erickson, 1996). In addition, she describes her marital relationship as emotionally distant and at times abusive. Consequently, she has received little if any social and emotional support from her husband. No data concerning her relationship with her mother and children are available. Further information is needed before it can be determined whether these individuals are perceived as supportive and help meet her basic love and belonging needs.

Debbie has multiple stressors and distress in her life. She is the mother of a preadolescent and an adolescent; her husband is unemployed; and her housing accommodations are unsanitary and unacceptable. She has had surgery, is nauseated, is in pain, is unable to void normally, and must learn intermittent self-catheterization. Her husband's unemployment and her low educational level affect their ability to achieve financial freedom and security. Subsequently, they are dependent on her mother for a place to live. Inability to provide a home for her children and one in which she feels safe to live is an additional loss Debbie faces. These losses indicate basic physiological, safety and security, and self-esteem needs deficits. Furthermore, surgery and related costs will only exacerbate an already difficult financial situation. Under the circumstances, it is highly possible that Debbie does not have health insurance, which is an additional stressor. Major physical alterations in her body, weight loss, surgery, nausea, pain, and problems with voiding are all real losses.

Expectations. Debbie has not offered any immediate or long-term expectations. However, she has expressed great concern over her future and the future of her children. These findings suggest impoverishment, unresolved losses, and threatened future loss. Because we do not have primary data (self-care knowledge), we do not know whether these are related to basic physiological, safety and security, or love and belonging needs secondary to her current health status, living situation, or interpersonal relationships. No information from the other

sources regarding her expectations is provided. The health care providers have identified their expectations for her as follows:

- Take her medications for pain and nausea
- Perform self-catheterization as needed
- Undergo radiation therapy on an outpatient basis

Resource potential. Debbie's social network includes her mother, husband, and two children, who are approximately 13 and 11 years old. No information regarding her support system is provided except that her husband is emotionally distant and abusive. Debbie is receiving postoperative care in an oncology unit. She has provided no data on the care she has received during her hospitalization, the nurse-client relationship, or her interpersonal family dynamics, including whether her family members are physically and emotionally accessible for her needs.

Debbie, who is extremely tearful, shares that she has not been performing breast self-examinations and that she has completed the eighth grade. She has not verbalized any personal strengths. Debbie has demonstrated some responsibility. She has cared for her children and practiced birth control for the past 11 years.

Goals and life tasks. Debbie has not identified any goals, although she has expressed concern about herself and the future of her children. Future goals will need to focus on helping Debbie meet her basic needs and helping her work on the developmental task of autonomy. The nurses' goals for Debbie include antibiotic therapy to prevent an infection, an antiemetic to help control nausea, and radiation therapy to destroy any remaining cancerous cells. No interventions to help her meet her basic or growth needs are identified.

Data Integration and Analysis

Debbie has recently experienced multiple losses that have affected her basic and growth needs satisfaction. Unfortunately she has minimal resources, so her ability to adapt to her current circumstances and achieve health and well-being is unlikely; she is impoverished. She is at high risk for further decline in her health status because of her inability to mobilize resources. Nursing interventions need to focus on helping Debbie achieve AI and basic and growth needs satisfaction.

Living at home, being married to a distant and abusive husband, having quit school after eighth grade, and lacking physical care of self all suggest that Debbie may be working on the developmental stage of autonomy versus doubt. Her life situation indicates that Debbie is having difficulty with AI. She has been unable to complete the education necessary to become financially independent. Debbie's family is residing with her mother. She is married to a man who does not meet her financial or emotional needs. She was an adolescent mother. All of these factors indicate her difficulty in being autonomous and simultaneously having healthy connections (or feelings or affiliation) with her significant others.

Nursing Impressions

Debbie has multiple survival, growth, and self-actualization needs deficits. She is in morbid grief, probably secondary to early life experiences. These are compounded by her recent and current life situation. She lacks a secure attachment object and thus suffers from inadequate AI. She cannot positively project herself into

the future and has diminished resources; therefore, she is impoverished. Her collective situation suggests that she has minimal trust and (developmental) residual, unhealthy shame and doubt, guilt, and inferiority. She probably has difficulty with role confusion as well. She is currently confronted with the task of intimacy and appears to have more isolation (developmental) residual than intimacy.

Nursing Interventions

The aim of MRM nursing interventions is to build trust, affirm and promote client strengths, promote positive orientation, facilitate perceived control, and set health-directed mutual goals. The first step in the process for this client is to collect self-care knowledge. This will help the nurse confirm, revise, and/or adapt nursing interpretations and impressions. Because the MRM nurse also approaches the interview process with unconditional acceptance and with a belief that all humans have the potential to grow, the nurse's attitude will promote a sense of positive orientation in the client. (Note that this approach is used to facilitate the developmental stage of trust.) As an MRM nurse, you will want to explore your client's perceived strengths and goals. It will also help you build a trusting, *functional* relationship with Debbie and help Debbie perceive a sense of control. (Note that this approach is used to facilitate the resolution of the developmental stage of autonomy.)

Remember that Debbie is impoverished. Thus she will not be able to project herself very far into the future. Perhaps the most that will be possible will be setting goals for increased physical comfort (basic physical needs) and a sense of being connected to you (belonging needs). By reinforcing her perceived strengths and helping her identify additional internal resources, she will continue to rework the tasks of trust and autonomy. She will also develop a sense of AI.

You can inform Debbie that we sometimes have life experiences that interfere with our ability to grow, that the miracle in life is that we always have new opportunities, and that it is never too late. Although it may seem that life is nothing but a cloudy storm, there usually is a rainbow if we can just learn how to find it. It might also be important to tell her that sometimes we do things to meet our needs. These actions seem right at the time but later we realize that they did not work very well. These actions make us neither bad nor wrong; they just alter our lives. It is never too late to start anew.

You can also ask Debbie what kind of information she would like to have. Tell her what information you can offer. (Start with survival needs and move up the hierarchy.) Let her choose whether she wants information and, if so, what information she wants. In this discussion you would probably offer to talk about how she could help herself be more comfortable or to quiet and calm her stomach if she receives chemotherapy or is feeling uncomfortable. It is important that we use language such as *comfort*—language that reflects health—rather than words that reflect illness, such as *pain*. You could also mention that when she is ready, you could teach her how to empty her bladder so she would be more comfortable.

To provide physical care it is essential that the approach include unconditional acceptance of the person and his or her body. Through soft voice tones, gentle and soothing touch, and eye contact, the nurse projects unconditional acceptance, love, and respect for the holistic person. Comments that identify physical strengths are

also important. Debbie needs to be assisted to discover what is right with her; with such discoveries she will be better able to handle her limitations.

Debbie also needs help with external resources. She has a social network, but she may not see them as her support system. Although the nurse will want to keep this in mind, Debbie probably will not want to talk about her family until she has developed new internal resources. Impoverished people have difficulty viewing the world from another person's eyes. Instead, they often see the other as a part of their problems. However, Debbie will need help in planning if she has chemotherapy. Thus you might inform Debbie that you are there to talk and to help her problem solve and that Debbie should be encouraged to think about how she can meet her own needs when she is ready, but there is no rush. Right now the focus is on helping her rest and find comfort.

When Debbie indicates she is ready, she may need time to simply tell her story. Although we can only imagine that she has had a difficult childhood and marriage, only she can relate it in such a way as to express her real feelings. Informing her that all people deserve to be loved and respected but that it does not always happen is one way to initiate such a discussion.

Debbie will also want to discuss how she can care for her children and what will happen to them. To facilitate this discussion, you might comment about how beautiful her children are and how they are like their mother. When Debbie is ready and has built sufficient trust, she will raise the issue.

Remember that each of these topics is related to unmet needs, loss, and grief. Therefore, the nurse should expect to see behaviors that represent the grieving process, such as denial, shock, anger, bargaining, and sadness. Until Debbie has worked through the grieving process, you will not see acceptance with attachment to new objects or attachment to old objects in new ways. Do not be fooled by behaviors that suggest giving up; giving up is not the same as letting go. Giving up represents continued morbid grief (with unresolved losses); letting go represents moving on, attaching in new ways.

As Debbie continues to rework the tasks related to the first two stages of life, she will begin to work on initiative, followed by industry, identity, and intimacy. Throughout these processes it is important to help her begin to think about her life, what it has meant, and what her purpose in life might be. These processes are especially important for Debbie because she may be facing physical death. If that is the case, it is essential that she be given an opportunity to develop a sense of positive orientation, find meaning in life, and express her purpose for being. This will help her develop a sense of spiritual well-being.

CASE HISTORY OF JOHN

Background

John, a 70-year-old male, was admitted to the hospital for shortness of breath secondary to exacerbation of his emphysema. After a few days he was ready for discharge. John's medical records indicate that he has been admitted 16 times

Continued

CASE HISTORY OF JOHN—cont'd

in the past 18 months. John is referred to the community case manager to see “if something can be done about this.” The following report was provided at that time.

Secondary and Tertiary Data

John is well known by the nurse, who states, “John’s a regular here. It seems he is here all the time. That’s fine. John really doesn’t require much care once he is stabilized. It gives us a break. He often comes in drunk, but he isn’t a mean drunk. Once his breathing gets better, he’ll leave so he can smoke. He smokes like a chimney!”

John’s medical history indicates that he is 5 feet, 11 inches and weighs 160 pounds. He has cirrhosis of the liver, emphysema, and mild anemia; has a history of chronic alcohol use; and smokes three packs of cigarettes a day. His physician documented that John will not take care of himself and is noncompliant. Following his admission John is started on oxygen therapy 2 L per nasal cannula and given respiratory treatments. The respiratory therapist greets John by his first name and asks how he is doing. After 3 days John says he is “feeling better and ready to be discharged.”

Primary Data

Description of the Situation

The nurse asked if she could speak with John before his discharge. He replied, “Sure. I’d be happy to help however I can.” She asked him to tell her why he feels he has had so many admissions in the past 18 months. He replied, “I live alone in an apartment building for senior citizens. My daughter lives 400 miles away, and we don’t see each other very often. I wish she were closer. I miss her. I don’t have any other family. My wife divorced me years ago because of my drinking. It was my own fault. I wish there was somebody in my life that cared about me. I don’t do much anymore, because my breathing won’t let me. I don’t get out and see people or go bowling like I used to. It’s too bad. I was pretty good. My only real enjoyment comes when I’m drinking or having a smoke. Sometimes I have a smoke with some of the other guys who live in my building. It’s good to get together and talk. I don’t eat much anymore. It’s too much work for just me. I know I should quit smoking and drinking, but why bother?”

John was asked what would help him feel better. He responded, “I guess if I knew somebody cared and was there when I needed him or her, but that probably isn’t going to happen. Everybody is pretty busy at the hospital. I expect that I will just continue to see them when I have problems breathing.”

Expectations

When John was asked to describe what he expected for his future health, he stated that he believed that some day he would come to the hospital with shortness of breath, be put on a ventilator, and never be able to get off, and die.

CASE HISTORY OF JOHN—cont'd***Resource Potential***

When John was asked about his ability to help himself, he said that he could try to be compliant but commented that he probably could not stop smoking and drinking even though that would make the doctors feel better. When asked what he thought about the care he had received while he was in the hospital, he said, "They do okay. Some of the nurses really care and take a few minutes to talk. I like that. It is always kind of nice to see people. My doctor doesn't want to be bothered. He's frustrated because he says I don't take care of myself and it's a waste of his time."

Goals and Life Tasks

John was then asked what health goals he would like to achieve in the future. He stated that he wanted to have fewer hospitalizations and be able to breathe more easily, and he would like to quit smoking and drinking, but he did not think these goals were very realistic.

Nursing Care of John with Modeling and Role-Modeling**Data Interpretation and Analysis*****Description of Situation***

John is friendly and interested in sharing his story. He seeks affiliation and hopes to find someone who will care for him and take care of him. His coping mechanisms (smoking and drinking) reflect oral stage one developmental processes with related unmet needs and developmental residual. His perception of his health status is congruent with that of his health care providers. He knows that he is physically compromised, that he drinks and smokes too much, that he has not followed his physician's advice, and that this makes the doctors unhappy. He also recognizes that it would help his physical health if he quit smoking and drinking, but he expresses inability to give up these coping strategies at this time. This is because he does not have adequate developmental residual from the first two stages of life; he lacks drive, self-control, and willpower.

His living conditions facilitate some sense of AI, but it is not growth-directed. Although he lives alone in an apartment in a senior housing unit, his shortness of breath limits his daily activities. He is no longer able to bowl or carry out a number of activities that he enjoyed in the past. His recreational activities include visiting with other residents, smoking, and drinking. He recognizes that he is not eating enough but states that he lacks the interest or energy to cook.

John has experienced many losses in his life and probably has morbid grief with multiple related needs deficits. The changes that he has had to make, the activities that he has had to discontinue, and his inability to breathe without assistance and to complete his activities of daily living are all regular occurrences in his life. These have created perceived and real loss. He is also divorced, lives alone, and does not have children who visit regularly. Although his daughter lives 400 miles away, he commented that she probably would not visit him very often because of

his drinking. He expressed feelings of sadness related to his divorce, his distant relationship with his daughter, and his inability to visit people outside of his residence because of his breathing problems.

Expectations

John does not envision significant changes occurring in his life situation. He believes that if there were people in his life who cared about him and were available when needed, his health situation would improve. He does not believe, however, that this is a realistic expectation. The nurse expects that caring for John would be easy while he was hospitalized and that he would leave as soon as he was stable. No other expectations for John were identified by the nurse or by the other health care providers. They no longer believed that John would be able to stop smoking or quit drinking.

Resources

When he was asked why he thought he had so many frequent hospitalizations, John talked about the lack of a social network and support system. His statement that he has a daughter who he rarely sees indicated his feelings of loneliness. He also stated, “I wish she was closer. I miss her. I don’t have any other family. My wife divorced me years ago because of my drinking.” In addition, he talked about visiting with the nurses who “cared” about him and took the time to visit with him as well as listen to his regrets about not visiting other people outside of his residence. In regard to John’s relationship with his physician, he perceived that he was frustrated with him and did not want to waste his time working with him. His feelings were corroborated by the physician.

John’s limited social network includes his friends with whom he smokes and drinks, the hospital staff he sees when he is admitted for hospitalization (the respiratory therapist greets him by his first name on admission and asks how he is doing), and his daughter. He does not seem to have a support system, but he communicates easily and openly with the nurse.

Goals and Life Tasks

His current goals include continuing to live independently and to experience minimal episodes of respiratory distress. His desired future goal would be to have a caring relationship with someone. The nurse’s goals for John include the following:

- Less frequent hospitalizations
- Improved nutritional status
- Cessation of smoking and drinking
- Decreased episodes of respiratory distress

The physician would like John to be “compliant” with the medical plan. These goals are not compatible because John cannot stop smoking and drinking and is not motivated to eat better until he feels love, support, and connection to others.

Nursing Impressions

John has multiple survival, growth, and self-actualization needs deficits. He probably has a deficit motivation for relationships. This means that he has probably

developed relationships to meet his own needs without much consideration of the needs of the other member in the relationship, as is evidenced by the fact that he is divorced, his daughter is estranged, and his “friends” drink and smoke with him.

He lacks a sense of AI. Because of his strong need to be connected (affiliated) with someone who will care for him and because he has no such relationship, he has difficulty taking health-directed self-care actions. Instead, his actions are aimed at meeting his basic, oral needs. He cannot positively project himself into the future and has diminished internal and external resources; he is impoverished. John is at the age of generativity but is having difficulty projecting into the future. He has trouble with the task of initiative, which is most likely secondary to issues that deal with the tasks of trust and autonomy.

Thus John’s survival and growth needs deficits are related to early life experiences. He has unmet physical, safety and security, love and belonging, and self-esteem needs as well as unresolved losses. His psychosocial and physical subsystems interface in a way that jeopardizes his physical health.

Nursing Interventions

Because the aims of interventions are to build trust, promote positive orientation, gain a sense of control, affirm and build strengths, and set goals, initial interventions were designed to meet survival needs, facilitate secure attachment (related to developmental trust), and encourage autonomy following secure attachment. This would result in survival and growth needs satisfaction and would facilitate growth and new trust and autonomy residual.

To accomplish these outcomes, the nurse made weekly visits to John’s home for the first month. During these visits John and the nurse identified his strengths, reaffirmed his worth, and talked about his concerns, how he was feeling, and what would help him feel better. The nurse gave John a business card and told him that he could call whenever he wanted to talk with someone or needed help. She also called him about once a week to see how he was doing. During their phone calls and visits, John and the nurse also talked about generativity issues such as what his life had been about, what he had contributed, and what he could continue to contribute.

To help John continue to work on meeting his survival and growth needs (related to trust and autonomy), John was invited to join a support group that met every other week. The support group not only helped John build a support system but also provided him with people with whom he could connect. Group members were encouraged to discuss their feelings first and then to talk objectively about possible solutions to their problems. Then they were encouraged to think about the differences between their feelings and their thinking.

Finally, the nurse served as an advocate for John with the rest of the health care team and other agencies. She discussed his needs deficits, developmental processes, and relationships with the health care team. She also discussed the difference between compliance and adherence and the importance of facilitating adherence with clients like John. She explained that client adherence develops from goals set by clients, within the context of their world, rather than from expecting compliance based on goals set by others. Facilitating adherence is based on the assumption that all people want to grow, be the best they can be, and will grow when they have

repeated *perceived* needs satisfaction. Although this did not seem to change the team members' goals, it did help alter their attitudes. They seemed more interested in John's view of the world.

Summary

The nurse continued to see John for 2½ years. Shortly after she initiated the interventions, which were based on MRM, John quit smoking. He attended regular meetings and called the nurse regularly. He began to take his medication as prescribed and had no additional side effects. His hospitalizations decreased to once a year. Later, he quit drinking as well.

After about 2½ years, the nurse left the hospital. Later, the new nurse assigned to John decided that John was doing so well that he no longer needed to receive phone calls, attend the support group, or have special attention from the health care team. Within 6 months, he had an acute respiratory episode, was hospitalized, and died.

CRITICAL THINKING EXERCISES

1. Identify a client from your practice and follow the interview guidelines in Table 16-2. What evidence would you consider for each category of data to support evidence-based practice?
2. Review the list of evidence prepared from question 1. What are your impressions based on the initial interpretation of the data? Does the list lead you to consider evidence that is alike or different from what you would have considered as you currently practice?
3. Based on the major theoretical linkages in Box 16-1, consider the data once again in the context of each linkage. Use the Adaptive Potential Assessment Model (APAM) in Figure 16-6 to consider how these linkages assist your interpretation of the data and expectation of client outcomes. What insights do the linkages contribute to your understanding of this client?
4. Review your client interview focusing on self-care actions and self-care resources. Are self-care actions directed toward meeting dependent (or affiliation) needs? Are self-care actions in your plan directed toward independent (or individuation) needs? What outcomes do you anticipate from affiliation needs or from individuation needs? Why?
5. Based on interpretation of data from your client interview, use Table 16-1 and reflect on your use of the process. How does your process compare with the intervention goals? Did you use the process for assessment in Table 16-3 for description of the client, expectations, understanding of the client's internal and external resource potential, and goals? Review the goals, principles, and aims in Table 16-1 and evaluate how their use in the caring process is evident in your anticipated outcomes in question 4.

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Mercer's Becoming a Mother Theory in Nursing Practice

Molly Meighan

Although guidelines, printed handouts, and educational materials are important, they cannot replace a nurse's dialogue with the mother that leads to identifying and understanding her concerns. Nurses are in a unique position to have long term positive effects on mothers during this transition.

(Mercer, 2006, p. 650)

Women becoming mothers face increasingly complex situations with fewer role models. The period of transition into the new identity, from pregnancy and over the first year, is a time of much uncertainty that motivates the woman to seek out information and help. The kind of help or care she receives can have long-term effects for her and for her child. For that help or care to be relevant, the caregiver must understand the woman's experience in this process.

(Mercer, 1995, p. vii)

The study of parental role attainment is complex because of the many factors and processes influencing its achievement. Table 17-1 lists factors that have been identified as having a direct effect on the maternal role. Despite the efforts of researchers to identify and study these and other factors, an understanding of the transition to the parental role remains elusive. Research with women in this process has been beneficial, improving the nursing care of families in a wide variety of settings. Mercer is among the researchers contributing most to understanding this process. She continued to develop and refine her theory based on additional research.

History and Background

Mercer's Theory of Maternal Role Attainment was based on her extensive research on the topic beginning in the late 1960s and early 1970s. The initial stimulus for

TABLE 17-1 Factors Influencing Maternal Role Identity

| Factors | Effect on the Maternal Role |
|----------------------------------|---|
| Maternal age | <i>Adolescent mothers</i> are at increased risk for preterm birth and low-birth-weight infants, as well as increased risk for long-range financial, educational, and family structural problems. <i>Older mothers</i> (>30 years) are at increased risk of fetal/infant and maternal health problems, as well as increased risk of depression. |
| Birth experience | Birth is seen as a formal entry into motherhood. The mother's experience during birth is related to her knowledge, her self-concept, and her perceived control over the process. |
| Early separation from infant | Early separation of mother and infant decreases opportunities for bonding or attachment to the child. Therefore, it may delay the process of maternal role attainment. |
| Social stress/ social support | Stress has been associated with increased illness, but the effect of stress can be mediated by effective social support. The emotional support from a mate appears to be the most helpful support in the transition to the maternal role. |
| Personality traits | Temperament and learned traits of flexibility and empathy influence maternal role-taking. Empathy is especially important to the maternal role. |
| Self-concept | A positive self-concept influences an individual's ability to relate to another, thus facilitating the process of maternal role attainment. |
| Childrearing attitudes | Maternal attitudes about childrearing have a direct effect on mothering behavior and are believed to have a direct effect on the child's socialization. |
| Health status | Maternal illness decreases self-esteem and produces fatigue, which interferes with mothering. Illness may delay the process of maternal role transition. |
| Infant temperament | An infant who is not easily consoled or comforted can make the transition to motherhood more difficult by decreasing the woman's perception of competence and her confidence in being a mother. |
| Infant health status | Health status is directly related to the infant's ability to respond to the mother. The separation of mother and infant because of poor health delays the attachment process. The mother may be reluctant to begin the transition to the maternal role for fear that the infant may die. |

Data from Mercer, R. T. (1986). *First-time motherhood: Experiences from teens to forties* (pp. 6-22). New York: Springer.
 Note: Research on these factors yielded empirical evidence of a direct effect on the maternal role.

the development of the theory came from Reva Rubin, who was Mercer's professor and mentor at the University of Pittsburgh, where Mercer earned a PhD (Bee, Legge, & Oetting, 1994). Rubin's (1961, 1967a,b) work in defining and understanding maternal role attainment served as a foundational theory for obstetric nursing care for many years. Rubin (1977) described maternal role attainment as a process of "binding-in" (being attached to the child) and "maternal role identity" (seeing oneself in the role and having a sense of comfort about it) (p. 67). Rubin's concepts and assertions about the variables influencing maternal role attainment served as the basis of Mercer's research. Whereas Rubin focused on maternal role attainment during pregnancy and the first month after birth, Mercer expanded her concepts to include the first year following birth (Meighan, Bee, Legge, et al., 1998; Mercer,

1995). In addition, Mercer considered the parents, the influence of high-risk pregnancy, and maternal illness in her theory of role attainment.

The mother's ability to cope with having an infant with a congenital defect was among Mercer's earliest research interests. In addition, she studied the needs and concerns of breastfeeding mothers, adolescent mothers, and mothers with postpartum illness, as well as the response of fathers to stress and complications during the childbearing process. In 1981, Mercer introduced a framework for studying factors that affect the maternal role. The framework was more clearly defined in her book *First-Time Motherhood: Experiences from Teens to Forties* (Mercer, 1986). Mercer's maternal role attainment theory and descriptive model were proposed in 1991 during a symposium at the International Research Conference, sponsored by the Council of Nurse Researchers and the American Nurses Association, Los Angeles, California (Bee, et al., 1994; R. Mercer, personal communication, January 4, 2000). Her theory and the theoretical framework for research were presented in her latest book, *Becoming a Mother* (Mercer, 1995).

In 2003, Mercer began to reexamine the Theory of Maternal Role Attainment and proposed changes based on current nursing research (Meighan, 2010). Mercer (2004) supported retiring the term *Maternal Role Attainment* in favor of the term, *Becoming a Mother*, because role attainment suggests an endpoint rather than the continuing involvement that occurs in the role of mother. Mercer's conclusions were based mostly on nursing studies about the cognitive and behavioral dimensions of women in the maternal role. Walker, Crain, and Thompson (1986a,b) raised questions about the continuing changes in a woman's role as a mother, and Koniak-Griffin (1993) reached similar conclusions about maternal role attainment. Hartrick (1997) concluded that women undergo a process of continual self-definition in the role. McBride and Shore (2001) also suggested there may be a need to retire the term *maternal role attainment* because "it implies a static situation rather than a fluctuating process" (p. 79). Mercer (2004) explained that *becoming a mother* connotes continued growth and change in the mothering role and is more descriptive of the process. Mercer writes of motherhood as a lifelong commitment evolving over time.

Overview of Mercer's Original Theory of Maternal Role Attainment

Mercer not only relied on the previous works of Rubin but also based her research on both role and developmental theories. In addition, she selected study variables from an extensive review of the literature, borrowed from several disciplines, and used a variety of research tools. Her studies served as the platform for the design and development of her Theory of Maternal Role Attainment. Many of the assumptions, definitions, and concepts are based on Rubin's work, transition theories, and the role theories of Thorton and Nardi (1975).

Mercer's (1979) definition of maternal role attainment was based on Rubin's description of the process:

The maternal role may be considered...attained when the mother feels internal harmony with the role and its expectations. Her behavioral responses to the

role's expectations are reflexive and are seen in her concern for and competency in caring for her infant, in her love and affection for and pleasure in her infant, and [in] her acceptance of the responsibilities posed by the role (p. 374).

Mercer (1995) later explained:

The personal role identity stage is reached when the mother has integrated the role into her self system with a congruence of self and other roles; she is secure in her identity as mother, is emotionally committed to her infant, and feels a sense of harmony, satisfaction, and competence in the role (p. 14).

According to Mercer (1986, 1995), “the major components of the mothering role are: (1) attachment to the infant, (2) gaining competence in mothering behaviors, and (3) expressing gratification in maternal-infant interactions” (1986, p. 6; 1995, p. 13). Borrowing from transition theory, Mercer (1995) described the following concepts as having to do with maternal role attainment: “(1) pregnancy is a marker event upsetting the woman’s status quo, (2) pregnancy requires the woman to move from one reality to another, and (3) pregnancy requires a new role identity” (pp. 13, 14). Mercer (1986) stated that a woman who becomes a mother must do the following: “(1) recognize the permanency of the required change, (2) seek out information, (3) seek role models, and (4) test herself for competency” (p. 14).

Four stages of maternal role attainment adapted from Thornton and Nardi (1975)—anticipatory, formal (role-taking), informal (role-making), and personal (role identity)—are part of Mercer’s (1979, 1981, 1985a, 1986, 1990) theory. Table 17-2

TABLE 17-2 Comparison of Stages of Maternal Role Attainment and Becoming a Mother

| Maternal Role Attainment Stages | Stages of Becoming a Mother |
|--|--|
| 1. Commitment and preparation <i>Pregnancy</i> <i>(Anticipatory stage)</i> | This stage begins during pregnancy and includes the social and psychological adjustments to pregnancy. Expectations of the maternal role are explored. The woman seeks information from others in the role and visualizes herself as a mother. |
| 2. Acquaintance, practice, and physical restoration <i>First 2 weeks</i> <i>(Formal stage)</i> | This stage begins with the birth of the infant and includes recovery from birth. In this role-taking stage, the woman learns from others in the role or from professionals and replicates their behavior. She gains competence through practice. |
| 3. Approaching normalization <i>2 weeks to 4 months</i> <i>(Informal stage)</i> | This stage begins as the woman structures the maternal role to fit herself based on past experiences and future goals. The woman learns infant cues and develops her own unique style of mothering. Mercer (2004) describes it as “settling in” and becoming a new family (p. 17). |
| 4. Integration of maternal identity <i>4 months and beyond</i> <i>(Personal stage)</i> | This stage begins as the woman integrates mothering into her self-system, internalizes the role, and views herself as a competent mother. |

Data from Mercer, R. T. (1981). A theoretical framework for studying factors that impact on the maternal role. *Nursing Research*, 30, 73-77; Mercer, R. T. (2004). Becoming a mother versus maternal role attainment. *Journal of Nursing Scholarship*, 36(3), 465-477.

lists and describes these stages. The anticipatory stage is closely related to Rubin's cognitive operations and fantasy stages (Rubin, 1967a,b), which included the mother's acceptance of the fetus as a separate individual and fantasizing about the new baby. Mercer's definition of the anticipatory stage included the initial social and psychological adjustments to pregnancy. Expectations of the maternal role are learned during this stage by seeking information from others in the role and by visualizing oneself in the role of mother. The formal (role-taking) stage begins with the birth of the infant. Professionals and others in the woman's social environment often guide this stage. Maternal behavior is learned and replicated in this early stage. The informal (role-making) stage begins as the woman structures the maternal role to fit her based on past experiences and future goals. In the informal stage, she learns infant cues and develops her own unique style of mothering. The final stage is the personal (role identity) stage. The woman integrates mothering into her self-system. The role is internalized, and she views herself as a competent mother (Mercer, 1981).

Stages of maternal role attainment and corresponding behaviors overlap and are often readjusted as the infant grows and develops. Maternal role identity may be achieved in 1 month or may require several months (Mercer, 1995). Several factors—including stress, social support, family functioning, and the mother's relationship with the father—may have indirect or direct effects on role identity. Table 17-1 lists some of the factors related to maternal role identity.

Mercer (1995) expanded her earlier concepts to emphasize the importance of the role of the father or significant other. According to Mercer (R. Mercer, personal communication, January 4, 2000), the father (or the mother's intimate partner) contributes to the process of role attainment in a way that cannot be duplicated by any other supportive person. As described by Donley (1993), maternal attachment to the infant develops within the emotional field of the parents' relationship. Figure 17-1 illustrates the interactions among father, mother, and infant. The previously described stages of maternal role attainment are represented in layers *a* through *d*. Infant developmental stages are displayed in a similar fashion.

The father's interactions help diffuse tension and facilitate maternal role identity (Donley, 1993; Mercer, 1995). The father's role identity also occurs and increases with infant development and maternal role identity (Mercer, 1995). The interaction of mother, father (or significant other), and infant is an important concept added to the larger model presented by Mercer (1991) and described by Bee and colleagues (1994) (Figure 17-2).

Mercer used a general systems approach in her model of maternal role attainment (see Figure 17-2). Bronfenbrenner's (1979) design of nested circles provided the overall framework. The original model proposed by Mercer in 1991 during the International Research Conference in Los Angeles, California, was revised in her fifth book, *Becoming a Mother* (Mercer, 1995). In this book, the term *exosystem*, used earlier in the second circle, was replaced with the term *mesosystem*, used in a personal communication (R. Mercer, January 4, 2000). Mercer explained that this change was made to be consistent with Bronfenbrenner's model, on which it was based.

The mother's microsystem, which is the most influential on her maternal role attainment, includes the mother, her infant, her partner, and intimate relationships within her family (R. Mercer, personal communication, January 14, 2000).

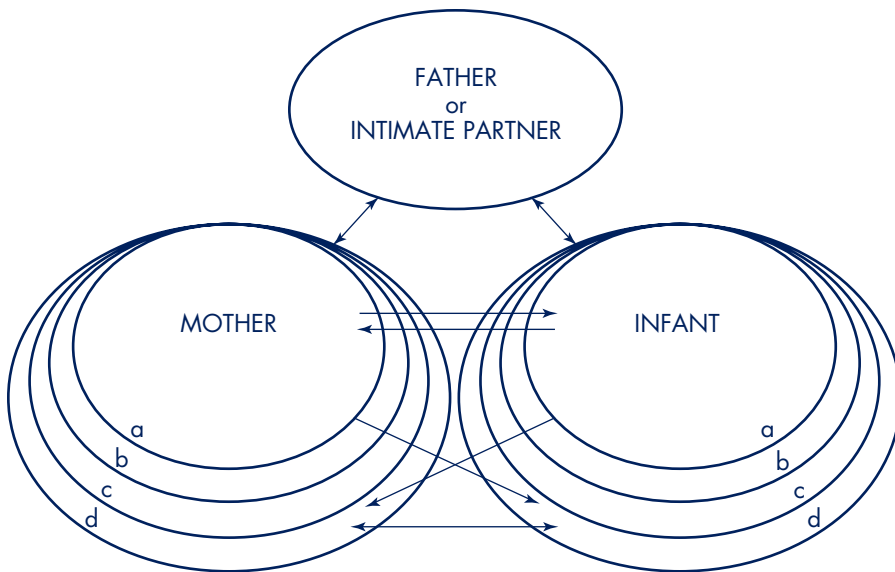


FIGURE 17-1

A microsystem within the evolving model of maternal role attainment. (From Mercer, R. T. [1995]. *Becoming a mother*. New York: Springer.)

Maternal role attainment is achieved within this microsystem of father-mother-infant interaction (illustrated in Figure 17-1). The mesosystem includes extended family, school, work, church, and other systems within her more immediate community that directly influence the mother and her microsystem. The exosystem is an extension of the mesosystem and is described by Mercer (1995; R. Mercer, personal communication, January 4, 2000) as interrelationships of two or more settings (subsystems) that influence the mother more indirectly. Examples of mesosystem factors are interactions between the woman's work setting, daycare, local laws/rules, or church. Examples of the outer circle or macrosystem include the social, political, and cultural influences on all of the systems.

Traits and behaviors influencing maternal role identity are included in the model. Maternal characteristics are empathy or sensitivity to infant cues, self-esteem or self-concept, parenting received as a child, maturity and flexibility, attitudes, pregnancy and birth experience, overall health, and role conflict or strain. Infant characteristics that influence maternal role attainment include temperament, ability to give cues, appearance, responsiveness, and health. The outcomes of maternal role identity include competence and confidence in the role, gratification in the role, and attachment to the child. Child outcomes are cognitive and mental development, behavior, attachment, health, and social competence.

A Revised Theory of Becoming a Mother

Mercer (2004) recognized theory building as a continual process as research provides evidence to clarify concepts, deletions, and additions. She continued working

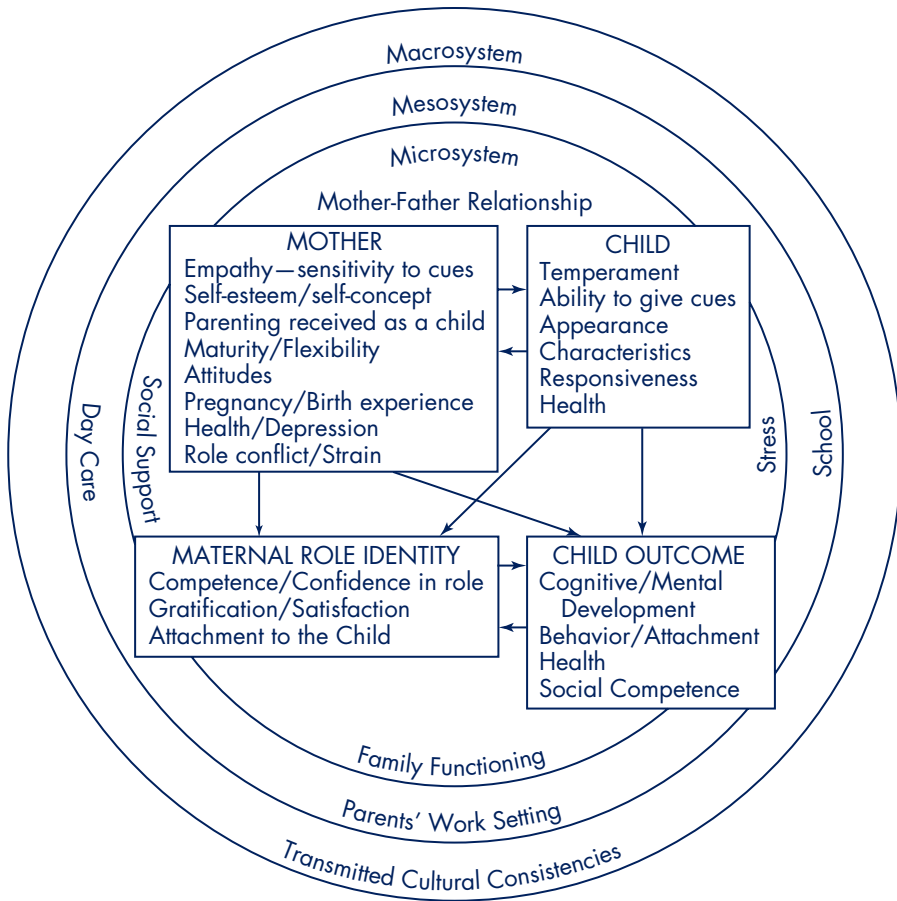


FIGURE 17-2
 Model of maternal role attainment. (From Mercer, R. T. [1991]. Paper presented at the Maternal Role: Models and Consequences Symposium, International Research Conference, Council of Nurse Researchers and the American Nurses Association, Los Angeles, Oct 24. *Note:* The figure has been modified based on personal communication with Mercer on January 4, 2000. The word *mesosystem* has replaced *exosystem*, consistent with Bronfenbrenner’s model [1979].)

toward greater clarity and usability of her theory. Therefore, after extensive review of research, Mercer (2004) proposed adopting the process phrase *becoming a mother* and retiring the phrase *maternal role attainment*. Qualitative studies inspired Mercer to make additional changes in terminology based on the actual words used by women who were undergoing the experience of becoming a mother. Although there are some changes in the original terminology and concepts, the Theory of Becoming a Mother closely parallels the original Theory of Maternal Role Attainment as illustrated in Figure 17-3.

Although she continued to use Bronfenbrenner’s concept of interacting nested ecological environments, Mercer (R. Mercer, personal communication,

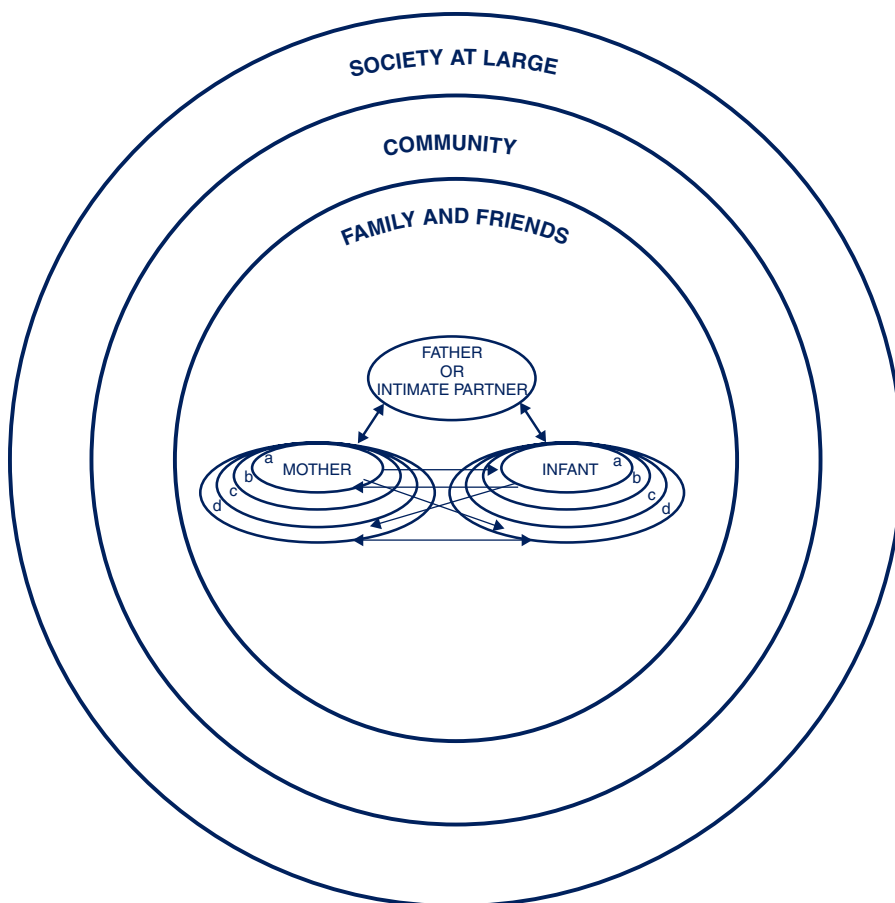


FIGURE 17-3

Revised model of becoming a mother. (Copyright 2003 by Ramona T. Mercer, Burlingame, CA.)

September 3, 2003) proposed renaming the environments. Figure 17-3 illustrates the interactions of the mother, infant, and father in the center with the living environments of *Family and Friends*, *Community*, and *Society at Large* surrounding them. Factors within the *Family and Friends* environment include family functioning, family values, stressors, social support, and cultural guidelines for parenting. Day care, school, work settings, places of worship, recreational facilities, hospitals, and cultural centers are included in the *Community* environment. *Society at Large* influences include transmitted cultural consistencies, laws affecting women and children, national health care programs, and evolving reproductive and neonatal science.

Mercer and Walker (2006) presented a detailed description of the interacting environmental factors that affect the process of becoming a mother (Figure 17-4). The interacting environments influence the process of becoming a mother, based on the original model of becoming a mother and on a construct by Keller,

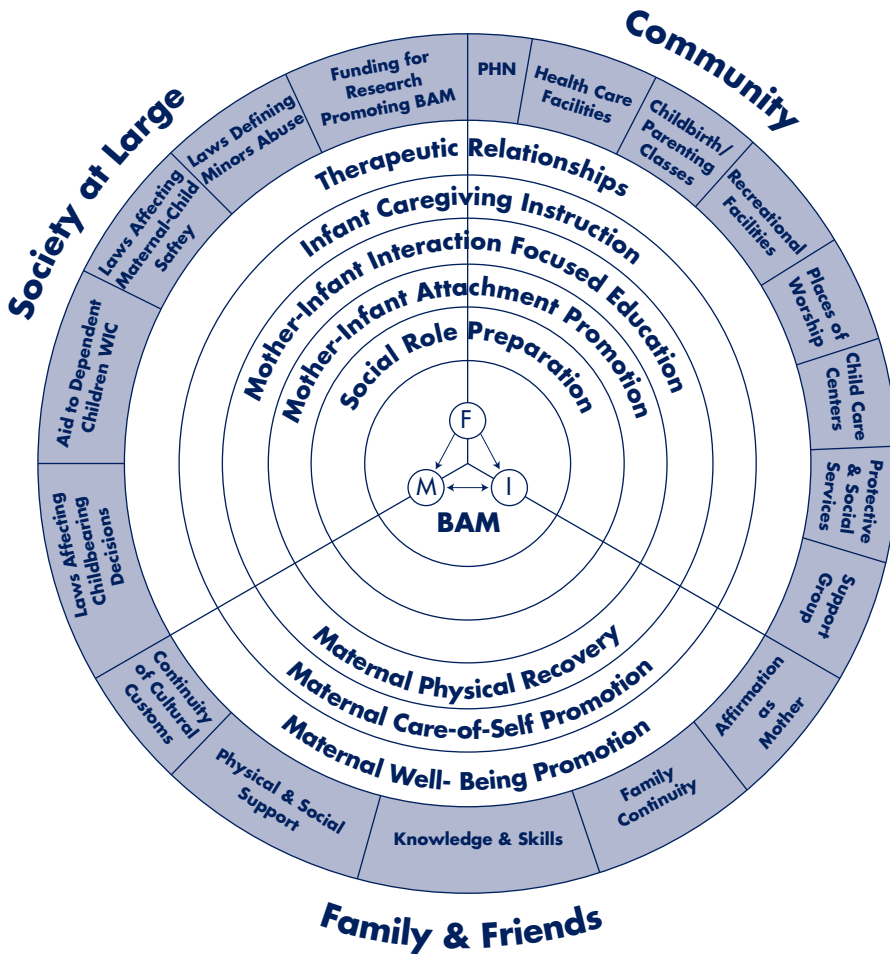


FIGURE 17-4 Interacting environments that affect the process of becoming a mother. (From Mercer, R. T., & Walker, L. O. [2006]. A review of nursing interventions to foster becoming a mother. *Journal of Obstetric, Gynecologic, and Neonatal Nurses*, 35, 579.)

Strohschein, Lia-Hoagberg, and colleagues (2004). The environments have the potential to influence the process positively or negatively and are therefore important considerations for nursing practice and research.

To summarize the changes in Mercer’s revised Theory of Becoming a Mother: Mercer’s concept of maternal role identity is unchanged. Using Burke and Tully’s (1977) work, Mercer (1995) described role identity as having an internal component and an external component. Identity is a woman’s internalized view of herself as a mother, and role is the external behavioral component. Based on Nelson’s (2003) synthesis of qualitative studies, Mercer (2004) changed the names of the stages that lead to maternal role identity using actual words and expressions from

studies of women who were in the process of becoming a mother. The changes are as follows:

- Commitment and preparation (pregnancy)
- Acquaintance, practice, and physical restoration (first 2 weeks postpartum)
- Approaching normalization (2 weeks to 4 months after delivery)
- Integration of maternal identity (approximately 4 months after delivery)

See Table 17-2 for a comparison of the original stages of maternal role attainment with those of becoming a mother.

Critical Thinking in Nursing Practice with Mercer's Theory

The use of Mercer's theory directs you to consider many of the factors identified by Mercer that affect maternal role identity. Table 17-3 illustrates how the theory guides your thinking in nursing practice. During your assessment of the Family and Friends environment, you should determine both the health and the responses of mother, infant, and father (or the mother's intimate partner). The involvement of other immediate family members is also considered if they need to be included in the teaching of infant care.

According to Mercer (1995), the relationship between the mother and father (or the mother's intimate partner) is of utmost importance. The initial interaction between mother, father, and infant and other immediate family members most often begins in the hospital and can be influenced by nurses. Helping the father or significant other understand the importance of the role as a caregiver and support person to the mother should begin immediately after delivery. For this reason an assessment of the availability of a support person for single mothers or those mothers separated from their mates is also an important consideration for the nurse.

The stages of maternal role identity are taken into account during the assessment of the Family and Friends environment, including commitment and preparation; acquaintance, practice, and physical restoration; approaching normalization; and integration of maternal identity. You should continue this assessment during subsequent visits or contacts with the mother. As her nurse, you lead her through many of the steps associated with these stages. The infant's developmental stage and ability to send cues or elicit responses from the parents should be considered. This interaction, presented in Figure 17-1, illustrates the infant's interactive influence on the developing process (levels *a* through *d*). First-time parents are often surprised to learn of their infant's communication capabilities. You can assist them as they learn to recognize infant cues after delivery. The parents also need to understand how infant behavior and cues change as the infant grows and develops.

Health care professionals—and nurses in particular—play a significant role in all stages of maternal role identity. Prenatal education, either formal classes or informal teaching, assists the woman during the stage of commitment and preparation. Nurses in any childbirth setting are usually teachers and role-models during this stage. The mother relies heavily on the nurse to guide the immediate postpartum care as she begins her journey toward role identity. Professional role-models, such as home-care nurses and nurses in clinics and pediatric settings, also influence the woman as

TABLE 17-3 Applying Mercer’s Theory of Becoming a Mother to Practice

| Assessment | Nursing Considerations |
|--|--|
| FAMILY AND FRIENDS ENVIRONMENT | |
| Mother | Has the mother recuperated from childbirth, and is she free from illness, discomfort, or extreme stress? |
| Infant | Is the infant free from illness and able to respond to the parents as expected? |
| Father or intimate partner | Is the father or significant other present, supportive, and actively involved with the mother and infant? Are other family members supportive? Do they live nearby? Does the mother have extended family or close friends nearby on whom she can depend if needed? |
| STAGES OF MATERNAL ROLE IDENTITY | |
| Commitment and preparation | Did the couple attend prenatal classes or receive information about infant care before delivery? |
| Acquaintance, practice, and physical restoration | Since childbirth, has the mother asked for information or assistance about providing care and nourishment for the infant? Does the mother perform infant care appropriately? Does the mother display empathy and attachment toward her infant? |
| Approaching normalization | Does the mother seek advice from others in the role? Does the mother have role-models to emulate in the home environment? |
| Integration of maternal role identity | Has the mother adjusted her lifestyle and patterns for her infant? Is there evidence that the mother is committed to her child and willing to make personal sacrifices for the well-being of her child? Does the woman see herself as a mother? |
| COMMUNITY ENVIRONMENT | What resources in the community, at work, in schools, or in the church are immediately available for the new family? Does the mother plan on returning to work outside the home? Does the family need advice or assistance regarding childcare? |
| SOCIETY AT LARGE ENVIRONMENT | Are there cultural influences on childbirth or childcare that need to be addressed? Are there social or political issues that directly affect the new family? Will changes within the health care system, including short hospital stays, access to nearby services, or limited services, affect the new family? |

she progresses through stages toward integration of maternal identity. Mercer (2006) stressed the importance of open dialogue between nurses and new mothers because nurses play a unique role in supporting and boosting the confidence of new mothers as they develop maternal identity. Important parts of the dialogue are active listening and efforts to understand what mothers mean by what they say to you.

Your assessment of both the Community and the Family and Friends environments is essential when preparing the new family for discharge from the hospital. Look at some of the nursing considerations listed in Table 17-3 during the assessment. After returning home, the new mother's need for experienced role-models is fulfilled by extended family, neighbors, and friends. Many young couples relocate away from family and friends, have few resources, and need help in locating someone on whom they can rely. The new family may need your assistance finding resources within the community. Local agencies may be available to help with breastfeeding, housekeeping, childcare, and other needs. Because reliance on two incomes has become the trend in American families, returning to work and daycare arrangements have become major issues for new parents. Therefore, new parents may ask your advice about childcare facilities.

Cultural and societal factors that may affect the new family include beliefs and traditions surrounding childbearing. Table 17-3 guides your consideration of the Society at Large environment's effect on the new family. Figure 17-4 provides an overview of potential influences on parenting. You should be aware not only of cultural differences and expectations of new families but also of the social status and the larger health care system. The trend toward shorter hospital stays in some situations limits access to health care services. Therefore, during a shorter hospital stay you must assist the new mother and father to become acquainted with their newborn and to learn how to provide care before discharge. Remember to consider and provide information to families about available health care resources within the community. Assistance may be needed on how to apply for resources such as state or federal financial assistance; supplemental food programs such as Women, Infants, and Children (WIC); or follow-up programs sponsored by the U.S. Department of Health and Human Services.

Nursing goals and patient care outcomes are included under *maternal role identity* and *child outcome* in Mercer's theory of Maternal Role Attainment (see Figure 17-2). Nursing care is evaluated based on outcome achievement for maternal role identity and child outcome. Maternal role identity is determined by the woman's feelings of confidence and competence in the role, her satisfaction in the role, and her attachment to her child. You evaluate these goals based on the mother's statements about her role, her ability to provide infant care, and her behavior toward her child. Showing genuine concern for the child, responding to the child's needs, providing competent care, and demonstrating affection for the child are behaviors that you might observe as indications of maternal role identity. Outcomes for the child include continued cognitive or mental development, attachment behaviors, health state, and social competence. Although there may be some exceptions, even infants who are born small, sick, or premature continue to grow and develop physically and cognitively and eventually gain some social ability. Maternal role identity in these situations is determined by the response of the woman to the unique needs of her infant and by her infant's continued growth and development to his or her fullest capability.

Factors that influence both maternal and child outcomes are also included in Mercer's original model (see Figure 17-2). The following can affect maternal role identity and child outcome: the mother's empathy or sensitivity to infant cues; her self-esteem; the parenting she received as a child; her maturity and flexibility; her attitude; her experiences during pregnancy and birth; and the presence of health,

depression, and role conflict. In turn, the child's temperament, ability to give cues, appearance, characteristics, responsiveness, and health also affect maternal role attainment and child outcome. You can help the mother and child move toward positive outcomes by considering these factors in your nursing plan of care. An example of using this information is to increase the mother's empathy by helping her understand her infant's cues and needs and how to respond appropriately. You can provide support and give information to the mother to help her overcome problems associated with most of the factors previously listed. Although some factors cannot be changed they are influenced by teaching, guidance, and role-modeling by the nurse.

CASE HISTORY OF JANIE

Janie is a 20-year-old primipara who is 6 days postpartum. She and her husband live on a nearby military base. Her husband was present at the delivery but was required to leave for duty overseas before Janie's discharge from the hospital. He will be away for at least 6 months.

A friend who also lives on the base has brought Janie to the clinic this morning with her baby. Janie's temperature is 101.6° F, and she is complaining of a severe headache and pain on urination. During your assessment you note that the baby is crying and irritable and is gnawing on her fist. However, she appears healthy and you note a weight gain of 6 ounces over her birth weight. Janie appears tired, anxious, and depressed. She begins to cry and says, "I just can't seem to feed her enough. She cries all the time. I'm just not a very good mother. I wanted to breastfeed her, but my nipples are sore, and I don't think she is getting enough. I don't know what to do. I just can't do this."

Based on Janie's urinalysis, antibiotics and an analgesic are prescribed. Janie is told that she has a urinary tract infection (UTI) and is instructed to drink extra fluids. All other findings are within normal limits.

Nursing Care of Janie with Mercer's Theory

Assessment

Using Mercer's Theory of Becoming a Mother, both Janie and her baby are considered as separate entities within the Family and Friends environment. Therefore, a complete assessment of both of them is in order. Urinary tract infections (UTIs) following childbirth are not uncommon and are usually treated successfully with antibiotics. You should provide information about the prescribed antibiotic and forcing fluids, and you should reinforce discharge instructions regarding perineal care and personal hygiene. There are several possible causes of nipple soreness. Improper grasping of the nipple by the infant is one common cause. The infant's weight gain suggests that she is getting nourishment. Because Janie's baby is breastfeeding, it is not uncommon for her baby to be hungry every 2 to 3 hours. Frequent crying can indicate hunger, but it can also indicate frustration or simply a desire to be held. You should perform a physical assessment of the infant that includes the frequency of voiding and the consistency and number of stools.

In addition to assessing both Janie and her infant individually, you should assess the interaction between them. The source of difficulty with breastfeeding is identified while observing the process. In addition, Janie's ability to read infant cues and the infant's reaction to her mothering attempts can be assessed. In assessing the Family and Friends environment, a major problem for Janie is revealed. She does not have the immediate emotional support and assistance from her husband, which makes her situation even more difficult.

According to Mercer's theory, Janie is in the stage of acquaintance, practice, and physical restoration but she is also beginning to approach normalization. She is still seeking information and needs the support of role-models while she attempts to assume the role she has learned thus far. Because they live several hundred miles away, there are no immediate role-models available to Janie from her own family. You should consider both Janie's friends and the Community environment in search of someone to provide emotional support and serve as a role-model. A close friend or neighbor could provide some support to Janie as she adapts to her new role. Janie needs enough help at home to rest and to recover from her present illness and general fatigue following the birth.

An assessment of the Community environment and the Society at Large environment will assist Janie in obtaining help with health care needs. Follow-up telephone calls and, if the service is available, a home visit would be beneficial. Janie needs more information to help her move toward normalization. Ensuring that Janie knows who to call and when to ask for help is essential. Therefore, you need to help Janie determine what resources are available to her as she works toward integration of maternal role identity.

Nursing Care Plan

The goals for nursing care of Janie are to recover from her present illness, regain confidence in her ability to be a mother, and reach the stage of maternal role identity. To help accomplish these goals, you should provide information about UTIs and some of the difficulties that Janie is facing. By pointing out the weight gain and general health of her infant, you can assure Janie that she has been taking good care of her infant. It may be helpful to explain to Janie that she and her infant are responding in a normal fashion and that she has done very well in caring for her baby alone thus far. Making arrangements for a family member or friend to help Janie at home is needed, at least temporarily. Although more teaching and guidance regarding breastfeeding would be helpful, assistance from a breastfeeding support person, such as a lactation consultant, is also needed over a longer period. La Leche League, a local childbirth educator, or a postpartum doula may be available to help Janie.

Evaluation

Follow-up care should be arranged for both Janie and her infant to determine the effectiveness of Janie's treatment for the UTI, her infant's growth and development, and her progress toward maternal role attainment. Therefore, you should determine if and when appointments have been made with the clinic or the physician's office. You should give Janie a list of phone numbers and information about when and who to call in an emergency.

CASE HISTORY OF LISA

Lisa is a 16-year-old single mother who has just delivered prematurely. Her infant is about 31 weeks' gestation. Lisa's mother was with her during the delivery and plans to provide a home for Lisa and her son after he is discharged from the neonatal intensive care unit (NICU). The infant's father has not participated in Lisa's care during pregnancy and was not present during the labor and delivery.

Lisa and her mother were permitted to see and hold the baby immediately after delivery before he was taken to the NICU. Since his admission to the nursery, he has been intubated and placed on a ventilator. The neonatologist has determined that the baby's condition is serious but stable. Lisa is able to visit her son in the NICU for the first time since delivery. She has named him Clarence after her maternal grandfather. She has asked you to take her to the NICU and Lisa's mother will accompany Lisa as well.

Nursing Care of Lisa with Mercer's Theory

Assessment of the Family and Friends Environment

A physical assessment of Lisa will determine her immediate needs and potential problems before she visits the nursery. An assessment of Lisa's expectations of seeing her son on a ventilator in the overwhelming environment of the neonatal intensive care unit (NICU) is also needed. An assessment of the condition and prognosis of the infant to realistically prepare Lisa and her mother before the visit is also warranted.

Lisa's mother has served as her significant other throughout the pregnancy and the delivery. Although the infant's father has not been present, an assessment of any of his future interactions with the infant should take place. You can ask Lisa whether the father knows about Clarence's birth and whether he knows that Clarence is in the NICU. If the father is planning on being involved with the infant, an assessment of his understanding about Clarence's birth and present condition would be beneficial. In the absence of the father, Lisa's mother is her primary support and should be included in Lisa's care.

According to Rubin (1984), a woman's mother is the strongest maternal role-model. Having a good relationship with her mother is extremely important to Lisa. Thus including Lisa's mother in teaching and caring for Lisa and Clarence and in trips to the NICU is important. In studying the relationship between mother and daughter during pregnancy and childbirth, Mercer (1985b) noted that mother-daughter relationships appear most critical during the early transition to the maternal role and become less essential over time as the daughter gains confidence and competence in the role.

Assessment of the Community Environment

An interview with Lisa and her mother may provide answers about school plans, work, friends, and other factors that may affect role identity for Lisa. Adolescents

often have difficulty with maternal role identity because of their own developmental stage and basic needs. The presence of both supportive and/or non-supportive situations may be identified within Lisa's Family and Friends environment and Community environment. Mercer (1986) noted that not all social support networks are helpful in the transition to the maternal role. For example, Lisa's adolescent peers would probably not encourage the self-sacrifice necessary for assuming the maternal role. However, some schools have developed special programs to help adolescent mothers continue their education while they fill the role requirements of motherhood. Seeking this support for Lisa would be beneficial.

Assessment of the Society at Large Environment

You can help determine what additional resources are available for Lisa and Clarence. Financial resources may be available through federally funded and/or state-funded assistance. Food resources are available to many women through the WIC program and are based on income. Additional resources for Clarence that are based on special needs may also be available.

Nursing Care Plan

Lisa's situation is extremely complex because of the effect of the baby's preterm birth, her infant's condition, her age, and her lack of support from the infant's father. The nursing care goals for Lisa are to become well acquainted with and attached to her son, demonstrate concern for his well-being, seek information about his care, and begin the stages of maternal role identity. Interventions for Lisa include preparing Lisa and her mother for a visit to the NICU, providing opportunities for Lisa to touch and hold Clarence, teaching Lisa about Clarence's condition and care, and assisting in finding needed resources for Lisa and her family.

Evaluation of Nursing Care for Lisa

Preterm birth is especially troublesome for new mothers who are adjusting to the maternal role. Feelings of anxiety, depression, guilt, and shame are not uncommon. There is uncertainty about the infant's general health and survival. In addition, the infant's immature state prevents many of the normal responses that encourage parental attachment. According to Mercer (1990), the initial stages of maternal role identity may be delayed beyond the expected 6 to 8 weeks prescribed by most experts. Discharge of the mother from the hospital without her infant, who must remain in the NICU, compounds the problem, delays role attainment, and increases the mother's feelings of sadness. All of these factors should be considered in evaluating Lisa's progress toward role identity.

Often, adolescents fail to recognize the permanency of becoming a mother and rely too heavily on their own mothers to fill the role requirements. Inconsistent responses are characteristic of teenage mothers and reflect their immaturity. Ambivalence is common and is present in many forms (Mercer, 1990). An adolescent mother may be happy about being a mother yet sad about being burdened with the responsibility of parenthood. In addition, adolescents are often reluctant to ask questions or seek solutions to problems; they tend to wait for information to

be provided. Finally, negative self-concept and decreased self-esteem are common problems for adolescents and prevent them from gaining confidence and competence in the maternal role (Mercer, 1986).

Keeping in mind the major components of the maternal role as stated by Mercer (1986), namely, “(1) attachment to the infant, (2) gaining competence in mothering behaviors, and (3) expressing gratification in maternal-infant interactions” (p. 6), you should assess Lisa’s response to Clarence on each visit to the nursery. Because teenagers tend to have poor self-concepts as persons, Lisa may benefit from being praised for her attempts at mothering Clarence. The complexity of Lisa’s case requires continued support and follow-up within the health care system.

Conclusion

Mercer’s Theory of Becoming a Mother is very useful in assessing, planning, implementing, and evaluating nursing care. The theory is applicable in a wide variety of settings and with diverse populations. Mercer’s theory provides not only a framework for practice but also a frame of reference for nursing research. Because of the influence of numerous factors, the process of maternal role identity is complex. Mercer and those building on her work have studied the effect of these factors as variables in research projects, laying the foundation for continued research in this area of nursing to improve practice and the care of women.

CRITICAL THINKING EXERCISES

1. How do Mercer’s model and the Theory of Becoming a Mother apply to new fathers? Now expand the application to include the relationships among father, mother, and infant.
2. Discuss the application of the Theory of Becoming a Mother to families suspected of neglect and abuse. What are the specific challenges and observations to be made in these situations?
3. You are planning parenting classes for first-time parents in the last trimester of pregnancy and meeting with the class every other month for a year (6 times). Using Mercer’s theory as a guide, develop a list of topics to be covered. Organize the topics into the best order to be presented. What is your rationale for the organization of the topics?
4. You are working in a pediatric primary care clinic. As you assess a 9-month-old infant you notice a severe diaper rash. The infant’s clothes are soiled, and he does not appear to have been bathed recently. From asking the young mother about the rash, you learn she is not very knowledgeable about diaper rash or general care of her infant. Further assessment reveals several important factors: her husband’s job requires a lot of travel so he is seldom at home, and her mother and older sister live 60 miles away. When you apply the maternal role theory to this case, what factors may be impeding maternal role identity development as a new mother? What nursing interventions would you include in the teaching plan for her?

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Leininger's Theory of Culture Care Diversity and Universality in Nursing Practice

*Marilyn R. McFarland**

Nursing is a learned, humanistic, and scientific profession and discipline focused on human care phenomena and caring activities in order to assist, support, facilitate or enable individuals or groups to maintain or regain their health or wellbeing in culturally meaningful and beneficial ways, or help individuals face handicaps or death.
(Leininger, 2002a, p. 46)

History and Background

Nurse anthropologist Madeleine Leininger developed the culture care theory and ethn nursing research method to help researchers study transcultural human care phenomena and discover the knowledge nurses need to provide care in an increasingly multicultural world (2002a,b, 2006). In the late 1950s she envisioned that the world was becoming one in which humans interact on a global level. She realized that she needed to go beyond anthropology with its emphasis on groups of people in different parts of the world to express her thoughts from a nursing perspective. At that time nursing practice was based on the medical model and nurses practiced primarily in hospitals or public health departments. Leininger had a holistic view of nursing that incorporated some anthropological concepts but also a strong nursing component—a vision for nursing that would focus on human beings in a multicultural world. Leininger (1995a) stated, “I envisioned that transcultural nursing was different from anthropology in that the focus was on

*The chapter author and editor acknowledge the scholarship of Marjorie G. Morgan, previous author of this chapter.

comparative health care, health, and well-being in different environmental contexts and cultures” (p. 26). Her vision addressed a deficiency in health care—the absence of cultural knowledge.

From the beginning, the language of culture and care was foundational to transcultural nursing. Before Leininger founded the field of transcultural nursing she believed that care was the most important component of nursing. She stated, “Care is the essence and the central, unifying, and dominant domain to characterize nursing” (Leininger, 1984, p. 3). She blended culture from anthropology and care from nursing and postulated that “human caring is a universal phenomenon, but the expressions, processes, and patterns vary among cultures” (Leininger, 1984, p. 5). For example, Leininger referred to *culture-specific care* and *culturally congruent care* as integral parts of the theory. The sunrise (model) enabler—based on the theory—is used as a guide for research on culture and care and for culturally congruent nursing care practice. The first transcultural nursing research was Leininger’s own study of the Gadsup people in Papua, New Guinea, in the early 1960s. In 1965 the first formal courses and doctoral program in transcultural nursing were established by Leininger at University of Colorado School of Nursing. The first book published on the culture care theory was Leininger’s (1970) *Nursing and Anthropology: Two Worlds to Blend*. Leininger and McFarland (2002) co-authored the third edition update to *Transcultural Nursing: Concepts, Theories, Research, and Practices* (1995b), and in 2006 they published the second edition of her theory book titled *Culture Care Diversity & Universality: A Worldwide Nursing Theory*.

In 1974, Dr. Leininger founded the Transcultural Nursing Society to serve nurses worldwide with its mission “to enhance the quality of culturally congruent, competent, and equitable care that results in improved health and well-being for people worldwide” (www.tcns.org). The society holds an annual international conference during which transcultural research studies from around the globe are presented. The *Journal of Transcultural Nursing* was first published in 1989 as the official journal of the society. In 1988 certification of transcultural nurses (CTN) was initiated and revised in 2010 (Pacquiao & McNeal) to encompass a basic (CTN-B) level and an advanced (CTN-A) level. With the growing emphasis on globalization and cultural competence, Leininger’s work gains added meaning and significance. *Contemporary Nurse Journal* has published the special issues of *Advances in Contemporary Transcultural Nursing* in 2003 and 2008 with practice applications and reviews of studies guided by the culture care theory conducted by nurse researchers from around the world.

Leininger (2002a,b, 2006, 2007, 2011) continued throughout her life to clarify the essential features of culture care diversity and universality theory within the context of transcultural nursing.

Transcultural nursing is a substantive area of study and practice focused on comparative human care (caring) differences and similarities of the beliefs, values, and practices of individuals or groups of similar or different cultures. Transcultural nursing’s goal is to provide culture-specific and universal nursing care practices for the health and well-being of people or to help them face unfavorable human conditions, illness, or death in culturally meaningful ways (Leininger, 2002a, p. 46).

Dr. Leininger's most recent work on the culture care theory has been through published work in peer-reviewed professional journals. She co-authored an interview piece in *Nursing Science Quarterly* (Clarke, McFarland, Andrews, et al., 2009) in which she discussed the history and future of transcultural care, the nursing profession, and global health care. In 2011, she authored a reflective article in the *Online Journal of Cultural Competence in Nursing and Healthcare*. She studied three Western and one non-Western culture (Old Order Amish Americans, Anglo Americans, Mexican-Americans, and the Gadsup of the Eastern Highlands of New Guinea) in order to obtain in-depth knowledge about father protective care beliefs and practices with the goal of using that knowledge to provide culturally congruent care. Leininger (2011) reported that culture care repatterning and/or restructuring actions and decisions were very difficult for fathers in the four cultural groups to consider as they wanted to preserve their cultures and traditional care practices. However, all groups reported that some members embraced modern technologies but feared harm from their use. Leininger began work on a new culture care construct, collaborative care, which she co-presented with Marilyn McFarland via a keynote videocast at the 37th Annual Conference of Transcultural Nursing Society in October 2011 and accepted for publication in the *Online Journal of Cultural Competence in Healthcare*.

Dr. Madeleine Leininger died peacefully on August 10, 2012, in Omaha, Nebraska. She continued to work until shortly before her passing, collaborating with colleagues on contributions to several projects and publications in progress including revisions to her website (www.madeleine-leininger.com/en/index.shtml) and updates to future editions of her books. Her legacy is the theory of culture care diversity and universality and transcultural nursing that continues to inspire those whom she mentored, taught, and influenced throughout her accomplished career.

Overview of Leininger's Culture Care Theory

The construct of culture in Leininger's theory borrows its meaning from anthropology. Culture is the "learned, shared, and transmitted knowledge of values, beliefs, norms, and lifeways of a particular group that are generally transmitted intergenerationally and influence thinking, decisions, and actions in patterned or certain ways" (Leininger, 2002a, p. 47). Culture can be discovered in the actions, practices, language, norms or rules for behavior (values and beliefs), and in the symbols that are important to the people. As Leininger has stated, culture is learned and then passed down from generation to generation.

The most significant effect of Leininger's theory has been on the construct of caring in relation to nursing practice (Clarke, et al., 2009, p. 234). The goal of the culture care theory (CCT) is to provide culturally congruent nursing care, which refers to "culturally based care knowledge, acts, and decisions used in sensitive and knowledgeable ways to appropriately and meaningfully fit the cultural values, beliefs, and lifeways of clients for their health and wellbeing, or to prevent illness, disabilities, or death" (Leininger, 2006, p. 15). As a companion to her theory Leininger developed enablers to guide nurses in gathering relevant assessment data or conducting a culturalogical assessment. The culturalogical assessment consists of a comprehensive

holistic overview of the client's background including communication and language, gender and interpersonal relationship customs, appearance, dress, use of space, food preferences, meal preparation, and other lifeways. Leininger's theory is applicable in the nursing care of clients from racially and ethnically diverse backgrounds as well as the culture care needs of individuals or groups belonging to cultures and subcultures identified on the basis of sexual orientation (lesbian, gay, bisexual, transgendered groups); ability or disability (the deaf or hearing impaired or blind or visually impaired); occupation (nursing, medicine, or the military); age (youth, adolescents, elders); or socioeconomic status (poverty or affluence; homelessness).

A key construct of Leininger's theory is *cultural diversity* which refers to differences that can be found among and between different cultures. By recognizing variations, the nurse can avoid stereotyping or assuming that all people will respond positively or in the same way to the standards or routines in nursing care. Another construct is that of *cultural universality*, which refers to the commonalities that exist in different cultures. These ideas led to an important goal of the theory—that is, “to discover similarities and differences about care and its impact on the health and well-being of groups” (Leininger, 1995c, p. 70). Nurses are familiar with professional care, and a construct of generic care is introduced. Generic care or folk care includes remedies passed down from generation to generation within a particular culture. Leininger (1995c) stated, “Interfacing generic and professional care into creative and meaningful nursing may well unlock the essential ingredients for quality healthcare” (p. 81).

Two other constructs of importance in the theory of culture care diversity and universality are culture-specific care and culturally congruent care.

- Culture-specific care refers to care resulting from the identification and abstraction of care practices from a particular culture that lead to the planning and application of nursing care to “fit the specific care needs and life ways” of a client from that culture (Leininger, 1995c, p. 74).
- Culturally congruent care is a major goal of the theory (Leininger, 2006). This refers to “culturally based care knowledge, acts, and decisions used in sensitive and knowledgeable ways to appropriately and meaningfully fit the cultural values, beliefs, and practices of clients for their health and wellbeing, or to prevent illness, disabilities, or death” (p. 15, 2006).

Leininger (2002b) postulated three modes of care actions and decisions for guiding nursing care so nurses in diverse practice settings can provide beneficial and meaningful care that is culturally congruent with the values, beliefs, practices, and worldviews of clients. The three modes of culture care are (a) preservation and/or maintenance; (b) accommodation and/or negotiation; and (c) repatterning and/or restructuring. These modes have substantively influenced the ability of nurses to provide culturally congruent nursing care and thereby fostered the development of culturally competent nurses. Nurses practicing in large urban centers typically care for clients from hundreds of different cultures or subcultures. Leininger's culture care theory provides practicing nurses with an evidence-based, versatile, useful, and helpful approach to guide them in their daily decisions and actions regardless of the number of clients under their care or complexity of their care needs.

Dr. Leininger developed the ethnonursing research method for nurse researchers to study and advance nursing phenomena from a human science philosophical perspective with the qualitative analytical lens of culture and care (Leininger, 1995 a,b,c; 2002a,b, 2006a; Leininger & McFarland, 2002, 2006). The method was developed with the theory of culture care diversity and universality to study the nursing dimensions of culture care that include care phenomena, research enablers, and the social structural factors (e.g., kinship and social; cultural values, beliefs, and life-ways; religious and philosophical; economic; educational; political/legal systems; technological; and, environmental context, language, and ethnohistory) and three modes of care action and decision (Leininger & McFarland, 2002, 2006; Ray, Morris, & McFarland, 2012).

Recently the ethnonursing method has been proposed for use in other health care disciplines. McFarland, Wehbe-Alamah, Wilson, and colleagues (2011) developed the meta-ethnonursing research method after analyzing and synthesizing 23 dissertations conceptualized with the theory of culture care diversity and universality using the ethnonursing research method. Using the CCT as a guide, culture care action and decision meta-modes were discovered that were focused on providing culturally congruent nursing care among cultural groups (McFarland, Mixer, Wehbe-Alamah, et al., 2012). Discovering data from these meta-modes supported the translational research component of Leininger's culture care theory and the meta-ethnonursing method. Translational research or implementation science is the foundation for research utilization as evidence-based practice (Ray, et al., 2012). This new meta-ethnonursing method promotes overall expansion and conceptual development of culture care in general for further explication, substantiation, and evolution of Leininger's theory of culture care diversity and universality and the ethnonursing research method (McFarland, et al., 2012).

Critical Thinking in Nursing Practice with Leininger's Theory

Leininger's (2002a, 2007) theory of culture care diversity and universality guides practice by assisting nurses to be culturally aware of and sensitive to individual cultures; then to groups and families; then to institutional, regional, and community, societal, and national cultures; and eventually to global human cultures. The sunrise enabler (Figure 18-1) guides decisions and nursing actions through a process focused on specific components of the theory as noted in Table 18-1.

The sunrise (model) enabler (see Figure 18-1) was revised and renamed enabler (Leininger in Leininger & McFarland, 2006, p. 25) to clarify it as a visual guide for exploration of cultures. As Leininger (1995d) stated, "This model should not be viewed as a theory per se, but rather as a depiction of the multiple components of the theory" (p. 107). Therefore, using the enabler, the nurse systematically progresses through the major care constructs and social structure dimensions of the theory with the goal of providing culturally competent and congruent care.

Beginning at the top of the figure, culture care is the overriding component of the enabler followed by worldview and then cultural and social structure dimensions. Worldview refers to the way in which people of a culture perceive their

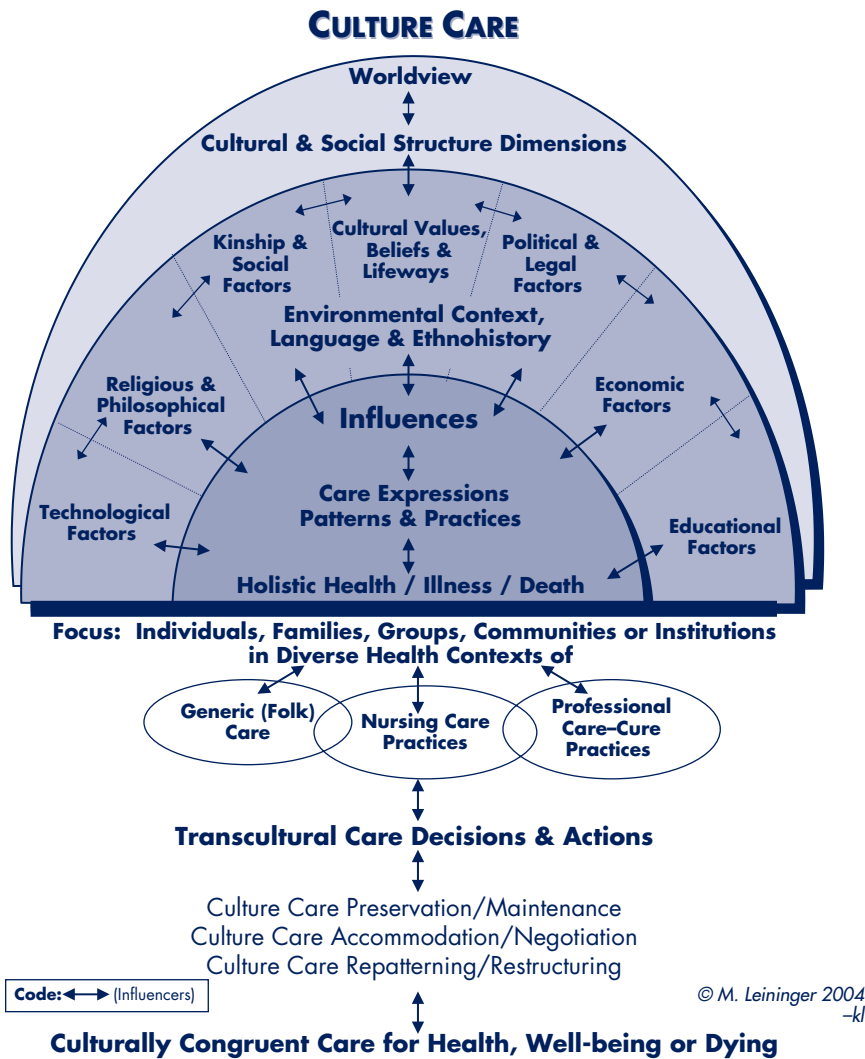


FIGURE 18-1

Leininger's sunrise enabler to depict the Theory of Culture Care Diversity and Universality. (Copyright © Madeleine Leininger. Modified by Madeleine Leininger, 2004.)

particular surroundings or universe to form certain values about their lives. The cultural and social structure factors encompass components of technological; religious and philosophical; kinship; political and legal; economic; and educational factors. These components are studied through participation, observation, and interview research techniques. Many specific study examples can be found in published transcultural research reports in articles, book chapters, dissertations, doctor of nursing practice (DNP) capstone projects, and master's theses.

Leininger (2002b) specified that nursing care preservation and maintenance be used to enable people of a particular culture to “retain or maintain meaningful

TABLE 18-1 Critical Thinking in Leininger's Theory

| Nursing Actions | Components of the Theory |
|--|---|
| 1. The nurse uses participation, observation, and interviews within the culture. | To discover the worldview of the member or members of the culture; the cultural and social dimensions considering the cultural values and the lifeways such as technological, religious and philosophical, kinship and social, political and legal, economic, and educational factors; and the influence of language, the ethnohistory, and the environmental context |
| 2. The nurse analyzes the information that has been gathered. | To discover patterns and themes related to health and well-being based on the factors listed in item 1 |
| 3. The nurse carefully considers the care according to the data. | To discover the generic (folk) care, nursing care, and professional systems of care indicated according to the data |
| 4. The nurse develops a plan of care based on the data and presents it to the patient for review and modification as needed. | To plan for culture care preservation or maintenance, accommodation or negotiation, and repatterning or restructuring |
| 5. The nurse implements the plan and observes the outcomes of culturally congruent care. | To promote health and well-being |

care values and lifeways for their well-being, to recover from illness, or deal with handicaps or dying” (p. 84). Accommodation and negotiation involves actions and decisions that help the people in a culture “adapt to or negotiate with others for meaningful, beneficial, and congruent health outcomes” (p. 84). Repatterning and restructuring helps “clients reorder, change, or modify their lifeways for new, different, and beneficial health care outcomes” (p. 84)...“while still respecting their cultural patterns and beliefs” (Leininger, 1995d, p. 106).

In most cultures the family is an important factor in care. Wehbe-Alamah (2011) reported the findings from her qualitative ethn nursing study of the culture care of Syrian Lebanese immigrants in the midwestern United States. She used the three modes from the CCT to describe her discovery that the provision of culturally congruent care was centered around the family. Culture care preservation was maintained by requesting that nurses avoid pressuring relatives of deceased Muslim patients to give consent for organ donation or autopsy because Muslims believe their bodies are a gift from God and themselves as trustees of this gift (2011). In order to practice culture care accommodation in the provision of culturally congruent care for Syrian Muslims, the nurses and other health care providers in an inpatient setting were encouraged to consider negotiating the number of visitors and duration of visits. Wehbe-Alamah (2011) found that the presence of a supportive network of family members and friends holds great importance for Syrian Americans as this is considered an essential caring practice as well as a social, religious, and cultural obligation.

McFarland and Eipperle (2008) addressed the issue of integrating the theory of culture care diversity and universality into advanced practice nursing in the role

of the family nurse practitioner (FNP) in providing culturally congruent care primary care contexts (p. 49). They discuss potential for future expansion of the theory in nurse practitioner practice. Given that culture care is a core competency domain for family nurse practitioners (U.S. Department Health and Human Services [DHHS], 2002), they stress the need for nurse practitioners to recognize the often missing component of culture care in nursing.

The nurse practitioner needs to be able to sensitively and competently integrate culture care into contextual routines, clinical ways, and approaches to primary care practice through role-modeling, policymaking, procedural performance and performance evaluation, and the use of the advanced practice nursing process. By using Leininger's sunrise enabler (Leininger & McFarland, 2006) and the three care modes to guide nursing actions and decisions, we predict the nurse practitioner would be able to provide culturally congruent, safe, meaningful, and beneficial care to clients in primary care contexts (pp. 49-50). McFarland and Eipperle (2008) list six criteria for theory application in advanced practice nursing:

1. Be inclusive rather than exclusive.
2. Foster a focus on the whole person rather than the disease or illness.
3. Include consideration of the patient's/family's/significant other's perception of the situation.
4. Be holistic in nature which is helpful to both practice and documentation.
5. Facilitate autonomous nursing practice (aspect of professionalism along with knowledge and service).
6. Encourage diverse ways of knowing, including empirics, ethics, aesthetics, personal knowing, and sociopolitical knowing (p. 52).

Through the many and various roles that nurse practitioners express their leadership and skills, their nursing perspective influences the actions and decisions of the larger body (group, committee, organization, institution) in which they are participants. Thus culturally congruent care as provided by nurse practitioners should be integrated into the collective worldview of that body and thereby be reflected in their vision, mission, goals and objectives, and ultimately its functionality, actions, and decisions for meeting the needs of the people for whom it offers assistance (McFarland & Eipperle, 2008). As has been noted, "Healthcare organizations should be committed, willing, and supportive of their staff to ensure the attainment of a culturally competent work environment" (McFarland & Eipperle, 2008, p. 50). Examples from recent studies follow.

In their study of African American elder healing practices with botanicals in the Mississippi Delta, Gunn and Davis (2011) discovered care practices related to strong spiritual beliefs and involvement of the family. African Americans revealed they depended on God for healing; nurses were encouraged to pray with elders to maintain those caring traditions. Because of the importance of the family, encouraging visits by family members is another nursing action that preserves their traditional caring ways. Providing foods that elders believe maintains their health and prevents disease is another preservation care practice that can be used to provide culturally congruent care. For culture care accommodation, nurses may invite elders with knowledge of botanicals to become involved with the health care team. Gunn found that African American elders viewed health as, "getting up and going

on about your business” (p. 45). This belief was problematic because elders diagnosed with hypertension did not think medication was necessary as long as they could be active. Nurses were encouraged to recommend care repatterning that included antihypertensive medications rather than botanicals for which there was no evidence for efficacy (p. 45).

Morris (2012) used the culture care theory to study urban adolescent gang members and identified ways for health care providers to maintain health and safety and promote wellness by using the positive attributes gangs can offer to an urban community. Nurses were urged to preserve health and promote wellness by partnering with gang members to distribute information about the availability of human immunodeficiency virus (HIV) testing throughout the neighborhood. In addition, as urban gang members were found to provide protection for residents within their own community, nurses were encouraged to seek assistance from gang members willing to provide this protection so neighbors could travel safely to clinics where these testing services were offered.

In her study of Lithuanian Americans, Gelazis (2002) discovered how “religious values and beliefs permeate the daily lives of Lithuanian Americans and are the basis for care expressions” (p. 446). She found that religion is “closely tied to cultural preservation, language, and education as well as other aspects...such as politics and welfare organizations” (p. 446). The nurse or student nurse using the sunrise enabler for research or practice readily understands the structure with two-way arrows between each item indicating influence or movement from one element to another.

Mixer (2011) used both the culture care theory and the ethnonursing research method to conduct a unique study of nursing faculty to discover the complex nature of teaching culture care to nursing students. Implications for nursing education were presented using data abstracted from synthesis and analysis of qualitative descriptors, patterns, and themes that supported nursing faculty teaching culture care. The findings of this study identified the need for a guiding framework such as the culture care theory for integrating culture care into nursing curricula (Mixer, 2011).

Mixer discovered nursing faculty were found to be engaged in many actions and decisions that supported teaching culture care and contributed to the health of faculty, students, and clients. The faculty was encouraged to maintain efforts to assist students in caring for culturally diverse clients in the clinical setting. The researcher recommended that faculty maintain combining generic care (teaching and individual cultural practices) with professional care (mentoring and modeling) to promote student health and well-being. The importance of learning to care from one’s generic family was a powerful influence on faculty professional care. When faculty combined their generic and professional care, students were able to succeed in their nursing programs and apply culturally congruent nursing actions and decisions to the care of patients and families.

Faculty religious values, beliefs, and practices facilitated their ability to care for students, clients, and families from similar and diverse backgrounds. Their ecumenical perspective contributed to faculty avoiding cultural imposition and facilitated teaching students how to provide culturally congruent care. Mixer (2011)

discovered preserving faculty generic care based on their religious values, beliefs, and practices would enhance teaching culture care. As faculty participated in this study, it became clear to them that teaching culture care was given minimal attention and was not integrated throughout their curricula. Nursing faculty were encouraged to incorporate culture care into their curricula. The researcher recommended nursing faculty to repattern by using an organizing framework for teaching culture care in the classroom, online, and in clinical contexts. Whereas the faculty members' rich experiences contributed to student learning, the use of an organizing framework, specifically the culture care theory, would enhance that student learning to provide culturally congruent care based on evidence from transcultural nursing research (Mixer, 2011).

CASE HISTORY OF DEBBIE

Debbie is a 29-year-old woman who was recently admitted to the oncology nursing unit for evaluation after sensing pelvic "fullness" and noticing a watery, foul-smelling vaginal discharge. A Papanicolaou smear revealed class V cervical cancer. She was found to have a stage II squamous cell carcinoma of the cervix and underwent a radical hysterectomy with bilateral salpingo-oophorectomy.

Her past health history revealed that physical examinations had been infrequent. She also reported that she had not performed breast self-examination. She is 5 feet, 4 inches tall and weighs 89 pounds. Her usual weight is about 110 pounds. She has smoked approximately two packs of cigarettes a day for the past 16 years. She is gravida 2, para 2. Her first pregnancy was at age 16, and her second was at age 18. Since that time, she has taken oral contraceptives on a regular basis.

Debbie completed the eighth grade. She is married and lives with her husband and her two children in her mother's home, which she describes as less than sanitary. Her husband is unemployed. She describes him as emotionally distant and abusive at times.

She has done well following surgery except for being unable to completely empty her urinary bladder. She is having continued postoperative pain and nausea. It will be necessary for her to perform intermittent self-catheterization at home. Her medications are (1) an antibiotic, (2) an analgesic as needed for pain, and (3) an antiemetic as needed for nausea. In addition, she will be receiving radiation therapy on an outpatient basis.

Debbie is extremely tearful. She expresses great concern over her future and the future of her two children. She believes that this illness is punishment for her past life.

Nursing Care of Debbie with Leininger's Theory

The following is an account of how a transcultural nurse would approach the care of Debbie in conjunction with other members of the health care team. The situation "in real life" would require more research and analysis than can be presented here. However, a representative sample of the steps taken to plan cultural care is

presented. The material presented is based on knowledge achieved through previous studies by Morgan (1992, 1995, 1996, 2002).

Observation, Participation, and Interviews

Mary is the transcultural nurse who has been assigned by her home health agency to provide culture-specific care for Debbie. She will cooperate as a consultant on an ongoing basis with the other home health nurses who are giving Debbie physical care.

On her first visit, Mary finds that Debbie is an African American who has lived in the small rural area of her Southern state all her life. Debbie and her family live in her mother's house, which is wooden with the door and window frames painted blue. Mary, who is knowledgeable about African American beliefs, recognizes that the blue paint may be to prevent haunts, or "haints," from entering the house and frightening or harming the occupants. The use of the paint also indicates to Mary that the family probably is knowledgeable about voodoo and may use voodoo from the African West Coast Vondun religion. She will explore this after she has established a relationship with Debbie.

Although Mary has done research in African American culture and knows a good bit about it, she realizes that she will have to explore the beliefs, practices, and values of Debbie and her family, because they will be both similar and diverse from the group in general. Only after this exploration can culturally competent nursing care be planned.

When Mary approaches the house, she finds Debbie, her two children (ages 13 and 11), her mother, her grandmother, and an aunt sitting in front of the house. Several other small children are playing in the yard. Mary introduces herself as a nurse from the health department. She carefully calls Debbie by her last name. She asks for the names of the other people present and makes a note of those present for future use. In the African American community, great respect is given to the adults, particularly the elders in the family or community. Last names are a sign of that respect and should be used by outsiders.

Mary is asked to sit down with the family, and she engages them in conversation. Both the mother and the grandmother express concern over Debbie's condition and mention that she "just looks too small and won't eat." Debbie's grandmother also worries that Debbie has "low blood." Mary knows that in the rural community, the expression of "low" or "high" blood can be interpreted in many ways. "Low" blood can mean anemia, too little blood in the body, low blood pressure, or blood that has "fallen" to the lower parts of the body. Conversely, "high" blood can indicate too much blood, high blood pressure, or blood that has "risen" and affected the brain in some manner. Mary will refer a nutritionist from the home health agency to help Debbie cope with her anemia and weight loss because Mary knows from the medical records that Debbie does indeed have anemia. She reassures the mother, grandmother, and Debbie herself that anemia is indeed a medical condition that can be managed and that she will arrange some help with it.

Mary notices the crosses around the necks of some of the family members and asks about their church. All regularly attend the African Methodist Episcopal Church just "down the road" from the house. All of the grown women tell Mary

that they sing in the gospel choir, although Debbie adds that she has not had the energy to participate in the choir work since her surgery. Debbie comments that her children and husband go there also. She volunteers that their pastor is a good man and that he “takes care of his flock.”

As is the custom in some areas, the front yard is the gathering place for families. Flowers and bushes are here and there, but the yard itself is dirt and is swept daily. The yard faces the street in front of the house, and Mary sees that everyone who passes by waves or “hails” the family in the front yard. The family responds with waves and smiles. Some neighbors stop and ask Debbie how she is doing and tell Debbie that she can call them if she needs any help.

Mary tells the family goodbye and makes arrangements to come back and talk to them again in 1 or 2 days. She explains that she would like to ask Debbie some more questions but does not want to tire her out during this first visit. She assures the family that the home health nurse that is Debbie's primary caregiver will be there every day for a while.

The next time Mary comes to the house, she finds Debbie lying on the sofa in the living room. A television is on in the room; a bathroom and kitchen can be seen from the living room; and a small fan blows on Debbie.

Mary, wanting to determine more about the technical aspects of Debbie's life, asks if the family has adequate refrigeration to preserve food and whether the bathrooms are working properly. Debbie assures Mary that the refrigeration and bathroom facilities are fine; Debbie states the main water problem is that the neighborhood does not have sewer lines, so the grease trap in the backyard often overflows because of excess sewage.

Debbie also tells Mary that her husband has been better since she got sick but that he verbally mistreats her sometimes, calling her “dumb” because she did not finish high school like he did. She adds that her mother is a “good, strong woman” who protects her from her husband at times. She says she hopes her children can get a better education than she had. Debbie continues that she tries to learn about new things that she might have missed in school, and she particularly wants to learn more about her own body, her illness, and the operation.

Mary asks Debbie about her economic situation, and Debbie answers that they “get by”—but barely. Her mother and grandmother work as housekeepers in motels in the nearby tourist area, and she worked in a textile mill before she got sick. However, she worked part-time and does not receive sick pay or unemployment benefits. Her husband picks up odd jobs now and then, but this is only sporadic. She hastens to add that although she has not had an appetite since surgery, the rest of the family members have enough to eat. They grow some vegetables and often share food between neighbors, particularly when extra vegetables or fruit is grown and when the men go hunting or fishing and return with game and fish.

Mary notices that certain symbols are in the house indicating a belief in both the Christian religion and possibly voodoo. Pictures of Jesus are in the house, and she also sees John the Conqueror oil, incense for luck and money, and two 7-day candles on the table. She asks Debbie about these, and Debbie states that although she and her family are Christians, “it is important to cover all bases” and that she and her mother do believe in the supernatural. In fact, she says she thinks that her

illness and operation may have been because she was “fixed” or “rooted” (i.e., hexed) by someone. She also volunteers that, in addition to the medicines prescribed by her doctor, she has relied on some generic medicines such as aspirin, Ex-Lax, and cod liver oil, as well as some herbs.

Mary makes several other visits to Debbie and, at the same time, consults with the other nurses caring for her. Mary’s final report includes the care patterns and themes she has found, along with the cultural care suggestions to follow.

Themes Formulated from Mary’s Research

The first patterns are that protection, presence, and sharing are viewed as important values to Debbie and her family. The theme emerging from this pattern is that health and well-being are dependent on protection, presence, and sharing. Another theme is based on the patterns found in social structural factors. This theme is that spirituality, kinship, and economics have great influence on the health and well-being of Debbie and her family. A third theme that evolves from the observation, participation, and interview findings is that folk health beliefs and practices are used by the family to promote health and well-being.

Culture-Specific Care

From these themes Mary forms the nursing care decisions and actions that she will share with the other home health nurses. To meet the goal of culture care preservation or maintenance, Mary realizes that religion can be used as a strengthening mechanism in Debbie’s care. She suggests that arranging for visits and consultations with the pastor of Debbie’s church is important. He may be able to help with Debbie’s belief that her sins in the past affected her illness. At the same time, she tells Debbie and her nurses that Debbie may benefit from consulting a “root doctor” to remove any hex that she may have suffered. Maintenance of strong caring by Debbie’s relatives, fictive kin, and friends will also contribute to Debbie’s well-being. Based on the pattern of presence being important, the importance of language, and the desire for education, the nurses should plan their visits so they have time to spend with Debbie and teach her about her body and illness.

Similarly, the findings from Mary’s visits and the resulting patterns and themes she has discerned will lead to the second form of culture care, that is, cultural care accommodation or negotiation. Mary plans to negotiate with the city to try to resolve the unhealthy sewage situation and the overflowing grease traps in Debbie’s neighborhood. City services and the local public health department will be contacted.

With the finding of the importance of presence as caring and with Debbie’s desire for further education about her body, the nurses will try to find Debbie a support group for women who have undergone hysterectomies. This offers a chance for Debbie to meet new friends and to learn about how others have coped with the operation. Mary (or the other nurses caring for Debbie) will investigate Debbie’s prescribed medicines to determine whether they are compatible with the generic or folk methods Debbie uses. Mary will also teach the other nurses about voodoo and its importance so that they will not degrade it or view its practices as superstitions.

Finally, cultural care repatterning or restructuring is considered. A dietitian will help Debbie with a menu that will be both agreeable to her and contribute to weight gain and relief of her anemia. Meals on Wheels or a similar organization will be contacted to begin delivery of a hot lunch every day. The nurses will also attempt to help Debbie stop smoking. Other people in the household who smoke will be instructed about the health hazards of second-hand smoke to nonsmokers and the children. If smoking continues, the smoker is encouraged to do it outside.

Conclusion

Through the use of observation, participation, and interviews, Mary was able to discover the diverse and similar beliefs, practices, and values of Debbie and her family. Prior research and articles related to the African American group were also used for the same purpose. Based on these beliefs, practices, and values, a nursing culturally congruent care plan could be devised for the client during her postoperative period.

Nursing Care Using Leininger's Theory

In order to use critical thinking criteria about actual clinical situations, the following scenarios may be useful exemplars for the reader to reflect upon and envision as ways that the culture care theory and transcultural nursing can be used to modify cultural biases and ensure more culturally congruent care across practice settings.

A DNP Project for Integrating Cultural Competence in a Primary Care Clinic

In a DNP project in progress, Courtney and Wolgamott (n.d.) have been using culture care theory and collaborative care constructs as the conceptual basis to develop and guide the implementation of transcultural teaching modules for nurse practitioners, physical therapists, and support staff in an urban primary care clinic for underserved patients from diverse cultural backgrounds. Two essential elements of Leininger's theory are that care is embedded in culture, and health care providers are challenged to understand both care and culture in order to practice transcultural care (Leininger & McFarland, 2002). Because the current project focuses mainly on health care providers, their engagement in the transcultural education process and application to practice is predicted to serve as the key foundational approach to expanding their cultural awareness, thus triggering the completion of cultural assessments of their patients as confirmed through chart review of relevant documentation (Courtney & Wolgamott, n.d.).

The evaluation is a twofold process of the learners as well as documentation of compliance elements affecting patient care. First, the staff began their journey toward cultural competency with a pretest before the first learning module using Jeffreys' (2006) Transcultural Self Efficacy Tool (TSET). The modular education approach was chosen with components focusing on cultural self-awareness, culture care theory and the new collaborative care construct, cultural assessments, and practical applications. A post-module TSET was administered to staff after

completing all the modules. It is imperative to remember that cultural competence is a process requiring time, education, and effort. This project will affect both practice of the health care team and the clinical experience of the underserved population. In line with the mission, vision, and values of the primary care clinic, the staff have been accountable to perform cultural assessments and documentation of interventions as part of an effort to provide culturally congruent care. The evaluation process involving staff education and documentation reviews provides confirmation of the outcomes for the foundation for this project.

Retrospective chart reviews to collect preintervention data were begun immediately prior to staff education sessions. Approximately 200 charts were examined for evidence of cultural assessments and interventions to evaluate current practices in the clinic. Two 40-minute education modules were made accessible for viewing during regularly scheduled staff development time. Videographies of the modules were made so as to be available for those staff members unable to attend and for future use. Additional items related to cultural assessment were developed to elicit triggers based on responses to cultural assessment queries on the patient assessment (history) form. The form was modified to include space for documentation of cultural assessment and culturally influenced interventions. Once the education sessions were completed, the staff began to include cultural assessments in their initial encounters and subsequent care with all of their patients. The assessment data were documented in the health record specifying what actions and decisions took place to address the patient's cultural needs. These steps have been performed by everyone who has interacted with the patient but have been primarily documented by the nurse practitioners.

Final analysis of the data is in progress. This includes qualitative feedback from staff responses to the project and anecdotal client reporting. All quantitative data from the TSET are analyzed using the statistical package for the social sciences (SPSS) software system and validated. Qualitative (narrative) data are reviewed and analyzed. Abstracts are prepared for publication and presentation at local and national venues. Outcomes are shared with the staff. A plan was developed to continue the project innovations in the primary care clinic. Congruent with translational and DNP project goals, a model is being created to offer this project to other practice settings to promote culturally congruent care.

Advanced Practice Primary Care Nursing Using the Culture Care Theory

Hubbert (2006) stated the importance of “nurse administrators who are knowledgeable about culture care constructs and transcultural nursing principles... [and] are able to demonstrate their use through action” (p. 355). Further, Hubbert identified that “the universal care constructs of *giving presence*, *helping*, *facilitating*, *providing assistive acts*, *being connected to*, and *providing attention* are essential to attain and maintain the [CCT] theory-based goal of providing culturally congruent care” (p. 355). Ludwig-Beymer (2012) cited Leininger's culture care theory with the sunrise [model] enabler as useful in assessing organizational culture (pp. 227-228).

Nurse practitioner Annie G. joined a collaborative nurse-managed urban health center practice that provided care and services to African American adolescents and adults who were under- or uninsured. A significant number of their clients were socioeconomically impoverished; many had low literacy skills. Annie had studied the theory of culture care diversity and universality and was familiar with its constructs. She believed using the theory as a framework for the entire practice would enhance client satisfaction and health care outcomes. Annie approached her colleagues with her ideas. Most were receptive; some had questions. After much discussion, study, and review it was agreed to use the theory as the basis for integrating culture care throughout the practice. Faculty from the local university and members of the community were invited to participate in the planning process. Client and staff surveys were performed over a 4-week period to discover locally indigenous culture-specific values, beliefs, and practices. Interviews were also conducted with key individuals to assess needs, preferences, and concerns regarding their health care delivery experience as well as the cultural traditions and worldview of the community at large.

As a result of these findings, many changes were integrated throughout the practice. Among these were the hiring of more African American reception and clinical assistant staff members as well as an African American nurse practitioner; placing of photographs of local African American community leaders, patients and their family members, and culturally congruent artwork; ordering of subscriptions to culturally relevant magazines and children's books; modifying the décor color scheme; updating the intake questionnaires to be more culturally congruent with the lifeways and social structure of the clients; and revising or replacing health education materials to reflect local cultural patterns in relation to food, family, religious practices, and other cultural lifeways.

Most important, staff, primary care providers, and other clinicians learned to use culturally appropriate approaches with which to engage clients during health encounters. A post-survey of the clients and staff is ongoing. The response has been predominantly positive. Clients reported feeling more welcome and comfortable in the environment. They found the modified approaches "less imposing." The post-survey client and staff suggestions were forwarded to the nurse practitioner manager for review and modification for continued implementation.

CRITICAL THINKING EXERCISES

1. Describe the social structure factors in your own practice setting and analyze how they might influence the health of the populations served.
2. Observe your office reception and waiting room spaces. What symbols do you see that represent the cultural beliefs and practices of clients? staff? providers? The choice of music, videos, books, and artwork is a strong clue. List and discuss those and other symbols discovered.
3. Develop a plan for providing and receiving culturally congruent care within your practice setting or organization from these findings.

Continued

CRITICAL THINKING EXERCISES—cont'd

4. For 1 or 2 days take note of the use of culturally insensitive terms or references in conversations. Can you think of examples of how the use of these words may be divisive when discussing clients' values, beliefs, or practices?
5. Review the process of using the sunrise enabler. Move through the steps of the process and reflect on a patient cared for or a person encountered from a different culture, lifestyle, or worldview. What discoveries were made? Are there examples of cultural imposition during these interactions based on own cultural assumptions from rather than that of the other person?
6. Analyze your style of approach to assess how to integrate culturally congruent and competent care into your nursing practice.

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Parse's Theory of Humanbecoming in Nursing Practice

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The assumptions and principles of humanbecoming incarnate a deep concern for the delicate sentiments of being human and show a profound recognition of human freedom and dignity.
(Parse, 2007b, p. 310)

History and Background

In the video series *Portraits of Excellence*, Parse (1990b) shared that the humanbecoming theory, now an aspect of the Humanbecoming School of Thought (Parse, 1998, 2007b, 2012a,b), was created over many years as she grew and matured with others and as she considered the values and ideas she engaged while living and learning. Her values led her to question the medical model as a suitable knowledge base for nursing. Parse found the medical model limiting and inconsistent with her experience of how people make health decisions. Accordingly, she searched for a different way to know and practice nursing. From the beginning, Parse chose to focus on people's experiences and their unique views of health. She believes that people co-author their health, and she asserts that nurses do not have control of people or of their health choices. Nearly 35 years ago Parse had a vision of nursing that was based on dialogue, presence, and participation. That was well before either the Theory of Humanbecoming (1981, 1987, 1992a, 1998) or the Humanbecoming School of Thought (Parse, 1998, 2007b, 2011b, 2012a,b) was fully formed. Parse knew that she wanted to contribute to the development of nursing as a unique science. The nursing science she envisioned is consistent with basic tenets of the human science tradition (Bunkers, 2002; Cody & Mitchell, 2002) and supports practices that truly honor the freedom and dignity of human beings (Parse, 1990a,b, 2007b, 2010).

Parse's work, originally called *man-living-health*, appeared in print in 1981. The name was officially changed to *human becoming* in 1992 (Parse, 1992a) and then to *humanbecoming* in 2007 (Parse, 2007b). Parse (1998, 2007b) explicitly presents the Humanbecoming School of Thought as a perspective grounded in human science—distinct from medicine and other sciences. Parse (1981, 1987, 1995, 1998) references Dilthey (1961), regarded as the architect of human science, as a person who influenced her thinking about science and about the possibility of systematically exploring the connectedness of life and the unity of human experience. The Humanbecoming School of Thought focuses on humans' living experiences and the meanings and patterns that create individuals' unique processes of life. For Parse (1998, 2007b, 2012b), humans are indivisible, unpredictable, and everchanging, and they make choices while living paradoxical patterns of becoming.

Parse (1981, 1998) also named other authors who influenced her development of the Humanbecoming School of Thought. Martha Rogers (1970, 1986, 1994), who conceptualized the Science of Unitary Human Beings, had a major influence on Parse's thinking—as did the existential-phenomenological philosophers Sartre (1966), Merleau-Ponty (1963, 1973, 1974), and Heidegger (1962). Parse developed a novel theory that is different from Rogers' work and more expansive than existential-phenomenological thought, yet the insights inspired by these authors are visible in humanbecoming. The Theory of Humanbecoming itself, which consists of three principles and nine concepts, was developed in deductive-inductive ways during the 1970s as Parse pondered the possibilities of a different kind of nursing (Parse, 1990b).

Parse (1981, 1998, 2007b, 2012a,b) has continually expanded and clarified humanbecoming over the past three decades. Several developments are noted in this chapter, including the refined assumptions and principles of humanbecoming (Parse, 2012b); specification of the postulates of humanbecoming (Parse, 2007b); development of teaching-learning (Parse, 2004a), mentoring (Parse, 2008b), leading-following (Parse, 2008c, 2011a), community (Parse, 2003a, 2012b), and family (Parse, 2009) models; development of the humanbecoming research and practice methodologies; and multiple conceptual additions and clarifications. For example, in order to advance thinking about the idea of indivisibility, Parse (2007b) deleted the physical space between the words *human* and *becoming* and *human* and *universe* to create the words humanbecoming and humanuniverse. The words provide an image, as well as explicit meaning, of the indivisibility of human experience. In addition, Parse (2012b) introduced new conceptualizations in 2012 that further specify the meaning of the all-at-onceness of human experience from a humanbecoming perspective. She said that the belief system (ontology) underpinning humanbecoming “specifies that with humanuniverse the human is an august presence, a seamless symphony of becoming, living the emerging now. *Becoming visible-invisible becoming of the emerging now* is the living moment that brings to the fore the idea that meaning changes with each unfolding living experience incarnating the remembered with the prospected all-at-once” (Parse, 2012b, p. 44).

The becoming invisible-invisible becoming of the emerging now is the universe of histories and experiences and hopes and dreams that co-create each moment, as humans live and shape their lives with their illimitable, unbounded knowing.

Human living experiences surface moment to moment like waves surfacing on an ocean. What is becoming visible in human experience can be described as what is happening in the moment that can be explicitly known and described by the person living it. It is like the waves that are swelling to the top of the ocean—visible for a moment, yet always shifting and changing and being co-created with what is happening in the entirety of the ocean, invisible beneath the surface yet co-creating the waves that are becoming visible with their invisible becoming (Bournes & Mitchell, 2013).

Since the original publication of *Man-Living-Health* in 1981, Parse has published many articles and has authored, co-authored, and edited several texts that have contributed significantly to the discipline of nursing (see Morrow, 2012b). A book on qualitative research (Parse, Coyne, & Smith, 1985) presents research studies guided by humanbecoming. That text was published before Parse (1998, 2001, 2005, 2011b) had developed research methodologies consistent with her theory. Further development of practice and research methodologies appeared in print in a general text on nursing science. The book *Nursing Science: Major Paradigms, Theories, and Critiques* presented various nursing theories and described their alignment with two nursing paradigms (worldviews) named by Parse: the totality and the simultaneity paradigms (Parse, 1987). And in 2012, Parse (2012a) added a third, humanbecoming paradigm, to the schema. In 1995, Parse edited *Illuminations: The Human Becoming Theory in Practice and Research*, that contains contributed works by various authors about the humanbecoming theory in practice and research. Several evaluation studies are included in the *Illuminations* text and also a hermeneutic research method, consistent with humanbecoming, as developed by Cody (1995) in his hermeneutic analysis of Walt Whitman's *Leaves of Grass*. Parse (1998, 2001) further articulated the humanbecoming hermeneutic method specifying three processes: “discoursing with penetrating engaging, interpreting with quiescent beholding, and understanding with inspiring envisaging” (Parse, 2001, p. 172).

In 1998 a revision of Parse's theory was published in her book *The Human Becoming School of Thought: A Perspective for Nurses and Other Health Professionals*. This marked an important development in the Theory of Humanbecoming as she formally defined the humanbecoming school of thought as a belief system with interrelated concepts offering a view of the humanuniverse process of how humans co-create their own becoming in unique pathways of situated freedom. Three texts followed the 1998 publication: one on hope research (1999), one on qualitative inquiry (2001), and a third on community (2003a). Her book on qualitative inquiry as sciencing offers a comprehensive view of different research methods consistent with several nursing theoretical perspectives. The text describing the humanbecoming view of community offers an innovative integration of art and metaphor to conceptualize a novel approach for working with community and change (Parse, 2003a).

Currently, within the humanbecoming school of thought, are assumptions; postulates; principles; concepts; practice and research methodologies; models of teaching-learning, mentoring, leading-following, family, and community (Parse, 2003a, 2004a, 2008a,b, 2009, 2011a, 2012b); and ethical tenets of human dignity (Parse, 2010a). The phrase *school of thought* is more comprehensive than the

humanbecoming theory itself, and development of methodologies, models, and ethical tenets indicates the potential of the belief system to support study, knowledge development, and work in multiple arenas. The school of thought may provide guidance for professionals and scholars from other disciplines who are interested in developing a human science consistent with the vision of Dilthey (1961) and those who seek a belief system that truly honors human experience and human mystery. Serious students of humanbecoming will want to study each of the postulates, concepts, principles, methods, models, and ethical tenets of the school of thought in order to know the integrity of the ideas and their potential contributions.

Numerous publications describe the difference that the Humanbecoming School of Thought makes in practice and how research enhances the understanding of living experiences while expanding the knowledge base of humanbecoming. It is not possible to note all the contributions of authors in this brief history and background of humanbecoming. Readers can access additional references in the text *Nursing Theorists and Their Work* (Alligood, 2013) and through online indexes and search engines. To represent the scope of work affiliated with the Humanbecoming School of Thought, selected examples of recent publications that illustrate the breadth of practice, research, education, and leadership activities are cited.

Humanbecoming has guided nursing practice in community settings, including clinics, parishes, and homeless shelters (Bournes & Naef, 2006; Milton & Buseman, 2002; Smith, 2002; Wang, 2008). Nurses have written about practice in hospital settings (Bournes & Ferguson-Paré, 2007; Bournes, Ferguson-Paré, Plummer, et al., 2009; McCarthy & Aquino-Russell, 2009; Mitchell, Bournes, & Hollett, 2006; Mitchell, Closson, Coulis, et al., 2000; Papendick, 2002), and with persons of various ages, including children (Baumann & Carroll, 2001; Karnick, 2005), adults (Mitchell, 2002; Tanaka, Katsuno, & Takahashi, 2012), and older persons (Hodges, Keeley, & Grier, 2001). Nurses rely on the humanbecoming theory to guide their relationships with families (Cody, 2000), groups (Noh, 2004), women (Kostas-Polston, 2008; Oaks & Drummond, 2009; Smith, 2002), soldiers (Flinn, 2007), persons with hearing loss (Aquino-Russell, 2005, 2006), and persons experiencing disasters (Hayden, 2010). The value of the Humanbecoming School of Thought has been considered from the perspectives of nurses in various practices (Bournes & Naef, 2006; Bunkers, 2012b; Cody, 2003b; Damgaard, 2012; Doucet & Maillard-Struby, 2009; Gantalao, 2002; Hegge, 2012; Jensen-Wunder, 2002; Karnick, 2007; McLeod & Spee, 2003; Melnechenko, 2003; Mitchell, 2002a; Mitchell & Bunkers, 2003; Morrow, 2012a,b; Peterson-Lund, 2011; Stanley & Meghani, 2001), by nurse leaders (Bournes, 2006; Bournes, Bunkers, & Welch, 2004; Bournes & Ferguson-Paré, 2007; Damgaard, 2012; Karnick, 2007; Mitchell, Bournes, & Hollett, 2006; Morrow, 2012a), and by clients (Williamson, 2000). Nurses have offered comparisons between humanbecoming and other theoretical approaches (Baumann & Englert, 2003; McCarthy & Aquino-Russell, 2009) and others have discussed how Parse's practice influences notions of listening/bearing witness (Kagan, 2008b; Tschanz, 2006), ambiguity (Mitchell & Pilkington, 2000), and patient-centered care (Mitchell et al., 2000; Mitchell, 2002; Parse, 1996d).

Parse's work has contributed significant knowledge development in the areas of teaching-learning (Aquino-Russell, Strüby, & Reviczky, 2007; Bunkers, 2003a,

2006, 2008, 2009a,b; Chan, 2005; Condon, 2010, 2011, 2012a,b; Condon & Hegge, 2011; Milton, 2003a, 2012; Norris, 2002; Parse, 2004a; Pilkington, 2002; Ramey & Bunkers, 2006; Ursel & Aquino-Russell, 2010), loss and grieving (Florczak, 2008; Jonas-Simpson & McMahon, 2005; Pilkington, 2005, 2006), ethical relating (Bournes & Flint, 2003; Cody, 2003a; Condon & Hegge, 2011; Milton, 2002, 2003b, 2004, 2005a,b, 2008a-d; Mitchell, 2001, 2002b; Mitchell & Bournes, 2000; Mitchell & Bunkers, 2003; Mitchell & Cody, 2002; Naef, 2006; Pilkington, 2004), listening (Jonas-Simpson, 2003; Jonas-Simpson, Mitchell, Fisher, et al., 2006; Kagan, 2008a,b), and mentoring (Bournes & Plummer, 2011; Carroll, 2004; Letcher & Yancey, 2004; Parse, 2008b; Yancey, 2005). The Humanbecoming School of Thought has influenced state board standards for decision making (Benedict, Bunkers, Damgaard, et al., 2000; Damgaard & Bunkers, 2012) as well as the development of Canadian standards of care for client-centered care and nursing (Bournes, 2000; Nelligan, Balfour, Connolly, et al., 2002; Rodgers, 2000).

Humanbecoming has inspired many scholarly papers that clarify connections with human science and views of nursing as a unique science (Arrigo & Cody, 2004; Baumann & Englert, 2003; Bunkers, 2002; Cody, 2003a; Cody & Mitchell, 2002; Northrup, Tschanz, Olynyk, et al., 2004; Paillé & Pilkington, 2002; Parse, 1992b,c, 1993, 2002; Pilkington, 2002) as well as views of evidence, wisdom, and truth (Milton, 2007; Mitchell, 2009; Parse, 2008a). Several articles chronicle the broad scope, challenges, and opportunities with humanbecoming practice and research (Cody, Mitchell, Jonas-Simpson, et al., 2004; Parse, 1996b) and Bournes (2002a) provides an overview of early research evaluating humanbecoming-guided practice.

A review of research studies guided by humanbecoming has been published (Doucet & Bournes, 2007). Humanbecoming studies have enhanced understanding about living experiences of courage (Bournes, 2002b), waiting (Bournes & Mitchell, 2002; Naef & Bournes, 2009), respect (Bournes & Milton, 2009; Parse, 2006), faith (Doucet, 2008), persevering (Bournes & Ferguson-Paré, 2005), joy-sorrow (Parse, 1997), feeling tired (Baumann, 2003; Bunkers, 2003b; Huch & Bournes, 2003; Parse, 2003b), feeling cared for (Bunkers, 2004), feeling unsure (Bunkers, 2007; Maillard-Struby, 2012; Morrow, 2010), feeling confined (Dempsey, 2008a), time passing (Northrup, 2002), changing expectations (MacDonald & Jonas-Simpson, 2009; Thomas, Riggs, & Stothart, 2013), being listened to (Jonas-Simpson, 2003), quality of life (Jonas-Simpson & Mitchell, 2005; Parse, 1994, 1996c; Pilkington & Mitchell, 2004), suffering (Pilkington & Kilpatrick, 2008), feeling respected-not respected (Bournes & Milton, 2009), feeling disappointed (Bunkers, 2012a), living on the edge (Peterson-Lund, 2012), doing the right thing (Smith, 2012), and feeling strong (Doucet, 2012). The research process has been developed with families (Baumann, 2006; Cody, 2000) and children (Karnick, 2008). The humanbecoming hermeneutic method has expanded understanding of wisdom, compassion, and courage (Baumann, 2008), hope (Parse, 1999, 2007a), and lingering presence (Ortiz, 2003). Scholars have examined the artful practice of humanbecoming (Dempsey, 2008b; Parse, 1992c), and have transformed research into art forms (Jonas-Simpson & Mitchell, 2005; Mitchell, Jonas-Simpson, & Ivonoffski, 2006). The theory has global appeal and has provided meaningful direction to many nurses in countries too numerous to list here.

Parse (1990b) suggests that the value of her work will be decided by future generations of nurses who live the theory, by the clients who experience practice with these nurses, and by the new knowledge that accompanies research guided by the theory. By viewing her work as an invitation to think and act differently, Parse provides new horizons for nursing as a human science focused on the experience of indivisible, unpredictable, everchanging human beings. Since the birth of humanbecoming, Parse has published many papers that continue to expand nurses' thinking. Her commitment to scholarship and knowledge development is evident in her own work, especially as founder and editor of the journal *Nursing Science Quarterly*, and in the works of nurses who accept her invitation to think and act differently in practice, education, leadership, and research.

Overview of Parse's Theory of Humanbecoming

The Humanbecoming School of Thought presents an alternative knowledge base for nurses to guide their practice and research activities. When first engaged, humanbecoming may be experienced as familiar-yet-unfamiliar, simplistic-yet-complex, and clear-yet-obscure (Mitchell & Pilkington, 2000). It requires as much willingness on the part of the interested professional nurse and others to *unlearn* as it does to learn a new way of thinking. The Humanbecoming School of Thought appeals to nurses who, like Parse, find the biomedical model restrictive and dehumanizing. The principles and concepts are abstract, and the language Parse uses is nonlinear and can be both unsettling and uplifting in its fluidity and process orientation. Humanbecoming is a foundation of knowledge that is very deep. Informed by people's living experiences, the school of thought is a source for dynamic and self-renewing understanding of humanuniverse and health.

It is interesting and quite important to appreciate the meaning of humanuniverse and health, especially in light of the idea that nursing's metaparadigm concepts—human beings, environment, and health—are often described separately. In the Humanbecoming School of Thought, they are not considered separate. It is the idea of the unity of person-with-universe—described by Parse (2012a,b) as the illimitable, indivisible, unpredictable, everchanging humanuniverse—that distinguishes the Humanbecoming School of Thought from other nursing theoretical perspectives. Parse (2007b, 2012a,b) deliberately uses the terms humanbecoming and humanuniverse to demonstrate through language that there is no space for thinking that humans can be separated from becoming or the universe—these notions are irreducible.

Health, according to Parse (1990a, 2012a) is humans' values becoming visible with their invisible becoming as they live personal commitments and make choices about what to do and who to be with the emerging now (Parse, 2012a). Humans are free to choose the meaning and significance of events, their attitudes, their concerns, and their hopes and dreams. Health relates to ways in which persons live their value priorities during the ups and downs that shape their experiences. In any given moment from birth to death, humans can and do choose their values and thus their health.

With humanbecoming, health cannot be given or taken, controlled or manipulated, judged, or diagnosed. Rather, health is the way people live their values

in accordance with their desires, hopes, and dreams. Patterns of health are paradoxical, including times of disappointment as well as times of success, and times of joy with times of sorrow. From Parse's perspective, individuals co-author their health and no outsider can define the values that another person will cherish and live by. This view of health, along with the assumptions and principles of humanbecoming form the foundation for the kind of practice directed by the theory.

The humanbecoming theory consists of three principles and nine concepts that flow from assumptions about humans and becoming. The nine assumptions (Parse, 2012b) are as follows:

1. The human with universe is co-existing while co-constituting rhythmical patterns.
2. The human is open, freely choosing meaning with situation, bearing responsibility for decisions.
3. The human is continually co-constituting patterns.
4. The human is transcending illimitably with possibles.
5. Becoming is human-living-health.
6. Becoming is rhythmically co-constituting humanuniverse.
7. Becoming is the human's value priority patterns.
8. Becoming is transcending with possibles.
9. Becoming is the human's emerging. (p. 44)

Three themes emerge from the nine assumptions: meaning, rhythmicity, and transcendence. Three principles of humanbecoming (the theory) flow from the themes (Parse, 1981, 1998, 2007b, 2012b):

1. Structuring meaning is the imaging and valuing of languaging.
2. Configuring rhythmical patterns is the revealing-concealing and enabling-limiting of connecting-separating.
3. Co-transcending with possibles is the powering and originating of transforming. (Parse, 2012b, p. 45)

Four postulates aligned with the assumptions permeate each of the three principles of humanbecoming (Parse, 2007b). The postulates are illimitability, paradox, freedom, and mystery. Illimitability conveys the unbounded nature of humanuniverse; paradox is the way humans experience patterns of living; freedom is the envisioned liberation of the moment; and mystery is the reverence for what is not knowable. The humanbecoming theory is unique in its identification of paradox as an inherent process of human experience. The three principles of humanbecoming form the knowledge base that shapes the nurse's view of humanuniverse. Each principle has a central theme as well as paradoxical rhythms that help define humanbecoming. Taken together, these principles are like a landscape that forms the background or fabric of knowledge that prepares the nurse's thinking and acting with clients in practice and research. These principles are values-based and therefore cannot be *tested* in the traditional sense of testing a theory. For example, a nurse would not test the hypothesis that people choose meaning in situations or that people reveal and conceal who they are. As in other theories, assumptions are not testable because they are assumed to be true. It is a choice to practice with humanbecoming, a choice made most often because of the fit between one's personal

values and the view of humanbecoming nursing. Readers are encouraged to go to the original sources of Parse's work for a full discussion of the theoretical assumptions, postulates, principles, and concepts because each nurse interprets and lives the theory in consistent and yet unique ways.

Principle One

The first principle of humanbecoming is, "Structuring meaning is the imaging and valuing of languaging" (Parse, 2012b, p. 45). Meaning is the central theme of this principle. This first principle provides one of the three essential frames that shape what nurses think about humans before they approach people in practice. Structuring meaning is what humans do; all people construct a unique view of the world in light of what is becoming visible to them with their invisible becoming in the emerging now. That is, their worldview is co-created with their experiences both explicitly and tacitly in the process of their living and relating with others. The meaning of life situations is connected to the choices persons make regarding hopes, dreams, fears, doubts, and cherished beliefs. Nurses who integrate beliefs contained in the first principle approach people as mysteries who assign unique meanings to their life situations. The first principle contains three concepts—imaging, valuing, and languaging.

1. *Imaging* is people's explicit-tacit knowing of their personal realities. Explicit-tacit is a paradoxical process in which explicit awareness co-exists with the concealed knowing of our realities. For instance, the reasons behind certain feelings or actions may be known, or the reasons may remain a mystery. Sometimes it is not possible to know "Why?" Imaging is a process of knowing and of coming to know as individuals accept and reject ideas, values, beliefs, and practices consistent with their worldview. Coming to know involves both reflective and pre-reflective processes. The reflective ways individuals change the meaning of their personal realities occur through processes such as questioning, speaking about what things mean, exploring personal views, picturing cherished possibilities, and comparing options and alternative views. Pre-reflective ways remain an aspect of human mystery. Imaging is the creating of reality, and one's reality reflects who one is as an irreducible, unpredictable, ever-changing person.
2. *Valuing* is the second concept of the first principle about structuring meaning. *Valuing* is a process of choosing and embracing what is important—it embraces the paradox of confirming-not confirming. Values reflect choices and help shape patterns of uniqueness. Persons act on values that are already integrated with their realities, and they assimilate new values into daily routines and decisions. Parse has suggested that people can know more about their own process of valuing by reflecting on those with whom they spend time, by thinking about what is important, and by considering what initiates action in day-to-day living. Confirming-not confirming is an important paradoxical process in light of the concept of valuing. Confirming is about embracing, accepting, and cherishing people, ideas, and projects that are most important. Not confirming is the opposite of confirming in that people, ideas, and projects may be denied, rejected, and ignored.

3. *Languaging* is the third concept of the first principle. *Languaging* is about the ways people are with the world and in relationships with others and self. Speaking-being-silent and moving-being-still are paradoxical processes of languaging. This process suggests that people tell and do not tell things in their patterns of speaking and moving and during times when they keep quiet and remain still. Humans language their unique realities in words spoken and choices made about how to be with others. Languaging is a way of expressing meaning to and with others in the many situations that constitute daily living. Parse says we language our understandings of reality as our health. An outsider can describe observations about another's languaging, but only the person himself or herself is in a position to interpret or explain its meaning.

Principle Two

The second principle of humanbecoming is, "Configuring rhythmical patterns is the revealing-concealing and enabling-limiting of connecting-separating" (Parse, 2012b, p. 45). The theme of this second principle is rhythmicity, and it focuses on the paradoxical rhythms that constitute patterns of becoming. The paradoxical unities embedded in this principle appear to be opposites, but Parse (1998, 2007b, 2012b) presents them as one lived rhythm. A well-developed description of living paradox is that described by Pilkington (2006) in her review of humanbecoming knowledge on grieving. Pilkington describes a predominant pattern of engaging with and disengaging from the cherished absence of others as persons lived with the communion-solitude of loss. Persons lived complex paradoxical patterns while grieving, patterns that shift over times as the intense reality of loss eases and integrates with one's way of becoming. This paradoxical pattern, being with and moving away, according to Pilkington, relates most directly with Parse's paradoxical unity of connecting-separating. There are three specific paradoxical unities embedded in the second principle: revealing-concealing, enabling-limiting, and connecting-separating.

1. *Revealing-concealing* concerns the ways individuals disclose and do not disclose meanings, thoughts, feelings, values, concerns, and hopes. Human beings reveal and conceal all-at-once through their choices, actions, and words. Patterns of revealing-concealing are co-created in that they vary in relation to who is present and what is happening. People reveal and conceal different things about themselves to different people and in different circumstances. Parse also connects revealing-concealing to the mystery of humans and to the reality that people are never fully revealed; there is always more to know about others and more to discover about self.
2. *Enabling-limiting* is the second paradoxical unity of the second principle. This concept concerns the choices people make moment to moment and the inherent opportunities and limitations that accompany those personal choices. The concept is connected with the notion of doors opening and closing as people make choices and move on in life. People often comment about the unanticipated opportunities that come from hardship. Enabling-limiting is about choice, consequence, and discovery.

3. *Connecting-separating* is the third paradoxical unity of the second principle. This paradoxical concept concerns the ways people can be with others while at the same time being separate from them, or how people can be together without being in the same location. Connecting-separating is also about the ways people are with projects and ideas. As people choose to participate in one project or as they choose to embrace a particular idea, there is at the same time a separating from that idea and other possible projects. People connect and separate with people, ideas, and situations. In this way, they show their unique patterns of humanbecoming.

Principle Three

The third principle of the humanbecoming is, “Cotranscending with possibles is the powering and originating of transforming” (Parse, 2012b, p. 45). This principle introduces ideas about change, struggle, and transcendence. It focuses on how humans create themselves while moving with their hopes and dreams. The theme of this principle is transcendence and it has three related concepts—powering, originating, and transforming.

1. *Powering* is the pushing-resisting process that propels people in life. It involves the way people consider the possibilities that lie ahead and how they choose to go on and find a way to be with situations. To power is to risk losing something of value or even one's life. The pushing-resisting paradox inherent in powering emerges with conflict and tension at times. Conflict can happen with others or can occur within the private thinking of one person as conflicting ideas and options perpetuate the pushing-resisting of change and growth. People clarify value priorities and move on through powering. People affirm and do not affirm values in light of the reality of being–non-being.
2. *Originating* is about human uniqueness and the ways persons create their own becoming as they choose from all the possibles that could be. The paradox of conformity-nonconformity surrounds the concept of originating. People strive to be like others while simultaneously striving to be unique and different from others. In choosing how to become, people face both certainty and uncertainty as they change and move beyond the *now* moment. It is never possible to know all the consequences of choices, yet people can move on with great certainty of direction. Originating is known through the unique choices people make when facing alternatives, and the consequences of those choices.
3. *Transforming* is the third concept of the third principle. This concept represents a process of deliberately shifting one's patterns of health. The shift may be a choice to change one's attitude about a certain situation, or the shift may be a change in how one lives day-to-day routines or habits. The paradox familiar-unfamiliar is embedded in the process of transforming. When new ideas or situations are encountered, people logically look for connections to what they already know—to what is familiar. In this process of considering the unfamiliar in light of the familiar, people discover something new about themselves and make change or they may decide they do not like the new, in which case they may reject the idea or proposed change. People who decide to stop smoking or to leave a difficult relationship are transforming their patterns of becoming.

The shifting of patterns may also occur as individuals discover insights about themselves that were not previously apparent to them. Transforming is about integrating unfamiliar ideas or activities into one's life. The unfamiliar is woven with the familiar and becomes integrated within the unity and coherence of lived experience.

In summary, the three principles with their essential concepts form the knowledge base of the humanbecoming theory. This knowledge base is essential for nurses using humanbecoming to guide their practice. Parse (1998) states, "The art of living humanbecoming is guided by the theoretical principles that espouse the human as free agent and meaning-giver, choosing rhythmical patterns of relating while reaching for personal hopes and dreams" (pp. 68-69). Parse maintains that nursing is a service to others.

The Humanbecoming Practice Methodology

The essence of living humanbecoming is making a commitment to be truly present with others, to bear witness, and to participate with another's unique process of becoming (Mitchell, 2002a). Parse (1998) distinguishes between the goal of the discipline of nursing and the goal of the nurse living the humanbecoming theory. She states that the goal of the discipline is quality of life from the person's perspective, whereas the goal of the nurse living the humanbecoming theory is to be truly present with others as they experience their quality of life. Quality of life, from Parse's view, is the *whatness* that makes life what it is. It encompasses the meanings, feelings, and thoughts of life experiences (Parse, 1994). Parse (1998) says that "quality or whatness is the essence of something—in this case, the essence of life, the core substance that makes a life different and uniquely irreplaceable" (p. 69). From this understanding of quality of life, the nurse expresses a profound respect for each person's reality as it is expressed in the nurse-person process. Judgment about the person's reality, in any form, diminishes respect for that individual's quality of life and living.

Dimensions and Processes

Nurses live true presence with others with an awareness of and focus on the following dimensions and processes of the humanbecoming theory (Parse, 2008d, 2012a):

1. **Illuminating meaning** is explicating with remembering-prospecting. *Explicating* is making clear what is appearing now with the speech, silence, movement, and stillness of languaging.
2. **Synchronizing rhythms** is dwelling with the humanuniverse pitch, yaw, and roll. *Dwelling with* is immersing with the flow of connecting-separating.
3. **Mobilizing transcendence** is moving with the becoming visible-invisible becoming of the emerging now. *Moving with* is propelling with the possibles of transforming.

The dimensions and processes happen simultaneously when nurses are with individuals, families, or communities. Nurses guided by humanbecoming prepare

to be present with others through focused attentiveness on the moment at hand and through immersion (Parse, 1998). The knowledge base—meaning the beliefs specified in the principles of humanbecoming—prepares the nurse to be truly present with the person, family, or group. Nurses have opportunities to be with others and participate with them during times of change, struggle, upset, uncertainty, recovery, and hope. During these times nurses invite individuals to speak about their situations. In the telling, there are moments when insights are clarified, discoveries are made, and change is proposed as people see themselves and their situations in a new light.

Of critical importance for nurses is the understanding that people cannot be assessed, controlled, or manipulated by outsiders. The nurse has the privilege of being present to serve others; this service respects that every person is already living a process of complex unfolding—structuring meaning while configuring rhythmical patterns and co-transcending with possibles (Parse, 1981, 1998, 2007b, 2008a, 2012a,b). The nurse's participation with others as lived through true presence makes a difference to people, and this qualitative difference is the outcome of practice guided by humanbecoming.

Critical Thinking in Nursing Practice with Parse's Theory

A theory “is a structure for critical thinking, reasoning, and decision making in practice that provides a perspective of the person for whom the nurse cares and specifies the approach to be taken in the delivery of care” (Alligood, 1997, p. 32). The ability to reflect on and define coherence between knowledge and action is thus an indicator of critical thinking. Parse (1996a) states that “critical thinking...is carefully choosing a direction in light of personal tacit and explicit knowing...and choosing a direction is moving beyond the moment with deliberateness” (p. 139).

In this text, the history of a woman named Debbie is provided for consideration from different theoretical perspectives. As noted, the practice of nursing and the focus of discussions guided by humanbecoming do not follow the problem-solving process (assess, plan, implement). Rather, nurses live true presence with people to participate with the process of illuminating meaning, synchronizing rhythms, and mobilizing transcendence. Documentation of humanbecoming practice varies across settings. In general, however, the person's description of his or her health as well as plans, hopes, and concerns are recorded. A nurse guided by humanbecoming documents paradoxical patterns that a person expresses and the desired directions/actions identified by the person. The desired change or goal is defined by the person rather than by the nurse. The nurse's responsibility is to record the person's evaluation, ongoing concerns, preferred choices, and meanings as they surface in practice. The two situations described in the following case histories represent the humanbecoming theory as a structure for thinking, reasoning, and choosing direction with deliberateness. Readers are encouraged to note the description of Debbie's situation presented in Box 19-1 illustrating the humanbecoming-guided approach and compare it to the traditional nursing assessment that follows.

CASE HISTORY OF DEBBIE

Debbie is a 29-year-old woman who was recently admitted to the oncology nursing unit for evaluation after sensing pelvic “fullness” and noticing a watery, foul-smelling vaginal discharge. A Papanicolaou smear revealed class V cervical cancer. She was found to have a stage II squamous cell carcinoma of the cervix and underwent a radical hysterectomy with bilateral salpingo-oophorectomy.

Her past health history revealed that physical examinations had been infrequent. She also reported that she had not performed breast self-examination. She is 5 feet, 4 inches tall and weighs 89 pounds. Her usual weight is about 110 pounds. She has smoked approximately two packs of cigarettes a day for the past 16 years. She is gravida 2, para 2. Her first pregnancy was at age 16, and her second was at age 18. Since that time, she has taken oral contraceptives on a regular basis.

Debbie completed the eighth grade. She is married and lives with her husband and her two children in her mother’s home, which she describes as less than sanitary. Her husband is unemployed. She describes him as emotionally distant and abusive at times.

She has done well following surgery except for being unable to completely empty her urinary bladder. She is having continued postoperative pain and nausea. It will be necessary for her to perform intermittent self-catheterization at home. Her medications are (1) an antibiotic, (2) an analgesic as needed for pain, and (3) an antiemetic as needed for nausea. In addition, she will be receiving radiation therapy on an outpatient basis.

Debbie is extremely tearful. She expresses great concern over her future and the future of her two children. She believes that this illness is a punishment for her past life.

Nursing Care of Debbie with Parse’s Theory of Humanbecoming

The nurse guided by humanbecoming approaches Debbie with the intent to be truly present with her as she struggles with this critical life situation. Humanbecoming guides the nurse to approach Debbie with openness, as an unknowing stranger who has opportunities to bear witness to Debbie’s unfolding experience and to provide service as directed by Debbie as she lives her value priorities.

Practice with humanbecoming is a participatory experience in that the nurse’s choices in relation to speaking and acting are guided by Debbie as she expresses her concerns, issues, wishes, hopes, and desires. The three principles of humanbecoming underpin the beliefs that the nurse holds about Debbie and her situation. The nurse caring for Debbie holds the following three beliefs:

1. Debbie structures the meaning of her health experience. The meaning of Debbie’s situation will be co-created with her personal values, life experience, hopes, and fears. The nurse cannot know Debbie’s meaning until she

BOX 19-1**Debbie's Personal Health Description, Paradoxical Patterns of Becoming, and Their Related Nursing Actions**

Debbie says that her life is falling apart. She cannot think about anything except her children and what is going to happen to them. Debbie says that she is having a lot of pain, and she wants to be able to smoke a cigarette. She says that smoking is the only thing keeping her sane. Debbie wants to go home, but she also wants to stay in the hospital because it will give her a bit more time to sort things out. She cries as she thinks about her situation and says her greatest worry is whether her husband and mother will take care of her children. Debbie wants her children to stay with their father, yet she does not want them with him because she is afraid he will not be there for them as they get older. Debbie wonders if her mother should keep the children. She says that on some days she just wishes she could walk away from all of them, yet she does not want to live without them; they are all she has. "Now," says Debbie, "I have to deal with everything happening here—cancer, pain, and the push to get me out of the hospital. They want me walking and taking care of this tube when I do not know how much I can handle right now."

AREAS FOR FURTHER DISCUSSION WITH DEBBIE

1. Ask Debbie to say more about how she is feeling. Explore her concerns about the catheter and how she wants to work with it. Explore what it will mean for Debbie to be expected to care for her own catheter. Ask Debbie what topics she wants to know more about.
2. Explore Debbie's comment about having pain. Ask her to describe the pain, what helps it, what she would like to do about it, and how she would like to have assistance from the nurse/team.
3. Continue dialogue as directed by Debbie. Follow up on her concerns. Provide assistance and information as she directs.
4. Take any opportunity to be present with Debbie's family. Explore their concerns, issues, hopes, and how they are doing.
5. Identify paradoxical patterns and explore them with Debbie as illustrated below.

PARADOXICAL PATTERNS

Debbie wants to go home,
yet she wants more
time in the hospital

NURSING ACTIONS

Explore Debbie's wish to go home: what she sees happening at home with her care, what help she thinks she will need at home. Explore her desire for more time in the hospital. Seek depth and clarity about all her issues, concerns, and needs. Explore what Debbie thinks will help her at this time. Follow up with her requests and/or issues.

DEBBIE'S EVALUATION

Two days later Debbie says she is glad she is still in the hospital, especially because they discovered that she has a bladder infection, and now she must take antibiotics. She says she is still sad and worried. Debbie also says she feels somewhat better because she spoke with her mother and they have agreed to talk about how best to care for the children while Debbie is ill. Debbie says she is ready to go forward day by day and has no desire to look beyond tomorrow.

has the chance to bear witness with its unfolding in practice. The meaning of the situation will be languaged by Debbie in her patterns of speaking-being-silent and moving-being-still. As she speaks about her situation, the meaning of the moment will be explicated for both Debbie and the nurse. The nurse believes that as Debbie speaks about the meaning that she is giving to her situation, there will be opportunities for Debbie to discover something new, something not explicitly known before. The discovery might be an insight that changes how Debbie looks at her situation, or it may lead her to a decision to choose a plan or to learn something new. Such opportunities for explicating meaning and discovering something new are created as nurses live true presence with others.

2. Debbie lives her becoming in paradoxical patterns that involve others in her life. Debbie reveals and conceals her values as she connects and separates with others and with ideas in the enabling-limiting process of moving beyond. This means that the nurse is open to hear about how Debbie relates with others, how she views the value of her relationships and activities, whether and how she would like to change them, and the opportunities and restrictions she sees for herself. The nurse believes that if she goes with the flow of Debbie's exploration of paradoxical patterns, there will be opportunities for insight and plans for change, if that is what Debbie wants. The nurse believes that change and learning are chosen by persons themselves and that the nurse's unconditional regard and respect for this choosing enhances clarity and the discovery of new possibles.
3. In the process of co-transcending with possibles, Debbie finds ways to move with the reality of her life situation. Debbie's way of being with the situation is a unique expression of her humanbecoming. Unique ways of being with and moving cannot be dictated by others. The nurse believes that Debbie's expressed concern for the future of her children is a place to invite additional discussion about her concerns and the possibilities she sees as she looks to the not-yet.

The practice dimensions and processes—*illuminating meaning* through explicating with remembering-prospecting, *synchronizing rhythms* through dwelling with the flow of connecting-separating, and *mobilizing transcendence* through moving with the becoming visible-invisible becoming of the emerging now (Parse, 2012a,b)—guide the nurse to be present as Debbie speaks about her meanings, concerns, and issues, as she sees them. The nurse will be with Debbie as she explores her situation and as she considers her options. The nurse does not judge or label Debbie. For instance, when Debbie states that she believes her illness is a punishment for her past life, the nurse accepts this belief and asks Debbie to say more about it. Regardless of what the nurse might think of this belief, humanbecoming guides the nurse to respect that Debbie has expressed it and to view it as an opportunity to further explicate the meaning she has chosen. The nurse does not judge Debbie for her smoking or for any other decisions she has made in life. The opportunity with humanbecoming practice is to invite disclosure, exploration, and clarification in whatever way Debbie chooses. It is Debbie's life, and any attempt by the nurse to control or manipulate Debbie would violate the principles of the humanbecoming theory.

For the nurse guided by humanbecoming, the information provided about Debbie with respect to her education, her home situation, her care, and her progress following surgery would all be explored from Debbie's perspective. From the stance of Parse's theory, the statements made about Debbie and her choices in life have no usefulness on their own. In the course of day-to-day care, the nurse would explore Debbie's experience of pain, her thoughts about going home, her priorities for learning, and her plans for change in light of her situation as she sees it. From these discussions, specific nursing activities that flow from and address the issues that Debbie identifies as important for her would be developed.

It is essential to note the subtle but important difference between a nurse who makes recommendations and suggestions based on his or her values and a nurse who invites the person to lead this process of discussing issues, needs, and possibilities. The reality is that when nurses invite others to clarify their concerns and possibilities, a different experience unfolds. Until this happening is experienced or witnessed in practice, it is difficult to appreciate. For instance, some nurses might ask Debbie whether she has thought about quitting smoking. A nurse guided by humanbecoming would learn about Debbie's view of smoking and whether change is possible given her values and life situation. However, the humanbecoming nurse would not target smoking unless Debbie identified it as an area of concern. The humanbecoming nurse might ask Debbie questions such as the following:

- What is this situation like for you?
- What is most important for you?
- Who is most important to you at this time?
- How would you like to change your situation?
- What information might be helpful to you?
- What concerns you most?
- What are your hopes and dreams?

The nurse who is guided by humanbecoming trusts that people will ask the questions and seek the information that they need to move on and that they will seek answers from the nurse when they are ready to engage that information. Based on Debbie's descriptions, a plan of care based on her priorities and wishes would be constructed. The nurse's documentation would reflect Debbie's personal health description as it was revealed in discussion with the nurse. The nurse might ask Debbie what she wants the health care team to know about her and what she wants recorded in her chart. Nursing actions flow from Debbie's areas of interest or concern, and the effectiveness of nursing practice would be evaluated by asking Debbie to comment on her satisfaction with care. For the purpose of enhancing understanding of the humanbecoming theory, a personal health description and patterns of becoming are presented in Box 19-1 as they might have happened with Debbie.

Humanbecoming nursing practice complements the medically driven aspects of health care for which many nurses hold responsibility. Completing tasks or assessing vital signs do not detract from the opportunities to practice nursing in relationships with others. From the humanbecoming perspective, nursing is a basic science that complements the practices of other health professionals. This means that a nurse will follow best clinical practices when completing physical assessments or complex treatments and procedures and will practice according to a nursing

theory that is radically different from medicine. The for-better-or-for-worse of nursing happens as nurses live their values and beliefs with individuals and families.

Humanbecoming-guided practice does not take more time, although some nurses find they spend their time differently after they see the difference this practice makes in the lives of clients. Surprisingly, nurses who choose to live true presence and to study humanbecoming do so in the same places (e.g., hospitals and other settings) and with all the same pressures regarding performance and efficiency as do nurses who practice in traditional ways (Bournes & Ferguson-Paré, 2007; Bournes & Naef, 2006; Mitchell, et al, 2006). Nurses describe instances when they were more vigilant and attentive to the concerns expressed by patients. In several situations, nurses describe how they sought medical intervention earlier than they would have if not guided by humanbecoming. The differences with humanbecoming-guided practice happen in the messages given and taken, in the words spoken and not spoken, and with the intent to be present with another without judgment or expectation. Living the art of nursing, as defined in the Humanbecoming School of Thought, is not easier than traditional nursing. Indeed, it calls for critical thinking, courage, and maturity. However, the theory offers a repeating pattern of meaningful nursing practice. Individuals, families, and groups let nurses know in many different ways that their humanbecoming practice makes a difference. In the following section Mr. Frank expresses what it meant for him to work with a nurse who was guided by humanbecoming.

CASE HISTORY OF MR. FRANK

Mr. Frank was referred to an advanced practice nurse for education and follow-up regarding a diagnosis of diabetes and the initiation of medication to control his blood glucose level. The nurse introduces herself and welcomes Mr. Frank before inviting him to tell her about the reason for his visit.

Mr. Frank's Personal Health Description

Mr. Frank says that he has always had high sugar, but this past year the doctor tells him it is staying too high, so medication will be necessary. He says that things are pretty good overall, but he sees himself slowing down and feels a bit tired since his wife died more than 3 years ago. He smiles as he comments that doing her work is too hard on him. Mr. Frank uses a cane to get around. He says that is a bit difficult for him because the cane is a nuisance, but he is glad to have it because it helps him stay on his feet.

Mr. Frank says that his main concern is that he sometimes cannot remember where he is going or what he is doing. His daughter called the police two times to find him because he did not return to his apartment at the expected time. Mr. Frank says he was very embarrassed and worried with the attention from police, and he knows that his daughter is upset with him and is talking about putting him in a nursing home. Mr. Frank shakes his head and says that he cannot believe he is being treated like some kind of criminal.

Continued

CASE HISTORY OF MR. FRANK—cont'd

Mr. Frank says that he knows he must take pills for his blood sugar and that, other than a bit of food, he is not in need of anything. Because he does not bother anyone else, he does not see why anyone should bother him. He says he wants to live but also that he would rather be dead than go to a nursing home. He is thinking about locking himself in his apartment if anyone tries to make him leave. The nurse asks him what would happen if he locked himself in his apartment. He hesitates before saying that his daughter would probably call the police; they would break down the door; and then he might be in real trouble. Mr. Frank sighs and says that maybe it would not be too bright to lock himself in his apartment.

Nursing Care of Mr. Frank with Parse's Theory of Humanbecoming

The nurse asks Mr. Frank what he wants to have happen. He indicates that he wants to get his blood sugar levels under control and keep living in his apartment. The nurse then asks Mr. Frank how he might accomplish those things. He establishes the following plan for himself:

- Keep a record of my blood sugar reading every morning.
- Take one pill a day as ordered by the doctor.
- Follow diet unless it is necessary to eat more.
- Talk to my daughter about staying in my apartment.
- Find out about eating the right food.
- Try to keep track of time so that my daughter does not need to call the police.

Over time, the nurse continues to help Mr. Frank meet the goals on his list and asks whether he is satisfied with his progress. The nurse explores with Mr. Frank the issues he describes as most important—wanting to live in his own apartment, getting his blood sugar levels in order, and remembering things. During the next visit Mr. Frank says that he has not yet talked to his daughter, but that he really wants to talk to her. The nurse goes with his struggle of deciding when to speak with his daughter. The nurse asks him what he wants to say to her and where and when he thinks it would be best to talk to her. Mr. Frank says he can picture himself talking to her, but he is worried that she will get upset. The nurse asks Mr. Frank what will happen when she gets upset and how he thinks he will be at that time.

During the next visit with the nurse, Mr. Frank reports his blood sugar is staying between 5 and 10 mmol/L, which he thinks is great. Mr. Frank also states that he spoke with his daughter, and he smiles as he tells the nurse that they had a talk, that she did not get upset, and that she is going to spend some more time with him. Then Mr. Frank says that if it had not been for the nurse helping him, he would not have talked to his daughter. He said the nurse helped him find the way to talk to her, and now he is not so worried about going to a nursing home.

Conclusion

These moments with Debbie and Mr. Frank represent a portion of a practice that is complex and challenging to capture with mere words on paper. The nurse guided by humanbecoming lives true presence and invites the person's participation in a different way, as the person co-authors his or her health and quality of life. Even people who cannot speak or who live with mental illness or cognitive impairment experience true presence in ways they describe as helpful, wonderful, meaningful, different, uplifting, and special. Practicing with humanbecoming may appear and sound predictable and even seem like the use of common sense, but it requires a deep level of thought and compassionate commitment to promotion of human dignity.

CRITICAL THINKING EXERCISES

1. The following are questions for reflection on your personal values and beliefs about nursing: What is most important for you in your nursing practice? How do you know you make a difference with clients? What do you want clients to remember about you as a nurse? What kind of nurse would you want for yourself, or for your loved ones?
2. Considering the assumptions and principles of the humanbecoming school of thought and the postulates of humanbecoming—illimitability, paradox, freedom, and mystery; examine your own beliefs for congruence or lack of congruence with the essential beliefs of humanbecoming. Write about what you have learned.
3. Review the health descriptions of Debbie and Mr. Frank and identify how you would have interacted with each of them in your practice. Examine your rationale for practice decisions with these two clients.
4. Reflect on your current practices in light of the dimensions and processes of humanbecoming practice. Consider the following: What is your main purpose or primary focus during discussions with clients? What do you hear yourself saying to people? What do your statements and questions tell you about your beliefs as a nurse? What are the primary messages you believe you are giving to clients in your practice?
5. Select a person and make a conscious intent to be with the person and understand his or her reality. Ask the person open-ended questions such as "How are things going?" or "What are your concerns about this situation?" As the person describes his or her reality, ask questions that seek depth and clarity without summarizing, making suggestions, interpreting, or leading the discussion. (This may take practice.) What did you learn about the person? What did you learn about yourself?

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Newman's Theory of Health as Expanding Consciousness in Nursing Practice

Janet Witucki Brown and Martha Raile Alligood

Nurses practicing within this perspective experience the joy of participating in the transformation of others and find that their own lives are enhanced and transformed in the process of the dialogue.
(Newman, 2008, p. 29)

History and Background

The first published version of Newman's theory appeared in her book *Theory Development in Nursing* (Newman, 1979). In this early writing, Newman presented a viewpoint of health as a dialectic fusion of disease and nondisease, thus encompassing disease as a meaningful aspect of the totality of life experience. This viewpoint of health was developed as a result of two influences: (1) Newman's early experiences of her mother's 9-year struggle with amyotrophic lateral sclerosis, during which time Newman came to realize that an individual may be whole even though illness is present; and (2) Newman's exposure to Martha Rogers' work, which assisted her in conceptualizing health and illness as a single unitary process (Newman, 1986).

Evolution of the conceptualization of Health as Expanding Consciousness (HEC) was influenced theoretically by several sources. Bentov's (1977) explanation of the evolution of consciousness, Moss's (1981) view of love as the highest level of consciousness, Bohm's (1980) theory of implicate order, de Chardin's (1959) belief that consciousness continues to develop beyond physical life, and Young's (1976) stages of human development all contributed to Newman's ability to synthesize her thoughts and experiences into a cohesive and meaningful theory (Newman, 1994a). The Theory of HEC evolved from a synthesis of these theoretical influences with Newman's own life experiences and thoughts.

Early application of this theory isolated and manipulated the theory concepts of space, time, and movement. Newman explored effects of changes in rates of walking on time perception in two studies (Newman, 1972, 1976) and the relationship between age, movement, and time perception of elders in another study (Newman, 1982). As work and research with the developing theory progressed, Newman discovered that research involving a person's pattern identification and the sharing of patterns with a person was nursing practice and that the research produced a therapeutic outcome. She noted "our participation in the process made a difference in our own lives. We suspected that what we were doing in the name of research was nursing practice" (Newman, 1990a, p. 37). Research began to be viewed as praxis. Theory, research, and practice are seen as one inseparable process (Newman, 1990a,d). The professional nurse is viewed as a therapeutic partner who joins with the client in the search for pattern with its accompanying understanding and impetus for growth (Newman, 1987a).

Newman (1990a) developed a practice methodology of pattern identification and research/practice process. This method reveals sequential patterns of persons' lives and facilitates recognition and insight into patterns. Authentic involvement of the nurse-researcher in the movement toward higher consciousness is emphasized. The theory and methodology have provided a basis for research/practice in a variety of clinical settings with diverse client populations for exploring and understanding the experience of illness to individuals and families.

The theory research or practice application has been used with cancer patients (Barron, 2005; Endo, 1998; Endo, Nitta, Inayoshi, et al., 2000; Kiser-Larsen, 2002; Newman, 1995b; Roux, Bush, & Dingley, 2001); elderly women with chronic disease (Kluge, Tang, Glick, et al., 2012); black-Caribbean women (Peters-Lewis, 2006); menopausal women (Musker, 2005); persons with coronary heart disease (Newman & Moch, 1991); dementia (Ruka, 2005); human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) (Lamendola & Newman, 1994); multiple sclerosis (Neill, 2004); rheumatoid arthritis (Neill, 2002); and spousal caregivers (Brown, 2011; Brown & Alligood, 2004; Brown, Chen, Mitchell, et al., 2007). Other groups that have been studied with the Theory of HEC include adolescent males incarcerated for murder (Pharris, 2002); depressed adolescents (Kweon & Lee, 2009); persons living with chronic skin wounds (Rosa, 2006); individuals with hepatitis C (MacNeil, 2012; Thomas, 2002); midlife women (Picard, 2000); and women who lose weight and successfully maintain weight loss (Berry, 2004). Further studies include family members following the death of a child (Picard, 2002; Weed, 2004); the transformative experience of Japanese and Canadian primary family caregivers of relatives with schizophrenia (Yamashita, 1998, 1999); and patterns of families with special-needs children (Falkenstern, 2003; Tommet, 2003).

Pharris (2002, 2005) advocated application of the theory to individuals, families, and communities. The theory has been applied to nursing management at Carondelet St. Mary's Hospital and Health Center in Tucson, Arizona (Newman, Lamb, & Michaels, 1991). Flannagan (2005) and colleagues (Flannagan, Farrell, Zelano, et al., 2000) developed a Preadmission Nursing Practice Model (PNPM) based on the theory. In further educational use, Picard and Mariolos (2002) reported using the theory teaching psychiatric nursing students. Recent global use

of Newman's theory is reflected in publications by nurses worldwide (Dyess, 2011; Kluge, et al., 2012; Kweon & Lee, 2009; MacNeil, 2012; Rosa & Suong, 2009; Yang, Xiong, Vang, et al., 2009) to list a few.

Overview of Newman's Theory of Health as Expanding Consciousness

In the early development of the theory Newman asserted that the phenomena of inquiry for nursing should be parameters of human wholeness and that there were characteristics of people that identified the whole (Newman, 1979). Time, space, and movement were identified by Newman as dimensions of pattern and consciousness and have been synthesized as the theory evolved to include the major concepts of health, consciousness, and patterns of movement and space-time.

Health

Newman's theory proposes a view of health as a unidirectional, unitary process of development (Newman, 1991). She acknowledges that Rogers' (1970) *Science of Unitary Human Beings* was a major influence in development of the Theory of HEC. In Newman's theory, health is an expansion of consciousness that is defined as the informational capacity of the system and is seen as the ability of the person to interact with the environment (Newman, 1994a). Disease is a meaningful reflection of the whole and, as such, is viewed as a manifestation of health. Disease and non-disease are not separate entities but are dialectically fused into health as a pattern of the whole. According to Newman (1999), "Health is the pattern of the whole, and wholeness is. One cannot lose it or gain it" (p. 228). Disruptions in patterns of human beings, such as disease or catastrophic life events, often become catalysts that potentiate unfolding of life processes that individuals naturally seek, thereby facilitating movement from one pattern of consciousness to another and transformation into order at a higher level—or expanded consciousness (Newman, 1997).

Consciousness

Consciousness is defined in the theory as the informational capacity of the system (human beings) or the system's ability to interact with the environment (Newman, 1990a). Newman asserts that an understanding of her definition of consciousness is essential to understanding the theory. Consciousness includes not only cognitive and affective awareness but also the "interconnectedness of the entire living system, which includes physiochemical maintenance and growth processes as well as the immune system" (Newman, 1990a, p. 38). Consciousness is further conceptualized as co-extensive in the universe and as the essence of all creation. Interaction, then, occurs openly, constantly, and instantaneously throughout the entire spectrum of consciousness (Newman, 1994a). The person does not just possess consciousness but is consciousness, as is all matter. The highest level of consciousness is absolute consciousness, which Newman equates with love that "embraces all experience equally and unconditionally" (Newman, 1994a, p. 48).

Movement through levels of consciousness occurs continuously and unidirectionally in stages and does not occur smoothly but rather in response to major

disorganization and disharmony. Newman drew from Prigogine's (1980) Theory of Dissipative Structures and Young's (1976) conceptualization of the evolution of human beings to describe the levels of consciousness in her theory and the dynamics of movement from one level to another. Figure 20-1 depicts the parallel between Newman's theory of expanding consciousness and Young's stages of human evolution. According to Newman, "We come into being from a state of potential consciousness, are bound in time, find our identity in space, and through movement we learn the 'law' of the way things work and make choices that ultimately take us beyond space and time to a state of absolute consciousness" (Newman, 1994a, p. 26). Within the theory, physical self-development binds one in time and space as one develops and establishes personal territory (stages two and three). Movement provides a way of controlling the personal environment and represents a choice point (stage four). When movement is restricted, as with illness or physical disability, "one becomes aware of personal limitations and the fact that the old rules don't work anymore" (Newman, 1990a, p. 39), and one experiences the disconnectedness, disorder, and disequilibrium that are precursors to moving to a higher level of consciousness. Transcendence (stage five)—or expansion of boundaries of self and awareness of broader life possibilities—occurs in response as new order is established at a higher level (Newman, 1994a). New ways of relating are discovered, and the freedom that comes with transcending old limitations is discovered (Newman, 1990d). The highest levels of consciousness occur at the sixth stage, in which timelessness occurs, and in the seventh stage, which is absolute consciousness.

Pattern

Pattern has dimensions of movement and space-time. It is constantly moving unidirectionally and evolving and may be enfolded in a larger pattern that is in the process of unfolding. Using Rogers' (1970) conceptualization of pattern, Newman (1986) states, "Pattern is information that depicts the whole, understanding of the

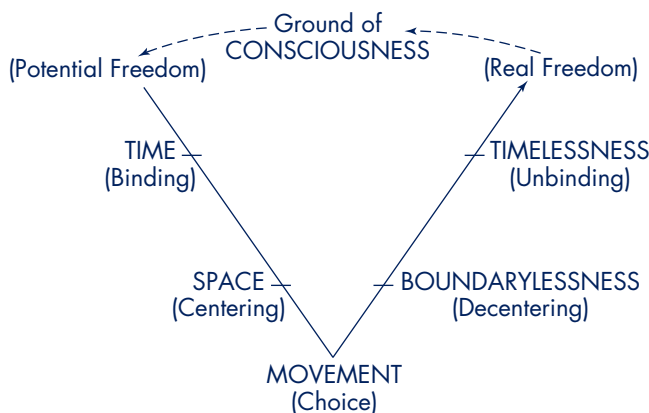


FIGURE 20-1 Parallel between Newman's Theory of Health as Expanding Consciousness and Young's stages of human evolution. (From Newman, M. A. [1990]. Newman's theory of health as praxis. *Nursing Science Quarterly*, 3[1], 37-41, with permission from Sage Publications.)

meaning and relationships at once. It is a fundamental attribute of all there is and gives unity in diversity” (p. 13). Pattern is also a characteristic of wholeness and reveals the meaning of life (Newman, 1999). According to Newman (1987b), “Whatever manifests itself in a person’s life is the explication of the underlying implicate pattern...the phenomenon we call health is the manifestation of that evolving pattern” (p. 37). This phenomenon also includes concepts of health and disease.

Time, as a dimension of pattern, is conceptualized as either subjective or objective and also is viewed in a holographic sense. According to Newman (1994a), “Each moment has an explicate order and also enfolds all others, meaning that each moment of our lives contains all others of all time” (p. 62). Further, time is considered an index of consciousness (Newman, 1983) because as consciousness expands, space-time transcends limitations of linear and physical boundaries to extend beyond what is the here-and-now. However, what is truly important is that one be fully present in the moment knowing that all experiences are manifestations of the process of evolution to higher consciousness (Newman, 1994a).

Time and timing are further described as a function of movement (Newman, 1983) and part of the rhythm of living (Newman, 1994a). Time has importance in revealing patterns because extending the time frame helps nurses and patients recognize patterns and reorganizing activities (Newman, 1994a). Temporal pattern synchronicity between human beings and health care workers is also important to receptivity and health because these patterns are highly individualistic and influence how people respond to each other. Nurses who attempt to practice within this theoretical framework must be sensitive to synchronize their rhythms with those of clients with whom they are working. Newman refers to this as “the rhythm of relating” (1999, p. 227) and states that it is an indicator of the pattern of interacting consciousness. By attuning themselves to the rhythms of others, nurses assist individuals to identify patterns and move to higher levels of consciousness.

The dimensions of space and time are complementary and inextricably linked to each other as space-time or time-space, with time being increased as one’s life space decreases (Newman, 1979, 1983). Space has further been identified as life-space, personal space, and inner space (Newman, 1979), with personal space or territory very much involved in a person’s struggles for self-determination and status (Newman, 1990a). As consciousness expands, the distinction between the self and the world becomes blurred as one recognizes that essence extends “beyond the physical boundaries and is in effect boundarylessness, as one moves to higher levels of consciousness” (Newman, 1994a, p. 47).

According to Newman (1994a), movement is a reflection of consciousness, indicates inner organization or disorganization of people, and communicates the harmony of a person’s pattern with the environment. It is integral to relationships and “is a means whereby time and space become a reality” (Newman, 1983, p. 165). Rate of movement is seen as a reflection of pattern (Newman, 1995b). Space, time, and movement are linked. In fact, “the intersection of movement-space-time represents the person as a center of consciousness and varies from person to person, place to place, and time to time” (Newman, 1986, p. 49). When natural movement is altered, space and time are also altered. When movement is restricted (physically or socially), it is necessary for one to move beyond oneself,

thereby making movement an important choice point in the process of evolving human consciousness (Newman, 1994a).

The evolution of consciousness is identified by patterns of increased quality and diversity of interaction with the environment (Newman, 1994a). Wholeness is identified in patterns of dynamic relatedness with one's environment (Newman, 1999). Expanding consciousness is seen in the evolving pattern, and episodes of pattern recognition are turning points in the process of an individual evolving to higher levels of consciousness. Newman states that an individual's current pattern is a composite of "information enfolded from the past and information which will unfold in the future" (Newman, 1990a, p. 39). Viewing this pattern in relation to previous patterns represents an opportunity for new action and expansion of consciousness.

Critical Thinking in Nursing Practice

From Newman's perspective, nursing is the study of "caring in the human health experience" (Newman, Sime, & Corcoran-Perry, 1991, p. 3). The responsibility of the professional nurse is to establish a primary relationship with the client for the purpose of identifying meaningful patterns and facilitating the client's action potential and decision-making ability. Newman emphasizes that the essence of the process is to be fully present in the transformation of clients and ourselves as we search for meanings in the lives of those who come to us at critical junctures of their lives (Newman, 2008). The nurse's presence assists clients to recognize their own patterns of interacting with the environment. Insight into these patterns provides clients with illumination of action possibilities, which then opens the way for transformation to occur (Newman, 1990a). There is authentic involvement of the nurse with the client and mutuality of the interaction in discovering the uniqueness and wholeness of the unfolding pattern in each client situation and movement of the life process toward expanding consciousness (Newman, 2008).

The nurse-client relationship is characterized by "a rhythmic coming together and moving apart as clients encounter disruption of their organized, predictable state and moving through disorganization and unpredictability to a higher, organized state" (Newman, 1999, p. 228). The nurse unites with clients at these critical choice points in their lives and participates with them in the process of expanding consciousness. The relationship is one of rhythmicity and timing. The nurse surrenders the need to direct the relationship or to "fix" things. As the nurse relinquishes the need to manipulate or control, there is a greater ability to enter into this fluctuating, rhythmic partnership with the client (Newman, 1999). Sensing into the whole requires a sensing into oneself, and a sense of stillness or centering is helpful to the process. Newman (1995b) elaborates, "The way to get in touch with the pattern of the other person is to sense into one's own pattern" (p. 88). The nurse resonates with the client and is fully present and in "sync" with the client to facilitate formation of shared consciousness in what has been described as a dance of empathic relating (Newman, 1999). As the nurse dialogues and shares impressions and feelings with the client, pattern recognition occurs. Nurses make holistic observations of "person-environment behaviors that together depict a very specific

pattern of the whole for each person” using terminology from individuals’ own stories and patterns (Newman, 1995a, p. 261). Descriptions of the total pattern of the person are then presented as sequential patterns over time (Newman, 1990b). The emphasis of the process is “on knowing/caring through pattern recognition” (Newman, 2008, p. 10). Figure 20-2 is Newman’s (2008) diagram of the nurse and patient coming together and moving apart in the process that includes recognition, insight, and transformation.

Newman (2008) has outlined the process (praxis) that involves a merging of the a priori Theory of HEC, research, and practice. The following steps are included in the process:

1. Engagement with the client/participant (CP), in which the emphasis is on the unfolding pattern of the CP’s life
2. Development of the narrative, in which the nurse notes the most important statements of the CP to form a trajectory of the most significant relationships and identifies sequential patterns over time, writing and diagramming the patterns
3. Participation in follow-up meeting(s), in which the nurse shares the data with the CP without interpretation for the CP to confirm or revise and insight occurs

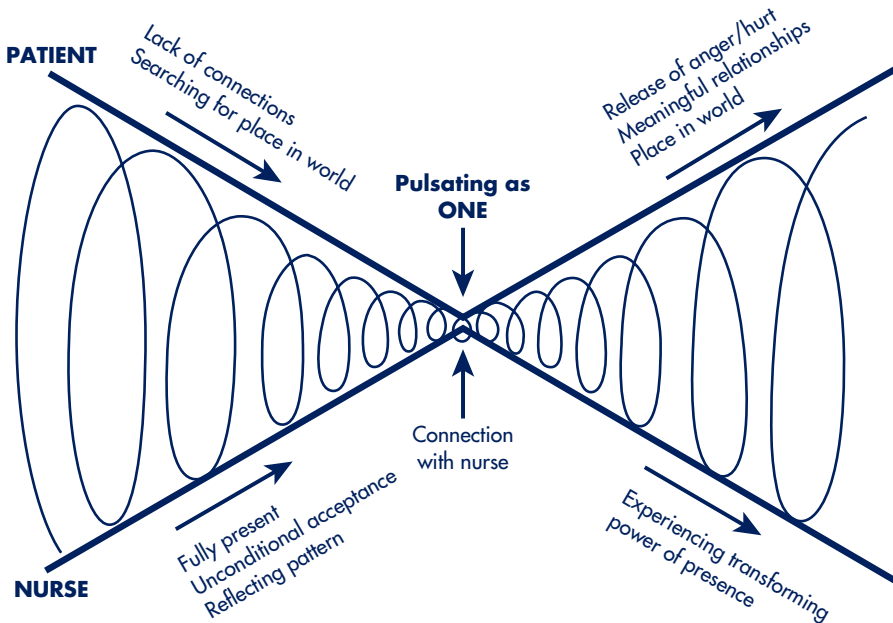


FIGURE 20-2

Nurse and patient coming together and moving apart in process recognition, insight, and transformation. (From Newman, M. A. [2008]. *Transforming presence: The difference that nursing makes* [p. 35]. Philadelphia: F. A. Davis.)

4. Application of the theory, in which, although the theory is active throughout the encounter, the nurse uses post-encounter analysis in relation to the Theory of HEC and notes transformational changes
5. Identification of reciprocal family and community patterns

Table 20-1 depicts critical thinking in nursing practice using the elements of this method. Pattern recognition occurs with a burst of insight when everything fits together and the client can see clearly. Through this heightened understanding, the pathways for action unfold and open up, and one can take action (Newman, 1995b). The action indicated in response to pattern identification becomes apparent only as the pattern becomes apparent and the client discovers the new rules that apply to the situation (Newman, 1989). It is different for every situation. When pattern recognition occurs, clients sense that nurses know them and are able to assist in facilitating desired changes in their lives (Newman, et al., 1991). The client resonates with the nurse through the period of chaos and disequilibrium until a new rhythm emerges from the client's center of consciousness (Newman, 1999). The nurse and client move apart, each having been transformed by the process (Newman, 2008).

Nurses practicing within the Newman framework are involved in a relationship process that co-evolves as a function of the interpenetration of evolving fields of the nurse, client, and environment in a self-organizing and unpredictable way (Newman, 1994b). By being open to whatever arises in the interaction with the

**TABLE 20-1 Critical Thinking and Newman's Theory
(Elaboration of Application)**

| Element | Nursing Action/Interaction |
|---|--|
| Engaging with the client/participant (CP) | Recognizes disequilibrium in client as a choice point. Prepares for interaction with client. Shares perception of need for nurse-client interaction and relationship with client. Opens self and grows with client. Shows unconditional acceptance of client experience. Becomes truly present with client as nurse and client fields interface and interpenetrate. |
| Development of the narrative | Examines client's story in terms of patterns of relating at critical points in time and diagrams pattern to facilitate pattern identification. |
| Follow-up meeting(s) | Facilitates client recognition of pattern by sharing perceptions and patterns of relating in diagrammatic form. Supports client unconditionally as insight into pattern occurs. Respects client choices in response to pattern recognition. Provides assistance to client in implementing choices as client requests. Recognizes client gaining independence and gauges support accordingly. |
| Application of the theory | Revisits data from encounters in relation to Theory of Health as Expanding Consciousness, seeking support of the theory. Notes transformational changes that occurred for both the CP and the nurse. |
| Family and community pattern | Recognizes and identifies that individual patterns have reciprocal patterns in environment, including family and community. |

client in an unconditional acceptance of the client's experience, the nurse in this process is fully present and is in sync with clients to facilitate forming of shared consciousness. Personal meaning becomes the main focus of nurse-client collaboration and mutuality (Newman, 1990c). Nurses address the clients' agendas and are fully present with them, attending to what was important to them, what choices they are facing, and how the unfolding of those choices will take place. Clients become engaged in viewing and managing their health in creative ways (Newman, et al., 1991).

CASE HISTORY OF DEBBIE

Debbie is a 29-year-old woman who was recently admitted to the oncology nursing unit for evaluation after sensing pelvic "fullness" and noticing a watery, foul-smelling vaginal discharge. A Papanicolaou smear revealed class V cervical cancer. She was found to have a stage II squamous cell carcinoma of the cervix and underwent a radical hysterectomy with bilateral salpingo-oophorectomy.

Her past health history revealed that physical examinations had been infrequent. She also reported that she had not performed breast self-examination. She is 5 feet, 4 inches tall and weighs 89 pounds. Her usual weight is about 110 pounds. She has smoked approximately two packs of cigarettes a day for the past 16 years. She is gravida 2, para 2. Her first pregnancy was at age 16, and her second was at age 18. Since that time, she has taken oral contraceptives on a regular basis.

Debbie completed the eighth grade. She is married and lives with her husband and her two children in her mother's home, which she describes as less than sanitary. Her husband is unemployed. She describes him as emotionally distant and abusive at times. She has done well following surgery except for being unable to completely empty her urinary bladder. She is having continued postoperative pain and nausea. It will be necessary for her to perform intermittent self-catheterization at home. Her medications are (1) an antibiotic, (2) an analgesic as needed for pain, and (3) an antiemetic as needed for nausea. In addition, she will be receiving radiation therapy on an outpatient basis.

Debbie is extremely tearful. She expresses great concern over her future and the future of her two children. She believes that this illness is a punishment for her past life.

Nursing Care of Debbie with Newman's Theory

The nurse working within the Newman theory focuses on assisting Debbie with pattern recognition. From the brief case history we do not know what Debbie's patterns of relating have been or currently are because information of this type can only be obtained from the nurse-client interrelationship. However, insight that Debbie experiences as a result of the nurse-client relationship will open new opportunities for action and interaction. Nursing care will involve establishing a rhythm of relating (Newman, 1999), during which both the nurse and Debbie become transformed as pattern recognition occurs and as consciousness expands.

Engaging with the Client/Participant

The nurse working with Debbie recognizes Debbie's illness and surgery as a period of disruption and disorganization that represents a critical life choice point with a corresponding action potential for expanding consciousness. In preparation for beginning a relationship with Debbie, the nurse could use centering meditation as suggested by Picard, Sikul, and Natale (1998) to foster the capacity to be fully present. The nurse further uses self-reflection to examine personal values and beliefs that may affect the ability to unconditionally accept and share Debbie's experience. These personal values and beliefs are identified and set aside. Finally, the nurse approaches Debbie and shares his or her perception of the need to mutually examine Debbie's past life experiences to illuminate possible future options and actions.

The nurse asks Debbie to describe the most meaningful events and people in her life. During this storytelling process that is guided by Debbie in a nondirective manner, the nurse opens self and grows with Debbie through nonjudgmental acceptance. The nurse empathically communicates in harmonic resonance and synchronization by "attending to the rhythm created by the silence between the signals" (Newman, 1999, p. 227). The focus is on the meaning of Debbie's evolving pattern. Through connecting and resonating with Debbie as they discuss meaningful life events and persons—such as health practices, pregnancies, the cancer and surgery, and relationships with her husband, mother, children, and others—patterns become apparent. Emphasis is placed on assisting Debbie to recognize her disease as a transformative opportunity to understand better and realize a fuller sense of self. The nurse's feelings are shared with Debbie during the interactions. Debbie determines the pace and frequency of interactions between herself and the nurse.

Development of the Narrative

The nurse notes the most important statements that Debbie makes and arranges them in chronological order to form a narrative trajectory of Debbie's most significant relationships. The importance of those relationships, choices, activities, and ways of relating is explored to identify past and present patterns of interacting. These patterns are then arranged sequentially over time to demonstrate the pattern of the whole. Past and present patterns are diagrammed to depict periods of disruption and key experiences. A narrative may be written to explain the diagram.

Follow-up Meetings

The nurse shares pattern perceptions and feelings in narrative and diagrams with Debbie, without interpretation, in a nonjudgmental manner, concentrating on the present flow of interactions that reveal and suggests areas where attention may be needed to facilitate interaction between Debbie and her environment. Diagramming and sharing Debbie's patterns of relationships help her identify blocks to communicating and interacting. Debbie clarifies or revises any areas that are needed. As Debbie gains insight into her past and present patterns of interacting, new possibilities emerge and she shares these with the nurse. The nurse assists Debbie to explore options that have become apparent, provides her with information, and arranges for referrals or other support that Debbie may need to implement her choices. Regardless of Debbie's choices, the nurse unconditionally supports her. The shared rhythm

and connectedness between the nurse and Debbie continues until a new pattern emerges from Debbie's own center of consciousness. When the chaos and disequilibrium of this major life event have been incorporated into the pattern of the whole and Debbie has moved to a higher level of consciousness, Debbie determines that the nurse-client relationship is no longer necessary. There is a mutual agreement to terminate the relationship. Both Debbie and the nurse have been transformed.

Application of the Theory

The nurse revisits the data from her encounters with Debbie in relation to the Theory of HEC, seeking support of the theory. The nurse also notes transformational changes that occurred for both the CP and the nurse.

Family and Community Pattern

The nurse recognizes that individual patterns have reciprocal patterns in environment, including family and community. These reciprocal, common family and community patterns are identified.

CASE HISTORY OF CHARLOTTE

Charlotte is an 86-year-old woman caring for her 88-year-old husband, who was diagnosed with Alzheimer's disease 5 years ago. She has been diagnosed with macular degeneration and has undergone experimental surgery to attempt to correct this problem in her left eye. The vision in the surgically treated eye has not yet improved, and there is uncertainty about whether it will improve at all. Charlotte states, "I may go completely blind. They had to try something." She has limited vision in her right eye and has not been able to drive since the surgery.

Charlotte and her husband have one daughter who lives about 10 minutes away and a son who lives out of state. They have not seen the son or his family for several years because Charlotte's husband refuses to travel and their son has a very demanding law practice that makes it difficult for him to visit. Their son has offered to pay their airfare to come visit, but the husband refuses to accept. Their daughter is in the midst of a divorce and has troubles of her own.

Over the past year Charlotte's husband has become increasingly difficult. His hearing has deteriorated, and his balance is becoming a problem. He insists on trimming his own shrubs and cutting the lawn, even though he has difficulty starting and operating the equipment. He insists that Charlotte help him. Although she is fearful that they will both be injured, she obeys her husband's requests. She had hired several young men to help in the past, but her husband became verbally abusive to them. They usually quit after one visit. Home repairs need to be done, but Charlotte delays hiring anyone because of fear of her husband's reaction. She also states "money is tight" and she cannot afford to hire professional help.

Now that Charlotte cannot drive, she must depend on her daughter or her neighbors to get groceries and to transport her and her husband to doctor

appointments. She does not go out otherwise. She stopped going to church because she did not feel safe going up the church steps and also because her husband became restless during church services. Most of her neighbors and friends have died or have stopped visiting. Church members and neighbors have offered to help, but Charlotte states that she is not comfortable asking people for help or "bothering" others. She cares for her home and her husband by herself but admits it is very difficult.

Charlotte is very concerned about the future for her husband and herself. She worries that they may not be able to live in their home much longer. She states that she has always been a very independent person. She was the oldest child of five and had to assume responsibility for her younger siblings when her father died and her mother was forced to return to work to support the family. Charlotte also describes a lengthy childhood disease that kept her out of school for many years. She states, "I learned how to take care of myself, but now what do I do?"

Nursing Care of Charlotte with Newman's Theory

Engaging with the Client/Participant

Nursing care for Charlotte incorporates utilization of the elements of Newman's method to assist in pattern recognition for the purpose of illuminating new potentials for action. The nurse enters a mutually transformative relationship with Charlotte by assisting her in this pattern recognition. Through relating to Charlotte in a synchronous manner, the nurse becomes dialectically involved with her to focus on the meaning of the evolving pattern.

The nurse recognizes the current situation as a choice point that has attendant potential for increased interaction with environment and therefore expanded consciousness. As Charlotte's current options decrease and she becomes increasingly bound with restricted movement both outside and within her home, it becomes apparent that the old ways no longer are effective and that new ways of relating and doing things are necessary. The nurse prepares for entering a relationship of unconditional acceptance with Charlotte. Initial contact with Charlotte is made, and the nurse shares the observation that an opportunity exists to examine her present circumstances and reflect on past life experiences for the purpose of illuminating possible future interactions that will assist both Charlotte and her husband. The nurse offers to engage in a mutual relationship with Charlotte that will assist in this process.

The nurse asks Charlotte to tell her story. Through dialogue and interrelating with Charlotte, the nurse focuses on exploration of Charlotte's past relationships with her husband, children, neighbors, friends, and church. They discuss past patterns of Charlotte relating to her husband and how some of these patterns are changed by present circumstances, whereas others are unchanged. The relationships that Charlotte and her husband have with their children and changes in those

relationships are also explored. Meaningful experiences in Charlotte's life—such as her childhood illness, her father's death, her husband's illness, and her own health problems—are mutually shared between Charlotte and the nurse. Emphasis is placed on understanding the meaning of these experiences. The nurse synchronizes her interaction with Charlotte to be fully present with her during the exploration of these life patterns. As the nurse resonates with Charlotte, feelings and impressions are shared. Several such meetings are arranged at Charlotte's request between the nurse and herself.

Development of the Narrative

To identify patterns in Charlotte's story, the nurse configures her story to depict relationships at important moments in Charlotte's life. These patterns of relationships are arranged chronologically to illustrate particular significant events and people in Charlotte's life and to present a sequential view of the pattern of the whole. Charlotte's past and current relationships with her husband, children, and others together form this pattern.

It becomes apparent that Charlotte's predominant patterns have been those of valuing independence and choosing to assume responsibility. Charlotte has always been the one to bear the burden and responsibility, first as a mother figure for her younger siblings, then as a self-reliant invalid during her childhood illness, next as the main disciplining and nurturing figure during the raising and rearing of her children, and finally as caregiver for her husband. During Charlotte's marriage, her husband has made the major decisions but she had to assume the responsibility for implementation of those decisions. Although her husband is no longer capable, she continues to allow him to make decisions. This is demonstrated by her acceptance of his decision to refuse help with lawn or home maintenance and by her attempts to repair their home or assist her husband with lawn care. Charlotte's vision problems have created sufficient disorganization and disequilibrium to become a choice point through which she can recognize that these past patterns of relating will no longer be effective.

Follow-up Meetings

The nurse shares pattern perception in narrative and diagram (Figure 20-3) with Charlotte, who confirms and verifies the pattern identification. She states, "I never thought about it, but I have always been the one to handle things." Charlotte also shares that her brothers and sisters resented her "bossing them around" and that she resented having the burden placed on her. She states with a burst of insight, "You know, I really resent having to handle all this by myself, too."

Through continued dialogue between Charlotte and the nurse about past and present patterns, Charlotte realizes that she does not need to bear the current situation alone and in fact is not able to do so in a manner beneficial to either herself or her husband. Charlotte shares that she would really like to get help with the lawn and household but is afraid of her husband's reaction.

The nurse helps Charlotte explore how to introduce help that her husband would accept into the household. Charlotte feels that if the people helping were older and more experienced, her husband might better accept them. The nurse

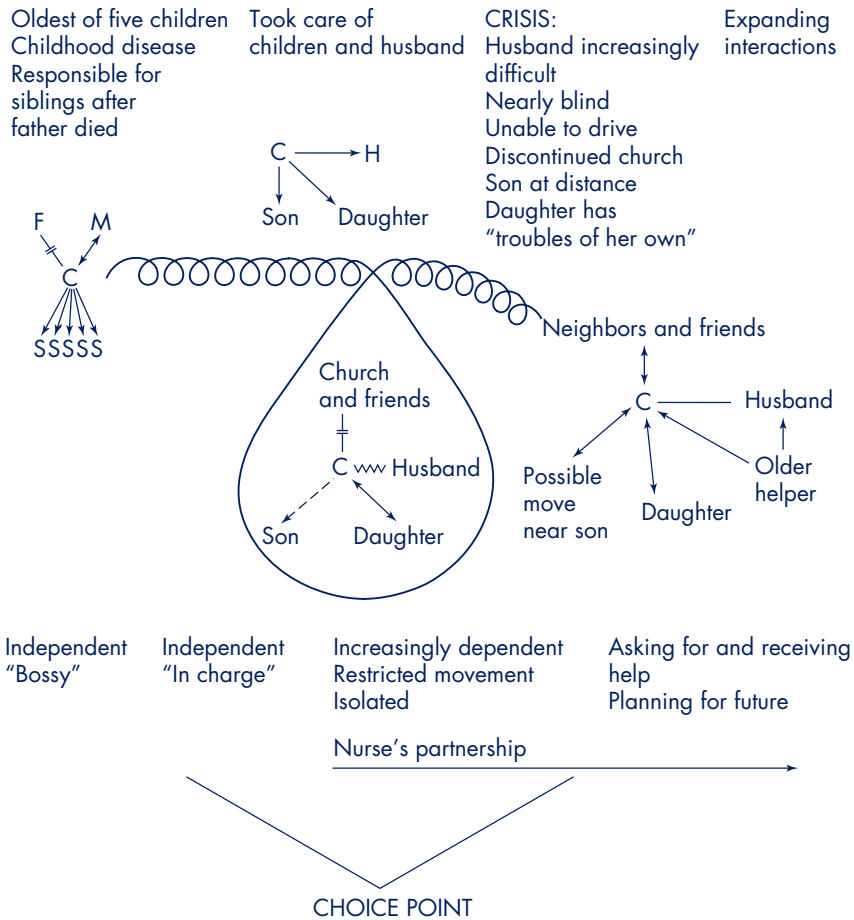


FIGURE 20-3 Diagram of Charlotte's pattern. Abbreviations: C, Charlotte; F, father; H, husband; M, mother; S, siblings. (From Margaret Newman and Janet Witucki. [2000]. Copyright Margaret Newman, St. Paul, MN, and Mosby/Harcourt Health Sciences, St. Louis.)

assists Charlotte in contacting a senior citizens home assistance group that provides senior volunteers for just such situations. Through this group, Charlotte finds an elderly but physically fit "gentleman jack-of-all-trades" over whom her husband expresses reluctance at first, but he eventually looks forward to the visits. When the volunteer finishes the work, he often visits with Charlotte's husband while she goes shopping with a neighbor.

Charlotte still is unable to drive and has accepted that she needs assistance from neighbors, friends, and her daughter to shop and go to doctor appointments. When some of the ladies of Charlotte's church offered home delivery of a hot meal once a week, she also accepted. She says she really enjoys not having to cook on Thursdays. The couple's son has been asking them to move into an assisted living

facility not far from his residence. Although Charlotte admits that the idea appeals to her, she feels that her husband would not do well in that environment. She states, “He would just die if he couldn’t be here in his own home.” She is considering having a live-in couple for assistance in the future. The nurse is assisting Charlotte in exploring these options. Figure 20-3 diagrams Charlotte’s pattern.

The shared rhythm and connectedness between the nurse and Charlotte continue as the husband’s condition deteriorates. During times of higher need, Charlotte and the nurse interact more often as the nurse assists Charlotte to determine what services she desires or needs and assists with access of services. However, Charlotte has been building her own support system and relies on the nurse less often. Charlotte stated recently, “I know I’m going to become more dependent and more aware of the outreach of people because many of my friends are reaching out.” She has found that many people are willing to help her if she asks for and accepts their help.

Application of the Theory

The nurse revisits the data from her encounters with Charlotte in relation to the theory of HEC, seeking support of the theory. The nurse also notes transformational changes that occurred for both the CP and the nurse.

Family and Community Pattern

The nurse recognizes that individual patterns have reciprocal patterns in environment, including family and community. These reciprocal, family and community patterns are identified.

CRITICAL THINKING EXERCISES

1. Keep a journal for 1 week of events, thoughts, feelings and interactions for self-reflection. Read and analyze the journal to identify and diagram your patterns.
2. Select a friend or co-worker and conduct an open-ended, tape-recorded interview focusing on past life events, persons, and interactions.
 - a. Practice being fully present as you interview.
 - b. Identify patterns to propose in the narrative and diagram.
 - c. Share with the person interviewed to experience the process of theory, practice, research Newman (1990a) has identified as praxis.
3. Think back to a time when you or someone close to you had a major catastrophic life event. Reflect on how this event changed or transformed you or that person. Consider this change in relation to the Theory of Health as Expanding Consciousness (HEC). How do they relate?
4. Reflect on a person you cared for recently in your practice. Divide a sheet of paper and list the items of care you delivered on the left side. On the right side list patient patterns you now see in retrospect using the Theory of HEC.

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PART
III

Expansion

The continued development of substantive nursing knowledge and the utilization and application of that knowledge as evidence for practice and health of society are essential to the future of the discipline of nursing and professional nursing practice.

- Part II of this text demonstrated the utilization of philosophies, nursing models, and theories of nursing as evidence supporting the thought and action of nursing practice, known as praxis.
- Areas of nursing practice for further theory utilization and application and the development of middle-range theories continue to stimulate the growth of substantive evidence on which to base quality nursing practice.
- Nursing works—philosophies, models, and theories—express the values of the discipline of nursing and the promise of the future for professional nursing practice to meet and address the healthcare challenges of this century.



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Areas for Further Development of Theory-Based Nursing Practice

Martha Raile Alligood

Nursing's potential for meaningful human service rests on the union of theory and practice for its fulfillment.
(Rogers, 1970, p. viii)

Systematic theory testing through application of nursing theories in practice with the participation of clinicians is essential for the enhancement of theory-based practice.
(Silva & Sorrell, 1992, p. 19)

This is a very exciting time in the history of nursing as theory utilization grows exponentially. Practice based on nursing models and theories has expanded as has development of creative applications of middle-range theories (see Chapter 2). This growth is due in part to the rapid development of doctor of nursing practice (DNP) programs. The American Association of Colleges of Nursing (AACN) *DNP Fact Sheet* (online, October 2012) reported the count was up to 184 DNP programs in the United States. The practice doctorate calls for nurses to deliver a professional style of practice from a nursing perspective for quality care in concert with other professional health care doctorates (Ahmed, Andrist, Davis, et al., 2012). This progress is supported by this text in its 5th edition and numerous other books focused on middle-range theory in their second and third editions (Peterson & Bredow, 2012; Sieloff & Frey, 2007; Smith & Liehr, 2008). Also theories from quantitative research derived from nursing models as well as qualitative approaches (Reed & Shearer, 2011; Renpenning & Taylor, 2011) and some from other countries such as those of McCormack, Brendan, and McCance (2011) flood the nursing literature. Expansion of theory utilization and application continues as noted in Chapter 2.

This text builds on a premise of the vital nature of the relationship between nursing theory and quality nursing practice. In Chapters 1 and 3, nursing philosophies,

models, and theories have been presented as critical thinking structures that guide clinical decision making. This chapter extends that premise by (1) illustrating the growth of middle-range theory applications derived from the seven nursing models, (2) identifying possible areas of nursing practice yet to be addressed with middle-range theories derived from the seven nursing models, and (3) illustrating the design of middle-range theories with examples that might be developed to address new areas with theoretical approaches.

New middle-range theories that are relevant to specific areas of nursing practice may be derived with linkages to the nursing models, grand theories, or theories. A characteristic of middle-range theories is their specificity to the details of actual clinical practice situations. Therefore, this chapter presents examples (ideas) using areas where middle-range theories were not found in Chapter 2 to illustrate areas where middle-range theories might be developed and how they might appear. As discussed in Chapter 3, the level of abstraction of middle-range theory is more concrete and includes specific details.

- The specifics are information such as the following:
 - The situation or health condition
 - The client population or age group
 - The location or area of nursing practice (e.g., home, hospital, community)
 - The action of the nurse or nursing intervention

It is these specifics that are characteristics of middle-range theory and make it applicable in nursing practice. Furthermore, variation in the characteristics among these specific aspects of practice multiplies the middle-range theories possible from any one model or grand theory.

The areas of nursing practice in which theory-based practice has been reported were illustrated with a solid circle in Tables 2-1, 2-2, and 2-3 (see Chapter 2). In this chapter the tables are reversed, focusing on the areas where theory-based practice has not been reported in order to *highlight* opportunities for possible middle-range theory expansion. Table 21-1 indicates areas for expansion where practice with nursing models is described in terms of a situation or health condition with a medical focus. Table 21-2 indicates areas for expansion where practice with nursing models focuses on human development, type of practice, type of care, or health. Table 21-3 indicates areas for expansion where practice with nursing models focuses on a nursing intervention or nursing role. Counting the types of theories with the dots in Chapter 2 illustrates published theories that have been developed and stimulates thought and action for the development of new middle-range theories in areas where they have not been developed or found in the nursing literature. Although the nursing models are holistic, the focus of the model (e.g., conservation or adaptation) is considered to determine the model that has the best fit in specific nursing situations.

Examples of middle-range theories are presented to illustrate the nature of that level of theory and potential areas for future theory development and use in practice. This chapter may be useful to the following readers who are at various levels of nursing or nursing education:

- Beginning nursing students may find this chapter useful for learning the appearance of middle-range theories and for identifying the specifics they contain for application in practice.

Text continued on p. 420

TABLE 21-1 Areas of Practice for Expansion with Nursing Models Described in Terms of Medical Condition Focus

| Practice Area | Johnson | King | Levine | Neuman | Orem | Rogers | Roy |
|------------------------------------|---------|------|--------|--------|------|--------|-----|
| Acute care | • | • | • | • | • | | • |
| Adolescent cancer | • | • | • | • | • | • | |
| Adult diabetes | • | | • | • | | • | • |
| AIDS management | | • | • | | • | | |
| Alzheimer's disease | • | • | • | • | • | • | |
| Ambulatory care | • | • | • | • | | | • |
| Anxiety | • | | • | | | | • |
| Breast cancer | • | • | • | | • | • | |
| Burns | • | • | | • | • | • | • |
| Cancer | | • | | • | | | |
| Cancer pain management | | • | • | • | • | • | • |
| Cancer-related fatigue | • | • | • | • | | • | • |
| Cardiac disease | | | • | • | | | |
| Cardiomyopathy | • | • | • | • | • | • | |
| Chronic inflammatory bowel disease | • | | • | • | • | • | • |
| Chronic pain | • | • | | • | • | | |
| Chronic sorrow | • | • | • | • | • | • | |
| Cognitive impairment | • | • | • | | • | • | • |
| Congestive heart failure | • | • | | • | • | • | • |
| Critical care | • | • | | | | | |
| Cystitis | • | • | • | | • | • | • |
| Diabetes | • | | • | | | • | • |
| Guillain-Barré syndrome | • | • | • | • | | • | • |
| Heart variations | • | • | • | • | | | • |
| Hemodialysis | | • | • | • | | • | • |
| Hypernatremia | • | • | • | • | • | • | |
| Intensive care | • | • | • | | | | |
| Kawasaki disease | • | • | • | • | • | • | |
| Leukemia | • | • | • | • | • | • | |

TABLE 21-1 Areas of Practice for Expansion with Nursing Models Described in Terms of Medical Condition Focus—cont'd

| Practice Area | Johnson | King | Levine | Neuman | Orem | Rogers | Roy |
|-------------------------|---------|------|--------|--------|------|--------|-----|
| Long-term care | • | • | | • | | • | • |
| Medical illness | • | | • | | • | | • |
| Menopause | • | | • | • | • | | • |
| Neurofibromatosis | • | | • | • | • | • | • |
| Obesity | | | • | • | • | • | • |
| Oncology | | | • | • | | | • |
| Orthopedics | • | | • | | • | • | • |
| Osteoporosis | • | • | • | • | • | • | |
| Ostomy care | • | • | | • | | • | • |
| Pediatric | | | | | • | | |
| Perioperative | • | | | • | | • | |
| Polio survivors | • | • | • | • | • | | • |
| Postanesthesia | • | • | • | • | • | • | |
| Postoperative | • | • | • | | | • | |
| Postpartum | • | • | • | • | • | • | |
| Posttrauma | • | • | • | • | • | • | |
| Preoperative adults | • | • | | • | • | • | • |
| Preoperative anxiety | • | | • | • | | • | • |
| Pressure ulcers | • | • | | • | • | • | • |
| Renal disease | • | | • | | | • | • |
| Rheumatoid arthritis | • | • | • | • | | • | • |
| Schizophrenia | • | • | • | • | • | • | |
| Stroke | | | • | • | • | • | • |
| Substance abuse | • | | • | • | | | • |
| Terminal illness | • | • | • | • | • | | |
| Ventilator patient | • | • | • | • | • | • | |
| Ventricular tachycardia | | • | • | • | • | • | • |
| Wound healing | • | • | | • | • | • | • |

AIDS, Acquired immunodeficiency syndrome.

TABLE 21-2 Areas for Expansion with Nursing Models Based on Human Development, Type of Practice, Type of Care, or Type of Health

| Practice Area | Johnson | King | Levine | Neuman | Orem | Rogers | Roy |
|------------------------|---------|------|--------|--------|------|--------|-----|
| Adolescents | • | | • | | • | | |
| Battered women | • | • | • | | | • | • |
| Caregiver stress | • | | • | | • | • | |
| Case management | • | | • | | • | • | • |
| Cesarean father | • | • | • | • | • | • | |
| Child health | • | | • | • | • | • | • |
| Child psychiatric | • | • | • | | • | • | • |
| Dying process | • | • | • | • | • | | • |
| Emergency | • | | | | • | • | |
| Gerontology | • | | • | | | | |
| High-risk infants | • | | | • | • | • | • |
| Holistic care | • | • | | • | • | • | • |
| Homeless | • | • | | | • | • | • |
| Hospice | • | • | | • | | • | • |
| Managed care | • | | • | | • | • | • |
| Mental health | | • | • | | | | |
| Neonates | • | • | | • | • | • | |
| Nursing administration | • | | • | | | | |
| Nursing adolescents | | | • | • | | • | • |
| Nursing adults | • | | | | | | • |
| Nursing children | | • | | • | | | |
| Nursing community | | | • | | | | |
| Nursing elderly | | | | | | | |
| Nursing of families | | | • | | • | | |
| Nursing home residents | • | • | • | • | • | | |
| Nursing of infants | | • | | | | • | |
| Nursing in space | • | • | • | • | • | | • |
| Nursing service | • | • | • | • | • | | • |
| Nursing women | • | • | • | • | | | • |
| Occupational health | • | • | • | • | | • | • |

TABLE 21-2 Areas for Expansion with Nursing Models Based on Human Development, Type of Practice, Type of Care, or Type of Health—cont'd

| Practice Area | Johnson | King | Levine | Neuman | Orem | Rogers | Roy |
|---------------------|---------|------|--------|--------|------|--------|-----|
| Palliative care | • | • | • | • | • | | |
| Pregnancy | | • | • | • | | | |
| Psychiatric nursing | | | • | • | • | | • |
| Public health | • | • | • | | • | • | • |
| Quality assurance | | • | • | • | • | • | |
| Rehabilitation | • | | | | | | |
| Risk education | • | • | • | | • | • | • |
| Transcultural | • | | • | • | • | • | • |

TABLE 21-3 Areas for Expansion of Nursing Intervention or Role

| Practice Area | Johnson | King | Levine | Neuman | Orem | Rogers | Roy |
|------------------------------|---------|------|--------|--------|------|--------|-----|
| Breastfeeding | • | • | • | | • | • | |
| Community presence | • | • | • | • | • | | • |
| Counseling | • | • | • | | • | | • |
| Collaboration | • | | • | • | • | • | • |
| Esthetic knowing | | • | • | • | • | • | • |
| Family therapy | • | | • | | • | • | • |
| Group therapy | • | | • | • | • | | |
| Health patterning | • | • | • | • | • | | • |
| Humor | • | • | • | | • | | • |
| Imagery | • | • | • | | • | | • |
| Intentionality | • | • | • | • | • | | • |
| Knowing participation | • | • | • | • | • | | • |
| Laughter | • | • | • | • | • | | • |
| Leadership and scholarship | • | | • | | • | | • |
| Life-patterning difficulties | • | • | • | • | • | | • |
| Life review | • | • | • | • | • | | • |
| Movement | • | • | • | • | • | | • |
| Nutrition | • | • | • | | | • | |
| Parenting | • | | • | | • | • | |
| Relaxation | • | • | • | • | | • | • |
| Spiritual intervention | • | • | • | | • | | |
| Storytelling | • | • | • | • | • | | • |
| Therapeutic touch | • | • | • | • | • | | • |

- Master's-level students often conduct their first research projects, and middle-range theories contain the specifics of practice for theory-testing clinical studies.
- Doctoral students may find this chapter helpful whether they are in research-focused PhD programs or in practice-focused DNP programs.

Doctoral students in research-focused PhD programs have used this text and reported its use as a guide for developing middle-range theories to test in their dissertations. Faculty members teaching in DNP programs have noted the utility of this text for teaching theory-based practice to advanced practice nursing students. DNP students have reported its utility for application in their clinical practice and projects.

Conceptual Models of Nursing

Johnson

Middle-range theories may be derived from Johnson's Behavioral System Model (see Chapter 8) and the grand Theory of the Person as a Behavioral System. In Tables 2-1, 2-2, and 2-3 from Chapter 2, areas have been identified for expansion of Johnson's model in nursing practice. There are 7 applications of Johnson's model included in the 57 situations or health conditions in Table 2-1; 50 potential areas for expansion of Johnson's theory (e.g., diabetes, menopause, chronic pain) are listed in Table 21-1. There are 10 applications included in the 38 areas in Table 2-2; therefore 28 possible areas for expansion exist in Table 21-2 (e.g., hospice, neonates, rehabilitation). Table 2-3 identifies 23 areas of practice with specific nursing interventions, and 1 was reported with Johnson's model; 22 areas for possible expansion are noted in Table 21-3.

By using the information in Tables 21-1, 21-2, and 21-3, an example of a testable middle-range theory from Johnson's grand theory might be as follows:

Women in menopause reduce symptoms through behavioral interventions.

King

Middle-range theories may be derived from King's Theory of Goal Attainment (see Chapter 9). The details of the actual clinical situation specify the theory; however, use of Tables 21-1, 21-2, and 21-3 may stimulate ideas for areas of expansion of King's theory in nursing practice. Of the 57 areas listed in Table 2-1, 15 reported the use of King's theory. Thus Table 21-1 offers 42 health conditions (e.g., diabetes, burns, congestive heart failure) for possible expansion. In Table 2-2, 13 of the 38 client groups or areas of practice were represented by publications based on King's theory, leaving 23 areas of practice for possible expansion (e.g., case management, palliative care, public health). Of the 23 nursing interventions in Table 2-3, 5 were King theory-based interventions, which suggests 18 areas for possible expansion (e.g., imagery, humor, presence) (see Table 21-3).

An example of a testable middle-range theory from King's Theory of Goal Attainment might be as follows:

Use of imagery in palliative care leads to increased patient satisfaction.

Levine

Middle-range theories may be derived from Levine's Theory of Therapeutic Intention (see Chapter 10). The details of actual clinical situations specify the theory;

however, Tables 21-1, 21-2, and 21-3 may be used to stimulate creativity and expand the use of Levine's model in practice. In Table 2-1, 10 of the 57 areas were applications of Levine's model, leaving 47 areas (e.g., breast cancer, hemodialysis, chronic pain) for possible expansion of middle-range theory in Table 21-1. In Table 2-2, 11 of the 38 client groups or areas of practice reported using Levine's model, leaving 27 areas for expansion (e.g., community, gerontology, occupational health) (see Table 21-2). Specific nursing interventions based on Levine's model were not found in Table 2-3, so Table 21-3 lists 23 areas for expansion.

An example of a testable middle-range theory derived from Levine's Theory of Therapeutic Intention might be as follows:

Conserving energy in the care of high-risk infants leads to reduced days in the neonatal intensive care unit (NICU).

Neuman

Middle-range theories may be derived from Neuman's Theory of Optimal Client Stability (see Chapter 11). The details of actual clinical situations specify the theory; however, Tables 21-1, 21-2, and 21-3 present some areas to consider for possible expansion. A total of 12 of the 57 conditions were reported in nursing practice guided by the Neuman model in Table 2-1. This leaves 45 areas of practice in Table 21-1 for possible expansion (e.g., ambulatory care, rheumatoid arthritis, critical care). In Table 2-2, 19 of the 38 client groups or areas of practice were addressed in publications based on Neuman's model, leaving 19 areas for possible expansion (e.g., nursing of women, psychiatric nursing, hospice care), as noted in Table 21-2. In Table 2-3, 9 of the 23 nursing interventions that use the Neuman model were reported in Table 2-3; therefore, Table 21-3 lists 14 areas for possible expansion (e.g., family therapy, health patterning, movement).

An example of a testable middle-range theory derived from Neuman's Theory of Optimal Client Stability might be as follows:

Ambulatory care reduces patient stress with structured movement exercises.

Orem

Middle-range theories are derived from Orem's Self-Care Deficit or Dependent-Care Theory (see Chapter 12). The details of actual clinical situations provide the specifics of the theory; however, Tables 21-1, 21-2, and 21-3 may be used to stimulate thinking for theory expansion possibilities. Use of Orem's model in practice was reported in 20 of the 57 areas included in Table 2-1, leaving 37 areas for possible expansion listed in Table 21-1 (e.g., cystitis, cancer pain management, burns). In Table 2-2, 15 of the 38 client groups or areas of practice were addressed in publications based on Orem's theory, leaving 23 areas for expansion (e.g., child health, managed care, quality assurance) listed in Table 21-2. A total of 2 interventions based on Orem's theories among 23 possible areas were reported in Table 2-3; therefore, 21 areas of possible expansion are noted in Table 21-3.

An example of a testable middle-range theory derived from Orem's Self-Care Deficit Theory might specify as follows:

Self-care assessment improves cancer pain management.

Rogers

Middle-range theories may be derived from Rogers' Theory of Accelerating Change (see Chapter 13). The details from actual clinical situations specify the theory; however, these are ideas for theory expansion generated from Tables 21-1, 21-2, and 21-3. Of the 57 conditions included in Table 2-1, 16 of the interventions were reported by nurses using Rogers' theory. This leaves 41 areas for possible expansion (e.g., adult diabetes, adolescent cancer, hospice) as listed in Table 21-1. Nurses reported theory-based practice using Rogers' theory in 18 of the 38 client groups or areas of practice listed in Table 2-2, which means there are 20 areas for possible development, as listed in Table 21-2 (e.g., adolescents, families, public health). In Table 2-3, 16 of the 23 interventions were based on nursing practice with Rogers' theory, with 7 areas for expansion remaining as seen in Table 21-3 (e.g., counseling, relaxation, family therapy).

An example of a testable middle-range theory derived from Rogers' Theory of Accelerating Change might be as follows:

Adolescents report improved outlook associated with family therapy.

Roy

Middle-range theories may be derived from Roy's Theory of the Person as an Adaptive System (see Chapter 14). The details from actual clinical practice generate the specifics for theory; however, ideas for theory expansion and new areas for theory-based practice are developed in Tables 21-1, 21-2, and 21-3. Table 2-1 illustrates 21 of the 57 health conditions that were addressed by nurses practicing with Roy's model. This leaves 36 areas for expansion listed in Table 21-1 (e.g., acute care, chronic pain, Alzheimer's disease). In Table 2-2, 18 of the 38 client groups or areas of practice were included in publications based on Roy's model, which leaves 20 areas for possible expansion in Table 21-2 (e.g., battered women, gerontology, emergency care). In Table 2-3, 5 of the 23 nursing interventions were based on Roy's model, which leaves 18 areas for possible expansion (e.g., family therapy, life patterning, laughter) listed in Table 21-3.

An example of a testable middle-range theory derived from Roy's Theory of the Person as an Adaptive System might be as follows:

Women experiencing chronic pain improve coping through adaptive life patterning.

Philosophies and Theories of Nursing

In addition to the opportunities for expansion of theory-guided practice in middle-range theories derived from nursing conceptual models noted thus far in the chapter, philosophies and theories of nursing also guide research and practice. Philosophies include Nightingale's (1946) classic work (see Chapter 5), which guides the nurse by identifying factors in the patient's surroundings (environment) that are pertinent to the design and delivery of care. Watson's work (see Chapter 6) emphasizes transpersonal caring and proposes 10 carative factors that guide the process of the nurse with the patient. Benner's work (see Chapter 7) emphasizes the importance of caring and the developmental process of skill acquisition. Her work proposes that the unique events of each nurse-patient relationship are best understood through hermeneutic interpretation of the process. These works guide nurses' contemplation and reflection about their practice.

Theories of nursing are at various levels of abstraction, and therefore their applications vary according to their specific focus (as discussed in Chapter 3). Orlando's (see Chapter 15) theory focuses on the process of the nurse in interaction with the patient. Her work guides practice, clarifies inferences and specifies deliberate action in the interactions with the patient. Thus Orlando's work is applicable in nursing communications and limited to the interaction process. Modeling and Role-Modeling Theory (see Chapter 16) guides the nurse to a comprehensive understanding (model) of the patient's world. That understanding is then used with the patient to develop interventions that fit the patient's world. Mercer's theory (see Chapter 17) is very specific to the maternal role, as she has clarified even further by renaming it the Theory of Becoming a Mother. Her work provides the wisdom of years of study and insights about the transition to motherhood and changes in the family. Leininger's theory (see Chapter 18) is specific to culture. Her Theory of Culture Care Diversity and Universality specifies culture care for every patient based on a situated view of the patient. Care is designed from the perspective of a full array of cultural dimensions, including the culture of the health care delivery system and folk practices. Parse's work (see Chapter 19) is the Theory of Humanbecoming. Her work recognizes the nurse-patient relationship as the heart of nursing. She emphasizes nurse presence to facilitate the living health process of patients. Newman's Theory of Health as Expanding Consciousness (see Chapter 20) guides the nurse to view patients and their health (wellness and illness) in a holistic manner. Her theory guides the nurse to focus on the patient's life pattern. The health and illness events of the patient's life are understood as a pattern of the whole.

Each of these theories is less abstract and more specific to practice than are the nursing models. As has been illustrated, they contribute to theory-based nursing practice by a specific focus that guides the nurses thought and action.

Conclusion

The importance of theory development and its utilization in practice is a major premise of this text. The exponential growth of the DNP programs and the explosive expansion of the nursing theory literature support the relationship of nursing theory to quality nursing practice.

Examples of middle-range theories have been proposed and possible new areas for theory-based practice were identified. With emphasis on evidence-based practice and quality care, the importance of theory-based research and theory-based practice cannot be overemphasized for continued discipline development. It has noted that "some knowledge base or perspective guides all nursing practice" (Smith, 1993, p. 8). Therefore, it is extremely important for nurses to reflect on their practice with consideration of the decision-making structure and process they are using.

Nursing philosophies, models, and theories have demonstrated structured decision-making capacity to generate knowledge for evidence-based practice as illustrated in Chapters 5 through 20.

If by evidence-based practice we mean practice that is based on "what is known," and if "what is known" comes from theory-based research, then it follows that theory links evidence generated in research to practice. That is, theory-based research generates quality evidence for application in practice (Fawcett & Garity, 2009;

Johnson & Webber, 2010). The American Academy of Nursing's Expert Panel on Nursing Theory–Guided Practice (2000) presented the following definition:

Nursing theory–guided practice is a human health service to society based on the discipline-specific knowledge articulated in the nursing frameworks and theories. The discipline-specific knowledge reflects the philosophical perspectives embedded in the ontological, epistemological, and methodological processes that frame nursing's ethical approach to the human-universe-health process (p. 177).

As nurses implement theory-based practice with theoretical works, the growth of the nursing profession continues. Nurses use substantive knowledge in service to society for the benefit of patients whom we serve. This basic value of nursing may be emphasized even more as evidence-based practice focuses attention on the linkage of knowledge to quality practice.

The tables in Chapter 2 (Tables 2-1, 2-2, and 2-3) demonstrate growth and expansion of theory-based practice in the nursing literature. The tables in this chapter address areas for further development with examples of possible middle-range theories. As nursing continues to develop and the vital nature of theory-based practice is realized, the words of Silva (1999) ring ever so true when she said “nursing will be best remembered...for what nurses did or failed to do in this new century” (p. 222).

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Nursing Philosophies, Models, and Theories: A Focus on the Future

Jacqueline Fawcett

I can only hope that enough nurses will make a commitment to becoming champions of nursing discipline-specific knowledge that our discipline will survive and that we may continue to provide a valued and respected service to human beings.
(Fawcett, 2003, p. 230)

Nursing knowledge—in the form of philosophies of nursing, conceptual models of nursing, and nursing theories—has been developed by nurse scholars who devote much time to observing nursing practice, thinking about what is important to nursing in practice, and then publishing their ideas. Nursing knowledge continues to evolve as nursing students and practicing nurses develop philosophies that articulate their values and use conceptual models and theories to guide their practice. Thus all nurses can contribute to the evolution of nursing knowledge and the advancement of the discipline of nursing.

The purpose of this chapter is to present a discussion of philosophies, conceptual models of nursing, and nursing theories. The chapter begins with definitions of philosophy, conceptual model, and theory and an explanation of how each of these components of nursing knowledge is used in nursing practice. The chapter continues with a discussion of the dangers that come from *not* using nursing knowledge. Next, the philosophical value of using explicit nursing conceptual models and theories to guide nursing practice is discussed, along with two contemporary trends in nursing practice—collaborative practice and quality and safety competencies (Quality and Safety Education for Nurses [QSEN]); Cronenwett, Sherwood, Barnsteiner, et al., 2007). Strategies that can be adopted by the individual nurse to implement nursing model-based and nursing theory-based nursing practice are identified. Recommendations for the work needed to determine the scientific value of nursing conceptual models and theories are then offered. The chapter concludes with a futuristic proposal that links nursing

conceptual models with the five types of theories necessary for evidence-based nursing practice.

Definitions: Philosophy, Conceptual Model, Theory

A *philosophy* of nursing is “a statement encompassing ontological claims about the phenomena of central interest to a discipline, epistemic claims about how those phenomena come to be known and ethical claims about what the members of a discipline value” (Fawcett & DeSanto-Madeya, 2013, p. 8). The function of philosophies is to stipulate beliefs and values. The ethical knowledge that is inherent in philosophies of nursing can be used as the basis for the ways in which practicing nurses act to protect the privacy of patients and family members and to treat people with respect.

A *conceptual model* is defined as “a set of relatively abstract and general concepts that address the phenomena of central interest to a discipline, the propositions that broadly describe those concepts, and the propositions that state relatively abstract and general relations between two or more of the concepts” (Fawcett & DeSanto-Madeya, 2013, p. 13). Nursing conceptual models are different ways to view nursing practice processes. Each nursing conceptual model, then, provides an alternative guide to the way that nurses work with patients.

A *theory* is defined as “one or more relatively concrete and specific concepts that are derived from a conceptual model, the propositions that narrowly describe those concepts, and the propositions that state relatively concrete and specific relations between two or more of the concepts” (Fawcett & DeSanto-Madeya, 2013, p. 15). Theories are less abstract than conceptual models. When linked with the parent conceptual model, the resultant conceptual-theoretical system of knowledge provides specific guidelines for nursing practice.

The Danger of Not Using Nursing Knowledge

Although many nurses use philosophies of nursing, conceptual models of nursing, and nursing theories, a significant danger to advancement of nursing as a discipline comes from the rapid growth of nurse practitioner programs since the 1980s. The emphasis on practitioner skills in nursing education programs has diverted attention away from *nursing* philosophies, conceptual models, and theories and toward the knowledge used by physicians as the base for practice. As a result, the human experiences of both health and nursing have been medicalized (Chinn, 1999), nursing practice typically is evaluated in terms of medical outcomes rather than outcomes of application of nursing knowledge, and nurses imitate physicians by performing tasks “traditionally within the domain of medical practice” (Orem, 2001, p. 69) that physicians no longer value (Hanson & Hamric, 2003). Not surprising, then, is that some nurses are said to resemble “quasi practitioners of medicine” (Orlando, 1987, p. 412), physician substitutes (McBride, 1999), physician extenders (Sandelowski, 1999), or junior doctors (Meleis, 1993) engaged in nursing-qua-medicine (Watson, 1996). Thus *advanced practice nursing* has evolved into limited medical practice rather than full nursing practice as nurses perform work that relieves deliberately controlled

shortages of physicians, which preserves their market value (Sandelowski, 1999) but not the market value of nurses. It is ironic that there are few, if any, recognizable medical conceptual models or theories. Rather, physicians use the knowledge of anatomy, biochemistry, pharmacology, physics, and physiology to guide their practice. Absent any evidence of a distinctive body of medical knowledge, medicine must be regarded as a skilled trade. Do nurses who imitate physicians prefer to be skilled tradespeople rather than professional practitioners?

Another danger comes from the use of *nonnursing* research as documentation for evidence-based *nursing* practice. This danger arises from two sources: (1) research done by members of other disciplines who do not understand nursing conceptual models and theories that should be used to guide nursing research, and (2) research done by nurses who have abandoned nursing models and theories in favor of conceptual models and theories from other disciplines as guides for their research. The research findings from either source should not be used as the evidence on which to base nursing practice because such research is not *nursing* research and therefore has nothing to do with *nursing* practice (Fawcett, 2000).

The Philosophical Value of Using Explicit Nursing Knowledge

Nursing, as Rogers (1985) maintains, has “no dependent functions” (p. 381). She explains that “like all other professions, nursing has many collaborative functions, [but]...[e]ach profession is responsible for determining its own boundaries within the context of social need” (p. 381). Rogers’ point is underscored by McCloskey and Mass (1998), who declared that maintaining a nursing perspective—a nursing conceptual model or theory—is crucial when nurses are members of inter- or multidisciplinary teams engaged in collaborative practice.

Nursing practice always has value but the *added* value of using *nursing* knowledge to guide nursing practice needs to be emphasized so that all nurses are identified as nursing practitioners (not “nurse practitioners”) (Orem, 2001) or senior nurses (Meleis, 1993). These nurses have the courage to follow the independent path of professional nursing (Orlando, 1987) and have the freedom and autonomy that comes from engaging in nursing-qua-nursing (Hawkins & Thibodeau, 1996; Watson, 1997). The philosophical value of using explicit, discipline-specific nursing knowledge to guide nursing practice is documented in numerous publications, many of which are listed in Chapter 2 of this text. Moreover, use of distinctive *nursing* knowledge for practice is the hallmark of professional nursing. As Rogers (1992a) eloquently states, “The practice of nurses...is the creative use of this knowledge in human service” (p. 29).

As structures for critical thinking within a distinctively nursing context, conceptual models of nursing and nursing theories provide the intellectual skills that nurses need to survive at a time when cost containment through the reduction of professional nursing staff is the *modus operandi* of administrators of health care delivery systems. Noteworthy are Chinn’s (1988, 2004) words: “As nurses, we are particularly vulnerable to an unrelenting sense of disparity between what we know and what we do” (1988, p. vii; 2004, p. 1). If nursing is to survive as a distinct discipline and profession, that disparity must be eliminated.

Fawcett and DeSanto-Madeya (2013) explain that nursing conceptual models and theories collectively identify the distinctive boundaries of nursing within all of health care. Each nursing model and theory provides a holistic orientation that reminds nurses of the focus of the discipline—concern for the “wholeness or health of humans, recognizing that humans are in continuous interaction with their environments” (Donaldson & Crowley, 1978, p. 119). Furthermore, each nursing conceptual model provides a nursing discipline-specific lens for viewing practice situations, and each theory provides details that are relevant to nursing practice. Each nursing conceptual model also provides a framework for incorporation of new knowledge. For example, the theoretical knowledge, along with the skills and attitudes, needed for competent, high quality, and safe practice—patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics (Cronenwett, et al., 2007)—can be linked to any nursing conceptual model.

Thus, nursing conceptual models and theories help nurses explicate what they know and why they do what they do. Nursing models and theories facilitate the communication of nursing knowledge and how that knowledge explains and governs the actions performed on behalf of or in conjunction with people who require health care. Ultimately, nursing practice that is based on explicit, distinctive nursing knowledge is “for our patients’ sake” (Dabbs, 1994, p. 220).

Implementing Nursing Knowledge–Based Nursing Practice: Process and Strategies

The substantive and process elements of implementing conceptual model-based or theory-based nursing practice at the health care organizational level are discussed in detail by Fawcett and DeSanto-Madeya (2013). In this chapter the focus narrows to the process that occurs and the strategies that can be used by each nurse when implementing nursing practice based on explicit nursing conceptual models and theories. Understanding and telling others about the process and using the strategies should ensure that nursing knowledge is used to guide practice in the future.

In Chapters 1 and 3, Alligood (2010) points out that the first step toward implementing nursing practice based on nursing conceptual models and theories is “the decision to do so” (p. 65). Clearly, the authors of Chapters 5 through 20 made that decision.

The second step is to recognize that adoption of an explicit nursing conceptual model or theory—or a change from one explicit conceptual model or theory to another—requires an adjustment in thinking about nursing and patient situations. More specifically, the successful implementation of nursing conceptual model-based or nursing theory-based nursing practice requires recognition of the fact that the nurse needs time to evolve from the use of one frame of reference for practice to another frame of reference. Time is required regardless of whether the original frame of reference is an implicit one or a different explicit conceptual model or theory. The process that occurs during the period of evolution is referred to as *perspective transformation*.

Perspective Transformation

Drawing from Mezirow's early work (1975, 1978) in the development of adult learning theory, Rogers (1989), a Canadian nurse who is not related to the theorist who developed the Science of Unitary Human Beings, explained that perspective transformation is based on the assumption that each person has a particular meaning perspective that is used to interpret and understand the world. She defined and described perspective transformation as the process:

whereby the assumptions, values, and beliefs that constitute a given meaning perspective come to consciousness, are reflected upon, and are critically analyzed. The process involves gradually taking on a new perspective along with the corresponding assumptions, values, and beliefs. The new perspective gives rise to fundamental structural changes in the way individuals see themselves and their relationships with others, leading to a reinterpretation of their personal, social, or occupational worlds (p. 112).

Thus the process of perspective transformation involves the shift from one meaning perspective or frame of reference about nursing and nursing practice to another, from one way "of viewing and being with human beings" to another (Nagle & Mitchell, 1991, p. 22).

Rogers (1989) points out that the cognitive and emotional aspects of perspective transformation represent a major change for each nurse. Moreover, she underscores the importance of recognizing, appreciating, and acknowledging that during the process of perspective transformation, each nurse evolves from feeling "a [profound] sense of loss followed by an ultimate sense of liberation and empowerment" (Rogers, 1992b, p. 23). Clearly, perspective transformation requires considerable effort and a strong commitment to change (Nagle & Mitchell, 1991).

Perspective transformation encompasses nine phases: stability, dissonance, confusion, dwelling with uncertainty, saturation, synthesis, resolution, reconceptualization, and return to stability (Rogers, 1992b). The prevailing period of stability is disrupted when the idea of implementing nursing conceptual model-based or nursing theory-based nursing practice or changing the model or theory is introduced. Dissonance occurs as the nurse begins to examine his or her current frame of reference for practice in light of the challenge to adopt or change a conceptual model or theory. As the nurse begins to learn the content of the new conceptual model or theory, he or she begins to appreciate the discrepancy between the current way of practice and what nursing practice could be. A phase of confusion follows. As the nurse struggles to learn more about the model or theory and its implications for practice, a feeling of "lying in limbo" between frames of reference prevails (Rogers, 1992b, p. 22). Throughout the phases of dissonance and confusion, the nurse often feels anxious, angry, and unable to think. Rogers (1992b) explained that these distressing emotions "seem to arise out of the grieving of a loss of an intimate part of the self. The existing [frame of reference] no longer makes sense, yet the new [model or theory] is not sufficiently internalized to provide resolution" (p. 22).

The phase of confusion is followed by the phase of dwelling with uncertainty. At this point, the nurse acknowledges that confusion "is not a result of some personal inadequacy" (Rogers, 1992b, p. 22). As a consequence, anxiety is replaced by

a “feeling of freedom to critically examine old ways and explore the new [model or theory]” (Rogers, 1992b, p. 22). The phase of dwelling with uncertainty is spent immersed in information that often seems obscure and irrelevant. It is a time of “wallowing in the obscure while waiting for moments of coherence that lead to unity of thought” (Smith, 1988, p. 3).

The phase of saturation occurs when the nurse feels that he or she “cannot think about or learn anything more about the nursing [model or theory]” (Rogers, 1992b, p. 22). The phase does not represent resistance but rather “the need to separate from the difficult process of transformation, [which] is part of the natural ebb and flow of the learning experience” (Rogers, 1992b, p. 22).

The phase of synthesis occurs as insights render the content of the new conceptual model or theory coherent and meaningful. The formerly obscure practice implications of the conceptual model or theory become clear and worthy of the implementation effort. Increasing tension is followed by exhilaration as insights illuminate the connections between the content of the conceptual model or theory and its use in nursing practice (Rogers, 1992b; Smith, 1988). As Smith (1988) explains, “These insights are moments of coherence, flashes of unity, as though suddenly the fog lifts and clarity prevails. These moments of coherence push one beyond to deepened levels of understanding” (p. 3).

The phase of resolution is characterized by “a feeling of comfort with the new nursing [model or theory]. The feelings of dissonance and discontent...are resolved and the anxiety is dissipated” (Rogers, 1992b, p. 23). During this phase, “nurses describe themselves as changed, as seeing the world differently and feeling a distinct sense of empowerment” (Rogers, 1992b, p. 23).

The phase of reconceptualization occurs as the nurse consciously reconceptualizes nursing practice using the new nursing conceptual model or theory (Rogers, 1992b). During this phase, the nurse compares the activities of practice—from patient assessment through shift reports—according to the old and new ways of thinking and changes those activities so that they are in keeping with the new model or theory. The final phase, return to stability, occurs when nursing practice is clearly based on the new nursing conceptual model or theory.

Strategies to Facilitate Perspective Transformation

Rogers (1989) identified several strategies that can be used to facilitate perspective transformation. These strategies are especially effective during the early phases of perspective transformation, when the nurse is moving from the original to the new frame of reference for practice.

One strategy is to use analogies to facilitate understanding of the terms *conceptual model* and *theory*. Analogies such as a chair or book can be used for concepts (conceptual), the analogy of a model home or model airplane can be used for models, and the analogy of a conjecture can be used for theory. Rogers (1989) notes that the acts of conceptualizing and theorizing can be demystified “by stating that it is not a process reserved for intellectuals but rather a cognitive process of all humans that begins in infancy as a baby puts together all the pieces to form the concept of mother” (p. 114).

Two other strategies are directed toward identification of the nurse’s existing frame of reference for nursing practice. One of those strategies is to list words that

reflect the nurse's view of nursing practice. Similarly, the nurse could depict his or her view of nursing practice in drawings or collages of photographs. Another strategy is to think about the details of, reasons for, and outcomes of a recent interaction with a patient.

Once the nurse has gained a clear understanding of the original frame of reference, he or she needs to explore the difference between the current state of nursing practice and what practice would be like if he or she were using the new conceptual model or theory. This can be accomplished through the use of provocative strategies. One provocative strategy is to think about how situations such as childbirth and death are currently managed and how they could be managed using the new model or theory. Another strategy is to describe what is unique about nursing practice or what would be done if physicians' orders did not need to be followed.

Rogers (1989) notes that as the nurse becomes aware of the differences between the present and the potential future practice of nursing, he or she experiences cognitive dissonance or discomfort that comes from "the awareness of the 'what is' versus 'what [c]ould be'" (p. 115). She concludes by noting that when cognitive dissonance "has been experienced by nurses both individually or collectively, then perspective transformation can occur, and a climate for the implementation of a nursing [model or theory] will have been created" (p. 116).

Subsequent stages of perspective transformation and the implementation of conceptual model-based or theory-based nursing practice are facilitated by constant reinforcement. Accordingly, all nursing activities should be tied to the conceptual model or theory in a systematic manner. The novice user of an explicit conceptual model or theory should not become discouraged if initial experiences seem forced or awkward. Adoption of an explicit nursing conceptual model or theory requires restructuring the nurse's way of thinking about clinical situations and use of a new vocabulary. However, repeated use of the model or theory should lead to more systematic and organized endeavors. Broncatello (1980) comments:

The nurse's consistent use of any model [or theory] for the interpretation of observable client data is most definitely not an easy task. Much like the development of any habitual behavior, it initially requires thought, discipline, and the gradual evolution of a mind set of what is important to observe within the guidelines of the model [or theory]. As is true of most habits, however, it makes decision making less complicated (p. 23).

Perhaps the most effective strategy for facilitating perspective transformation is the widespread use of attending nurses or patient care facilitators (PCFs). Attending nurses are nurses who are with people continually wherever they are—"in and outside of institutions, schools, homes, clinics, and community settings" (Watson, 1996, p. 163). Thus the patient always has his or her own nurse, who collaborates with other health professionals when the participant requires services from others. The Attending Nurse Caring Model, which is based on Watson's theory of human caring (see Chapter 6), is just one example of how attending nurses might function and enhance nursing practice in service to human beings (Watson & Foster, 2003). PCFs, who are part of a model of patient care also based on Watson's theory

of human caring, are similar to attending nurses, although their responsibilities are limited to care of hospitalized patients. More specifically, PCFs are nurses who:

provide leadership to a team of nurses assigned geographically in one segment (approximately 12-16 beds) of the [hospital], and whose primary job was to know each of the patients in this geographic area, acting as their advocate during the course of their stay... . The PCF acts as a liaison for physicians, nurses, and other involved members of the healthcare team...to coordinate the plan of care for each of the patients... . The PCF also becomes the one consistent nurse that patients and families identify with during the course of their stay (Clark, 2004, p. 107).

The Scientific Value of Using Explicit Nursing Knowledge

Documentation of the scientific value of using nursing conceptual models and theories as guides for nursing practice is done by evaluating the legitimacy of each conceptual model and the empirical adequacy of each theory. Readers are referred to extensive evaluations in *Contemporary Nursing Knowledge: Analysis and Evaluation of Nursing Models and Theories* (Fawcett & DeSanto-Madeya, 2013). Additional documentation is, of course, needed.

Communicating the Scope and Substance of Nursing Practice

The decision to implement nursing conceptual model-based or nursing theory-based nursing practice typically is undertaken in response to the quest for a way to articulate the scope and substance of professional nursing practice to the public and to other health care professionals and to improve the conditions and outcomes of nursing practice. Consequently, one potential outcome of nursing conceptual model-based or nursing theory-based nursing practice is enhanced understanding of roles of nurses in health care by administrators, physicians, social workers, dietitians, physical therapists, occupational therapists, respiratory therapists, other health care team members and those individuals, families, and communities who participate in nursing. Research is needed to determine the extent to which the role of nursing within the health care delivery system is better understood when practice is based on an explicit nursing conceptual model or theory.

Documentation of Nursing Practice

The methodology of nursing conceptual model-based or nursing theory-based nursing practice is operationalized by the documents and technology used to guide and direct nursing practice, to record observations and results of interventions, and to describe and evaluate nursing job performance. The methodology encompasses nursing practice standards, department and unit objectives, nursing care plans, care maps, patient database and classification tools, flow sheets, Kardex forms, computer information systems, electronic health records, quality assurance tools, nursing job description and performance appraisal tools, and other relevant documents and technologies (Fawcett, 1992; Fitch, Rogers, Ross, et al., 1991; Laurie-Shaw & Ives, 1988; Weiss & Teplick, 1993). Each existing document and all current technology must be

reviewed for congruence with the nursing conceptual model or theory and revised as necessary. Although revisions often are needed and the work may seem overwhelming at the outset, the importance of having documents and technologies that are congruent with the conceptual model or theory cannot be overemphasized. Indeed, congruence may be regarded as the *sine qua non* of nursing conceptual model-based or nursing theory-based nursing practice. Although at least one computer software program (Bliss-Holtz, Taylor, & McLaughlin, 1992) and many practice documentation tools (Fawcett & DeSanto-Madeya, 2013; Nelson & Watson, 2012; Watson, 2009; Weiss & Teplick, 1993) have been developed, systematic research to determine the utility of the software and the reliability and validity of the tools is needed.

Nurse-Sensitive Patient Outcomes

The evidence needed for evidence-based nursing practice must be nurse-sensitive. That is, the evidence must connect *nursing actions to patient outcomes*. The documentation of nursing conceptual model-based or nursing theory-based practice can provide the required empirical evidence of nurse-sensitive patient outcomes. For example, Poster and Beliz (1988, 1992) found that 90% of the 38 adolescent psychiatric inpatients studied had an adaptive change in at least one behavioral subsystem after 1 week of Johnson's (1990) Behavioral System Model-based nursing practice. Furthermore, on average, the patients demonstrated significant improvement in all behavioral subsystems during the discharge phase of hospitalization. Dee, van Servellen, and Brecht (1998) added empirical research evidence of Johnson's Behavioral System Model-based nursing practice with their findings of improvement in all behavioral subsystems for inpatients under managed behavioral health care contracts. Their study results revealed statistically significant differences in the dependency, affiliative, aggressive/protective, and achievement subsystems from admission to discharge.

Measuring Satisfaction

Another potential outcome of nursing conceptual model-based or nursing theory-based nursing practice is the nurse's increased satisfaction with the conditions and outcomes of his or her nursing practice through an explicit focus on and identification of nursing problems and actions and through enhanced communication and documentation (Fitch, et al., 1991). Still another potential outcome is increased satisfaction by patients and their families with the nursing they receive. The evidence regarding nurse, patient, and family satisfaction is primarily in the form of anecdotal comments from a few clinical agencies (e.g., Scherer, 1988; Studio Three, 1992). However, empirical evidence has emerged. For example, Moreau, Poster, and Niemela (1993) report that Johnson's (1990) Behavioral System Model-based nursing practice was well received by nurses and members of the multidisciplinary team. Moreover, the nurses reported an increase in job satisfaction and retention and a decrease in role conflict. Niemela, Poster, and Moreau (1992) reported that the nurses experienced increased general satisfaction and role clarity and decreased role tension. In addition, the nurses reported that they increased communication with patients' family members.

Additional empirical evidence comes from Messmer's (1995) report of an increase in female patients' satisfaction with nursing on a general surgical inpatient pilot unit that implemented King's (1981) Conceptual System-based

nursing practice compared with the satisfaction of patients on two other units that were not yet using the framework. Still other empirical evidence comes from Hanucharunkul and Vinya-nguag (1991), who found that patients who received a nursing intervention based in part on King's (1981) Theory of Goal Attainment reported greater satisfaction with nursing than those who did not receive the intervention.

A plethora of instruments have been designed to measure nurse and patient satisfaction. However, few of these instruments (e.g., Marckx, 1995) measure satisfaction with nursing practice that is based on an explicit nursing conceptual model or theory. Thus reliable and valid instruments need to be developed before more systematic, multisite studies, which are necessary to fully document nurse, patient, and family satisfaction, are undertaken.

Utility of Nursing Models and Theories Across Populations

The literature associated with the nursing conceptual models and theories included in this text challenges nurses to consider each conceptual model and theory for possible expansion of application to a wide range of nursing specialties and for many different patient populations (see Chapters 2 and 21). Aggleton and Chalmers (1985) noted that the literature:

“might encourage some nurses to feel that it does not really matter which model of nursing is chosen to inform nursing practice within a particular care setting” (p. 39). They also noted that the literature might “encourage the view that choosing between models is something one does intuitively, as an act of personal preference. Even worse, it might encourage some nurses to feel that all their everyday problems might be eliminated were they to make the ‘right choice’ in selecting a particular model for use across a care setting” (p. 39).

However, critical appraisals of the literature have not yet revealed the extent to which the fit of the conceptual model or theory to particular patient populations might have been forced. Indeed, the issue of forced fit has not yet been addressed in the literature. This is an area for future research.

Furthermore, little attention has been given to the extent to which a particular conceptual model or theory is modified to fit a given situation (C. Germain, personal communication, October 21, 1987). Although modifications certainly are acceptable, they should be acknowledged, and serious consideration should be given to renaming the conceptual model or theory to indicate that modifications have been made. Clearly, systematic exploration of the practice implications of various conceptual models, coupled with more practical experience with each model and theory in a variety of settings, is required.

A Vision for the Future

Throughout this chapter, most of the discussion has focused on nursing conceptual model-based or nursing theory-based nursing practice. A more comprehensive and futuristic focus links the various concepts of each conceptual model with many theories. Those theories more fully specify the content of the conceptual model.

To date, discussion of conceptual-theoretical structures for nursing practice has emphasized scientific or empirical theories (Fawcett & DeSanto-Madeya, 2013). However, Carper (1978) and White (1995) identified four other types of theories that are necessary for nursing practice: ethical nursing theories, theories of personal knowing in nursing, esthetic nursing theories, and sociopolitical nursing theories (Table 22-1). Their work “not only highlighted the centrality of empirically derived theoretical knowledge, but [also] recognized with equal importance and weight, knowledge gained through...practice” (Stein, Corte, Colling, et al., 1998, p. 43).

Empirical nursing theories—the science of nursing—are developed by means of empirical research (see Table 22-1). In contrast, ethical nursing theories—the ethics of nursing, theories of personal knowing in nursing—the interpersonal relations of nursing, and esthetic nursing theories—the art of nursing—are “forms of knowledge acquired through experience and envisioned as fundamental to humane, personalized, and [moral] nursing [practice]” (Stein, et al., 1998, p. 44). These types of theories are developed by means of nonempirical modes of inquiry (see Table 22-1). Sociopolitical nursing theories—the policies and politics of nursing—help nurses understand the context of nursing practice and facilitate acceptance of multiple perspectives of a situation (White, 1995). The knowledge embedded in sociopolitical nursing theories comes from hearing and acknowledging the many voices involved in nursing practice. Chinn and Kramer (2011) refer to sociopolitical knowledge as emancipatory knowing, and describe it as “the human ability to recognize social and political problems of injustice or inequity, to realize that things could be different and to piece together complex elements of experiences and context to change a situation as it is to a situation that improves people’s lives” (p. 64).

Carper (1978) and Chinn and Kramer (2011) point out that each type of nursing theory is an essential component of the integrated knowledge base for professional practice, and no single type of theory should be used in isolation from the others. When all five types of nursing theories are linked with the concepts of a nursing conceptual model (Table 22-2), holistic and humanistic nursing practice becomes a reality. Table 22-2 is a worksheet that encourages each nurse to think about which concepts of a particular nursing conceptual model should be more fully specified by which type or types of nursing theories. For example, the Roy Adaptation Model concept of adaptation might be linked with an empirical nursing theory about adapting to a focal stimulus, such as the lifestyle changes associated with a diagnosis of diabetes. The same concept (adaptation) could be more fully specified by an esthetic nursing theory of nurses’ ability to recognize, in a nonempirical way, patients’ adaptation to lifestyle changes associated with a diagnosis of diabetes. Furthermore, adaptation could be even more fully specified by an ethical nursing theory of what nurses should do to help patients adapt to a diabetic diet, and a personal knowing theory of how nurses convey their authentic concern to patients who are struggling to adapt to a diabetic diet. In addition, the Roy model concept of adaptation could be linked to a sociopolitical (emancipatory) nursing theory of the cultural context of and inequities in care of people with diabetes.

The idea of linking the concepts of a nursing conceptual model with various types of theories has been extended to actual practice situations by use of Reed’s Framework of Scholarly Reflection (Reed, 2007). The Framework is based on a

TABLE 22-1 Five Types of Nursing Theories, Characteristics, Associated Modes of Inquiry, and Examples

| Type of Nursing Theory | Characteristics | Mode of Inquiry | Example |
|---|--|---|---|
| Empirical The science of nursing | Factual descriptions, explanations, or predictions based on subjective or objective group data Publicly verifiable Discursively written as empirical theories | Empirical research, with emphasis on replication of studies | Study of correlates of functional status in a sample of childbearing women |
| Ethical The ethics of nursing | Emphasizes values of nurses and nursing Focuses on the value of changes and outcomes in terms of desired ends Addresses questions of moral obligation, moral value, and nonmoral value Discursively written as standards, codes, and normative ethical theories | Dialogue and justification of values, with emphasis on clarification of values about rights and responsibilities in practice | American Nurses Association <i>Code of Ethics</i> |
| Personal Knowing The interpersonal relations of nursing | Concerned with knowing, encountering, and actualizing of self; also concerned with wholeness and integrity in actualization of the personal encounter between nurse and patient Addresses quality and authenticity of interpersonal process between each nurse and each patient Expressed as autobiographical stories about the authentic genuine self | Self-reflection and response from others, with emphasis on authentic self through opening and centering the self | A nurse's story about a particularly meaningful experience with a patient |
| Esthetic The art of nursing | Focuses on particulars rather than universals Emphasizes the nurse's perception of what is significant in the patient's behavior Also addresses manual and technical skills Expressed as criticism of the art-act of nursing and through works of art | Envisioning of possibilities and rehearsing of the art and acts of nursing, with emphasis on developing appreciation of esthetic meanings in practice and inspiration for development of the art of nursing | A painting depicting a nurse's idea about a woman's joy following the birth of her child |
| Sociopolitical/ Emancipatory The policies and politics of nursing | Provides context or cultural location for nurse-patient interactions and a broader context in which nursing and health care take place Focuses on critically examining social, cultural, and political situations and exposing and exploring alternate constructions of reality and inequities | Critique and hearing all voices | Report of a dialogue among patients, family members, nurses, physicians about hospital visiting hours |

Data from Carper, B. A. (1978). Fundamental patterns of knowing in nursing. *Advances in Nursing Science*, 1(1), 13-23; Chinn, P., & Kramer, M. (2011). *Integrated theory and knowledge development in nursing* (8th ed.). St. Louis: Elsevier; Fawcett, J., & Garity, J. (2009). *Evaluating research for evidence-based nursing practice*. Philadelphia: F. A. Davis; White, J. (1995). Patterns of knowing: Review, critique, and update. *Advances in Nursing Science*, 17(4), 73-86.

TABLE 22-2 Worksheet for Linkage of Nursing Conceptual Model Concepts with Five Types of Nursing Theories

| Types of Nursing Theories | A Conceptual Model Concept Example: Roy Adaptation Model Concept of Adaptation | Select Another Concept of the Conceptual Model | Select Another Concept of the Conceptual Model | Select Another Concept of the Conceptual Model |
|---------------------------------|--|---|---|---|
| Empirical | Theory of adapting to lifestyle changes associated with a diagnosis of diabetes | | | |
| Esthetic | Theory of nurses' ability to recognize patients' adaptation to lifestyle changes associated with a diagnosis of diabetes | | | |
| Ethical | Theory of what nurses should do to help patients adapt to a diabetic diet | | | |
| Personal Knowing | Theory of how nurses convey their authentic concern to patients who are struggling to adapt to a diabetic diet | | | |
| Sociopolitical/ Emancipatory | Theory of cultural context of and inequities in care of people with diabetes | | | |

philosophy of reflective practice and helps students understand their nursing role and patients' health experiences. Four groups of Reed's students presented case studies from their clinical experiences that illustrate linkage of nursing models and different types of theories. Brown and Smith (2007) describe the linkage of Orem's Self-Care Framework with empirical theories for care of a man with kidney cancer and a stage IV pressure ulcer who was admitted to a hospice. Brinkley, Ricker, and Tuomey (2007) explain how they linked Johnson's Behavioral System Model with empirical, esthetic, and personal knowing theories for care of a woman who was morbidly obese. Leitschuck and colleagues (2007) linked Orem's Self-Care Framework with empirical, esthetic, and ethical theories for care of a teenager who was a new mother. Pelton and McLean (2007) linked Orem's Framework and Roy's Adaptation Model to empirical, ethical, and sociopolitical theories for care of a disabled 12-year-old girl who was in the process of assimilating into a school environment. Reed (2007) claims that her students' work "demonstrates how use of diverse dimensions of nursing knowledge can extend evidence-based

practice... . The students’ application of the [Scholarly Reflection] Framework... [to] their clinical practice helped provide them with new insights and innovations for practice” (p. 2).

Fawcett, Watson, Neuman, and colleagues (2001) propose that the various types of theories “are the basis for generating multiple forms of evidence” for evidence-based practice (p. 117). They maintain that the:

critique and interpretation of the evidence [reflected in each type of theory] is crucial for nursing practice because it is embedded in the values and phenomena located within a broad array of nursing theories. Moreover, by recognizing the [five] types of theories, more nurses and other health professionals may appreciate and use theories. They may agree with us that theories and values are the starting point for the critique and interpretation of any evidence needed to support... practices that may enhance the quality of life of the public we serve (p. 118).

Fawcett (2012) expanded understanding of various types of theories as multiple forms of evidence for nursing practice by explaining how each type of theory is the evidence for one or more of the different aspects of evidence-based nursing practice—the nursing assessment or intervention, the patient’s values and preferences, and the nurse’s clinical judgment (Table 22-3).

Conclusion

The belief that explicit nursing discipline-specific knowledge—rather than knowledge from medicine, psychology, sociology, social work, pharmacology, and other fields—is the proper guide for nursing practice has permeated the discussion in this chapter. The continued reliance on nonnursing perspectives, coupled with a rejection of nursing knowledge, reflects the thinking of an oppressed group (Bent, 1993). However, no one is forcing or even encouraging nurses to use nonnursing knowledge. Nurses must therefore break the intellectual chains associated with

TABLE 22-3 Types of Theories Used as Evidence for Each Aspect of Evidence-Based Nursing Practice

| Aspect of Evidence-Based Nursing Practice | Types of Theories |
|---|--|
| Nursing assessments and interventions | Empirical theories Aesthetic theories Ethical theories Theories of personal knowing Sociopolitical/emancipatory theories |
| Patient values and preferences | Sociopolitical/emancipatory theories Aesthetic theories Empirical theories |
| Nurse’s clinical judgment | Aesthetic theories Ethical theories Theories of personal knowing Empirical theories |

self-imposed oppression by rejecting nonnursing knowledge as the fundamental basis of practice and embracing nursing knowledge in the form of explicit nursing conceptual models and theories and use that knowledge as the evidence for high quality and safe nursing practice.

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Glossary

- accountability** The assumption of responsibility for action taken as a professional. It implies the use of professional judgment in determining appropriate actions. Thus it requires the use of a discipline's knowledge base in anticipating consequences.
- action process** (1) The person perceives an object or objects with any one of his or her five senses; (2) the perceptions stimulate automatic thought; (3) each thought stimulates an automatic feeling; (4) the person acts.
- adaptation** The process of change whereby individuals retain their integrity, or wholeness, with the realities of their environment. It is an expression of the integration of the entire organism.
- agency** Ability, capability, or power to engage in action in Orem's theory.
- application** Putting something to practical use such as a principle or a theory.
- attachment** Formation of an emotional bond with another person that lasts for a lifetime, such as the bond between a parent and a child.
- automatic personal response** (1) A nurse responds by withholding from the patient his or her immediate reaction—perception, thought, or feeling; (2) the patient cannot verify or correct any part of the reaction; (3) the patient makes assumptions about the nurse's verbal and nonverbal behavior; (4) the nurse acts without knowledge of the patient's reaction, which causes a situational conflict.
- basic conditioning factors (BCFs)** Factors identified by Orem that influence individual health-related demands and ability to engage in self-care; for example, age, gender, health state, and family patterns.
- behavioral system balance** A system's ability to maintain a certain level of behavior within an acceptable range. Synonyms are *stability* and *steady state*.
- behavioral system imbalance** Disturbances in structure, function, or functional requirements in one or more subsystems that may be described in terms of insufficiency, discrepancy, dominance, or incompatibility.
- CCNE** Commission on Collegiate Nursing Education.
- central (centrality)** That which is focal, pivotal, principal, or essential.
- change** The essence of life or process of adaptation that is directed, purposeful, meaningful, and eminently understandable.
- compartment** Style and manner of action and interacting, which includes gestures, posture, and stance (Benner, Hooper-Kyriakidis, & Stannard, 1999).
- conceptual model** A set of interrelated concepts that symbolically represent and convey a mental image of a phenomenon. Conceptual models of nursing specify concepts and describe their relationships to the phenomena of central concern to the discipline: person, environment, health, and nursing (Powers & Knapp, 1995).
- conceptualization** The creative thinking process that involves imagination, invention, contemplation, consideration, reflection, judgment, and conclusion.

- conservation** The keeping-together function of the nurse, specified by Levine as a product of adaptation.
- criteria for a profession** A set of standards that a discipline or group uses as a gauge to recognize its level of development.
- criterion** A standard by which something is measured or evaluated.
- critical thinking** A disciplined process in which one actively and skillfully uses reason and logic as a guide to belief and action in decision making.
- critical thinking structures** Organized systems of thought—such as nursing philosophies, conceptual models, or theoretical frameworks—that guide the reasoning process leading to decisive action.
- cultural diversity** Differences or variations that can be found both between and among different cultures.
- deduction** An approach to thinking and reasoning that proceeds from the general to the particular.
- developmental self-care requisites** Needs or goals that arise from maturational changes in the life cycle, such as pregnancy, or from situational events throughout human development, such as the death of a significant other.
- diagnostic statement** A product of the assessment process in Neuman’s model that reflects systematic consideration of actual or potential environmental stressors.
- disequilibrium** The absence of client system balance in Neuman’s Systems Model.
- evidence** A set of theory-derived, research-based information for decision making in practice.
- evidence-based nursing practice** The deliberate and critical use of evidence about the health-related experiences of human beings with individual needs and personal preferences to guide nursing practice (Fawcett & Garity, 2009; Ingersoll, 2000).
- external regulatory force** Role of the nurse specified by Johnson to preserve the organization and integration of the client’s behavior at an optimal level under conditions in which the client’s behavior constitutes a threat to physical and psychosocial health.
- folk care** The use of remedies for illness or injury passed down from generation to generation within a particular culture. Also known as *generic care*.
- functional requirements/sustenal imperatives** Protection, nurturance, and stimulation that the behavioral system must receive from the environment to survive and develop.
- “good”** Something that, if achieved, will benefit a person or a group of persons; for example, health care is a “good.”
- grand theory** Propositions derived from a conceptual model or framework that are at a sufficiently high level of abstraction to generate many different middle-range applications specific to variations in practice level details.
- health deviation self-care requisites** Self-care deficits that arise when persons are ill or injured, have defects or disabilities, or are undergoing diagnosis or treatment.
- hermeneutics** Derived from biblical exegesis, a term for interpretation or explication. As used in research, hermeneutics refers to describing and studying “mean-

ingful human phenomena in a careful and detailed manner as free as possible from prior theoretical assumptions, based instead on practical understanding” (Packer, 1985, pp. 1081-1082).

induction An approach to thinking and reasoning that proceeds from the particular to the general.

infant cues Infant sounds and behaviors that send signals to parents and others for needs to be met.

manifestation What is perceivable of field patterning (Rogers) or the aspect of the field that our perceptions can recognize.

metaparadigm The worldview of a discipline, the most global perspective that subsumes more specific views and approaches to the central concepts with which a discipline is concerned. Nursing’s metaparadigm is widely accepted to be human being, environment, health, and nursing (Fawcett, 2005; Powers & Knapp, 1995).

middle-range theory The least abstract set of related concepts that together propose a testable outcome and contain details of nursing practice and/or the nursing situation.

moral Appraisal of actions according to whether these are praiseworthy or blameworthy. An action is normally praiseworthy to the degree that it is focused on achieving a “good” of some sort for another person or group of persons.

moral imperative Action or practice that is absolutely required in order to promote a particular “good.”

mutual patterning The process by which the human and environmental field process is evolving. Known patterns are identified in the human/environmental field process.

naturalistic research A qualitative research approach used to discover the subjective and objective aspects of a group or culture.

NLNAC National League for Nursing Accrediting Commission.

normal science “[R]esearch firmly based upon one or more past scientific achievements, achievements that some particular scientific community acknowledges for a time [as a paradigm] supplying the foundation for its further practice” (Kuhn, 1970, p. 10).

nurse-patient situation A dynamic whole. Each nurse and each patient affect one another’s behavior and is unique for each situation. The patient’s behavior stimulates the nurse’s immediate reaction and becomes the starting point of the nurse’s investigation.

nursing art Expressive, creative, and skillful activities of nurses tailored by the individual nurse according to a blending of knowledge and values in actions for a personal style of practice.

nursing philosophy Presents a general meaning of nursing and nursing phenomena through reasoning and logical presentation. They are theoretical works that address one or more metaparadigm concepts in a general way.

nursing science Knowledge of practice produced through the unique interrelationship of theory and research with approaches aimed at understanding the discipline’s phenomena of interest.

- nursing system** All the actions and interactions of the nurse and client and/or family in a nursing situation at a point in time.
- perceived dissonance** A perception of disharmony or discomfort in the human/environmental field process in Rogers' theory.
- perspective transformation** The process whereby the assumptions, values, and beliefs that constitute a given meaning perspective come to consciousness, are reflected upon, and are critically analyzed. The process involves gradually taking on a new perspective along with corresponding fundamental structural changes in the way individuals see themselves and their relationships with others. This leads to a reinterpretation of their personal, social, or occupational worlds. The nine phases of perspective transformation are stability, dissonance, confusion, dwelling with uncertainty, saturation, synthesis, resolution, reconceptualization, and return to stability.
- praxis** A dynamic process informed by the reciprocal relationship between theory and practice.
- provocative facts** The presenting symptoms alerting one to a problem.
- role identity** Taking on a role. In Mercer's theory, it is seeing oneself in the role and having a sense of comfort about it.
- scholarship** Development and communication of knowledge.
- self-care agency** The individual's learned ability or power to perform self-care, including knowledge, skill, and motivation for self-care actions that promote life, health, and well-being.
- self-care deficit** An inadequacy of the individual's self-care ability to meet the therapeutic self-care demand.
- spiritual distress** A disruption of the human spirit. The human spirit gives meaning and purpose to life, serves to integrate the whole human being, and connects the individual to self, others, the universe, and the creator. In spiritual distress the individual may lose sight of the meaning and purpose of life or connectedness.
- stability** Equilibrium or client system balance in Neuman's Systems Model.
- stressor** Intrapersonal, interpersonal, or extrapersonal conditions or situations identified by Neuman as threats to the stability or integrity of the client system.
- substantive** Substantial, essential, having a solid basis, or independent in existence.
- subsystem** A minisystem with its own unique goal and function that is maintained as long as its relationship to other subsystems is in a steady state, functional requirements are provided, and/or the environment is not disturbed.
- theory** A set of statements that tentatively describe, explain, or predict relationships among concepts that have been systematically selected and organized as an abstract representation of some phenomenon. These systematic organized perspectives (models) serve as guides for nursing action in administration, education, research, and practice (Powers & Knapp, 2011).
- theory application** The operation of a system of ideas in action.
- theory development** A knowledge-building process in the context of syntax, structure, and growth.
- theory utilization** Orchestrating systematic ideas to accomplish a purpose.

therapeutic self-care demand The self-care actions that should be performed by the individual at a point in time to maintain health and promote well-being.

therapeutic self-care requisite The need or goal that will be met by satisfying the therapeutic self-care demand.

transcendence Going beyond what is customary or rising above the everyday physical world in some way.

transition Passing from one phase to another. It involves letting go of previous attitudes and behaviors and taking on new attitudes and behaviors.

trophicognosis A nursing care judgment achieved through the use of Levine's scientific process.

universal self-care requisites Human needs for self-care that promote structural and functional integrity of the person and well-being—including maintenance of air, food, water, and elimination; balance between activity and rest; solitude and social interaction; prevention of hazards; and the promotion of normalcy.

utilization The use for something.

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