Framework for Professional Nursing Practice

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Although the beginning of nursing theory development can be traced to Florence Nightingale, it was not until the second half of the 1900s that nursing theory caught the attention of nursing as a discipline. During the decades of the 1960s and 1970s, theory development was a major topic of discussion and publication. During the 1970s, much of the discussion was related to the development of one global theory for nursing. However, in the 1980s, attention turned from the development of a global theory for nursing as scholars began to recognize multiple approaches to theory development in nursing.

Because of the plurality in nursing theory, this information must be organized to be meaningful for practice, research, and further knowledge development. The goal of this chapter is to present an organized and practical overview of the major concepts, models, philosophies, and theories that are essential in professional nursing practice.

It can be helpful to define some terms that might be unfamiliar. A **concept** is a term or label that describes a phenomenon (Meleis, 2004). The phenomenon described by a concept can be either empirical or abstract. An empirical concept is one that can be either observed or experienced through the senses. An abstract concept is one that is not observable, such as hope or caring (Hickman, 2002).

Key Terms and Concepts

» **Concept**
» Conceptual model
» Propositions
» Assumptions
» Theory
» Metaparadigm
» Person
» Environment
» Health
» Nursing
» Philosophies

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Learning Objectives

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After completing this chapter, the student should be able to:

1. Identify the four metaparadigm concepts of nursing.
2. Identify and describe several theoretical works in nursing.
3. Begin the process of identifying theoretical frameworks of nursing that are consistent with a personal belief system.

A **conceptual model** is defined as a set of concepts and statements that integrate the concepts into a meaningful configuration (Lippitt, 1973; as cited in Fawcett, 1994). **Propositions** are statements that describe relationships among events, situations, or actions (Meleis, 2004). **Assumptions** also describe concepts or connect two concepts and represent values, beliefs, or goals. When assumptions are challenged, they become propositions (Meleis, 2004).

Conceptual models are composed of abstract and general concepts and propositions that provide a frame of reference for members of a discipline. This frame of reference determines how the world is viewed by members of a discipline and guides the members as they propose questions and make observations relevant to the discipline (Fawcett, 1994).

A **theory** "is an organized, coherent, and systematic articulation of a set of statements related to significant questions in a discipline that are communicated in a meaningful whole," according to Meleis (2007, p. 37). The primary distinction between a conceptual model and a theory is the level of abstraction and specificity. A conceptual model is a highly abstract system of global concepts and linking statements. A theory, in contrast, deals with one or more specific, concrete concepts and propositions (Fawcett, 1994).

A **metaparadigm** is the most global perspective of a discipline and "acts as an encapsulating unit, or framework, within which the more restricted … structures develop" (Eckberg & Hill, 1979, p. 927). Each discipline singles out phenomena of interest that it will deal with in a unique manner. The concepts and propositions that identify and interrelate these phenomena are even more abstract than those in the conceptual models. These are the concepts that comprise the metaparadigm of the discipline (Fawcett, 1994).

The conceptual models and theories of nursing represent various paradigms derived from the metaparadigm of the discipline of nursing. Therefore, although each of the conceptual models might link and define the four metaparadigm concepts differently, the four metaparadigm concepts are present in each of the models.

> **The conceptual models and theories of nursing represent various paradigms derived from the metaparadigm of the discipline of nursing.**

The central concepts of the discipline of nursing are **person**, **environment**, **health**, and **nursing**. These four concepts of the metaparadigm of nursing are more specifically "The person receiving the nursing, the environment within which the person exits, the health–illness continuum within which the person falls at the time of the interaction with the nurse, and, finally, nursing actions themselves" (Flaskerud & Holloran, 1980, cited in Fawcett, 1994, p. 5).

Because concepts are so abstract at the metaparadigm level, many conceptual models have developed from the metaparadigm of nursing. Subsequently, multiple theories have been derived from each conceptual model in an effort to describe, explain, and predict the phenomena within the model.

Overview of Selected Nursing Theories

To apply nursing theory in practice, the nurse must have some knowledge of the theoretical works of the nursing profession. This chapter is not intended to provide an in-depth analysis of each of the theoretical works in nursing but rather provides an introductory overview of selected theoretical works to give you a launching point for further reflection and study as you begin your journey into professional nursing practice.

Theoretical works in nursing are generally categorized either as philosophies, conceptual models, theories, or middle-range theories depending on the level of abstraction. We begin with the most abstract of these theoretical works, the philosophies of nursing.

> **www** **CRITICAL THINKING QUESTION** ✶
>
> What are the specific competencies for nurses in relation to theoretical knowledge? ✶

■ Selected Philosophies of Nursing

Philosophies set forth the general meaning of nursing and nursing phenomena through reasoning and the logical presentation of ideas. Philosophies are broad and address general ideas about nursing. Because of their breadth, nursing philosophy contributes to the discipline by providing direction, clarifying values, and forming a foundation for theory development (Alligood, 2006).

Nightingale's Environmental Theory

Nightingale's philosophy includes the four metaparadigm concepts of nursing (Table 2-1), but the focus is primarily on the patient and the environment, with the nurse manipulating the environment to enhance patient recovery. Nursing interventions using Nightingale's philosophy are centered on her 13 canons, which follow (Nightingale, 1860/1969):

- Ventilation and warmth: The interventions subsumed in this canon include keeping the patient and the patient's room warm and keeping the patient's

Metaparadigm Concepts as Defined in Nightingale's Model	
Person Recipient of nursing care **Environment** External (temperature, bedding, ventilation) and internal (food, water, and medications) **Health** Health is "not only to be well, but to be able to use well every power we have to use" (Nightingale, 1969, p. 24)	**Nursing** Alter or manage the environment to implement the natural laws of health

TABLE 2-1

room well ventilated and free of odors. Specific instructions included "keep the air within as pure as the air without" (Nightingale, 1860/1969, p. 10).

- Health of houses: This canon includes the five essentials of pure air, pure water, efficient drainage, cleanliness, and light.
- Petty management: Continuity of care for the patient when the nurse is absent is the essence of this canon.
- Noise: Instructions include the avoidance of sudden noises that startle or awaken patients and keeping noise in general to a minimum.
- Variety: This canon refers to an attempt at variety in the patient's room to avoid boredom and depression.
- Food intake: Interventions include the documentation of the amount of food and liquids that the patient ingests.
- Food: Instructions include trying to include patient food preferences.
- Bed and bedding: The interventions in this canon include comfort measures related to keeping the bed dry and wrinkle free.
- Light: The instructions contained in this canon relate to adequate light in the patient's room.
- Cleanliness of rooms and walls: This canon focuses on keeping the environment clean.
- Personal cleanliness: This canon includes measures such as keeping the patient clean and dry.
- Chattering hopes and advises: Instructions in this canon include the avoidance of talking without reason or giving advice that is without fact.
- Observation of the sick: This canon includes instructions related to making observations and documenting observations.

The 13 canons are central to Nightingale's theory but are not all inclusive. Nightingale believed that nursing was a calling and that the recipients of nursing care were holistic individuals with a spiritual dimension; thus, the nurse was expected to care for the spiritual needs of the patients in spiritual distress. Nightingale also believed that nurses should be involved in health promotion and health teaching with the sick and with those who were well (Bolton, 2006).

Although Nightingale's theory was developed long ago in response to a need for environmental reform, the nursing principles are still relevant today. Even as some of Nightingale's rationales have been modified or disproved by advances in medicine and science, many of the concepts in her theory have not only endured, but have been used to provide general guidelines for nurses for more than 150 years (Pfettscher, 2006).

Virginia Henderson: Definition of Nursing and 14 Components of Basic Nursing Care

Henderson made such significant contributions to the discipline of nursing during her more-than-60-year career as a nurse, teacher, author, and researcher that some refer to her as the Florence Nightingale of the 20th century (Tomey, 2006). She is perhaps best known for her definition of nursing, which was

first published in 1955 (Harmer & Henderson, 1955) and then published in 1966 with minor revisions. According to Henderson,

> The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will, or knowledge and to do this in such a way as to help him gain independence as rapidly as possible. (Henderson, 1966, p. 15)

In her work Henderson emphasized the art of nursing as well as empathetic understanding, stating that the nurse must "get inside the skin of each of her patients in order to know what he needs" (Henderson, 1964, p. 63). She believed that "the beauty of medicine and nursing is the combination of your heart, your head and your hands and where you separate them, you diminish them …" (McBride, 1997, as cited by Gordon, 2001).

Henderson identified 14 basic needs on which nursing care is based. These needs include the following:

- Breathe normally.
- Eat and drink adequately.
- Eliminate bodily wastes.
- Move and maintain desirable postures.
- Sleep and rest.
- Select suitable clothes; dress and undress.
- Maintain body temperature within normal range by adjusting clothing and modifying the environment.
- Keep the body clean and well groomed and protect the integument.
- Avoid dangers in the environment, and avoid injuring others.
- Communicate with others in expressing emotions, needs, fears, or opinions.
- Worship according to one's faith.
- Work in such a way that there is a sense of accomplishment.
- Play or participate in various forms of recreation.
- Learn, discover, or satisfy the curiosity that leads to normal development and health and use the available health facilities (Henderson, 1966, 1991).

Although Henderson did not consider her work a theory of nursing, and did not explicitly state assumptions or define each of the domains of nursing, her work includes the metaparadigm concepts of nursing (Furukawa & Howe, 2002) (Table 2-2).

Jean Watson: Philosophy and Science of Caring

According to Watson's theory (1996), the goal of nursing is to help persons attain a higher level of harmony within the mind–body–spirit. Attainment of that goal can potentiate healing and health (Table 2-3). This goal is pursued through transpersonal caring guided by carative factors and corresponding caristas processes.

Metaparadigm Concepts as Defined in Henderson's Philosophy and Art of Nursing	
Person Recipient of nursing care who is composed of biological, psychological, sociological, and spiritual components	**Health** Based upon the patient's ability to function independently (as outlined in 14 components of basic nursing care)
Environment External environment (temperature, dangers in environment); some discussion of impact of community on the individual and family	**Nursing** Assist the person, sick or well, in performance of activities (14 components of basic nursing care) and help the person gain independence as rapidly as possible (Henderson, 1966, p. 15)

TABLE 2-2

Metaparadigm Concepts as Defined in Watson's Philosophy and Science of Caring	
Person (human) A "unity of mind–body–spirit/nature" (Watson, 1996, p. 147); embodied spirit (Watson, 1989)	**Health (healing)** Harmony, wholeness, and comfort
Healing space and environment A nonphysical energetic environment; a vibrational field integral with the person where the nurse is not only in the environment but "the nurse IS the environment" (Watson, 2008, p. 26)	**Nursing** Reciprocal transpersonal relationship in caring moments guided by carative factors and caritas processes

TABLE 2-3

Watson's theory for nursing practice is based on 10 carative factors (Watson, 1979). As Watson's work evolved, she renamed these carative factors into what she termed clinical caritas processes (Fawcett, 2005). *Caritas* means to cherish, to appreciate, and to give special attention. It conveys the concept of love (Watson, 2001). The 10 caritas processes are summarized here:

- Practice of loving kindness and equanimity for oneself and other
- Being authentically present and enabling and sustaining the deep belief system and subjective life world of self and the one being cared for
- Cultivating one's own spiritual practices; going beyond the ego self; deepening of self-awareness
- Developing and sustaining a helping–trusting, authentic caring relationship

- Being present to, and supportive of, the expression of positive and negative feelings as a connection with a deeper spirit of oneself and the one being cared for
- Creatively using oneself and all ways of knowing as part of the caring process and engagement in artistry of caring–healing practices
- Engaging in a genuine teaching–learning experience within the context of a caring relationship, while attending to the whole person and subjective meaning; attempting to stay within the other's frame of reference
- Creating a healing environment at all levels, subtle environment of energy and consciousness whereby wholeness, beauty, comfort, dignity, and peace are potentiated
- Assisting with basic needs, with an intentional caring consciousness; administering human care essentials, which potentiate alignment of the mind–body–spirit, wholeness, and unity of being in all aspects of care; attending to both embodied spirit and evolving emergence
- Opening and attending to spiritual, mysterious, and unknown existential dimensions of life, death, suffering; "allowing for a miracle" (Watson, 2008)

Watson (2001) refers to the clinical caritas processes as the "core" of nursing, which is grounded in the philosophy, science, and the art of caring. She contrasts the core of nursing with what she terms the "trim," a term she uses to refer to the practice setting, procedures, functional tasks, clinical disease focus, technology, and techniques of nursing. The trim, Watson explains, is not expendable, but it cannot be the center of professional nursing practice (Watson, 1997, p. 50).

Regarding the value system that is blended with these 10 carative factors, Watson (1985) states:

> Human care requires high regard and reverence for a person and human life… . There is high value on the subjective–internal world of the experiencing person and how the person (both patient and nurse) is perceiving and experiencing health–illness conditions. An emphasis is placed upon helping a person gain more self-knowledge, self control, and readiness for self-healing. (pp. 34, 35)

The carative factors described by Watson provide guidelines for nurse–patient interactions; however, the theory does not furnish instructions about what to do to achieve authentic caring–healing relationships. Watson's theory is more about being than doing, but it provides a useful framework for the delivery of patient-centered nursing care (Neil & Tomey, 2006).

Patricia Benner's Clinical Wisdom in Nursing Practice

Benner's work has focused on the understanding of perceptual acuity, clinical judgment, skilled know-how, ethical comportment, and ongoing experiential learning (Brykczynski, 2010, p. 141). Also important in Benner's philosophy is an understanding of ethical comportment. According to Day and Benner (2002),

good conduct is a product of an individual relationship with the patient that involves engagement in a situation combined with a sense of membership in a profession where professional conduct is socially embedded, lived, and embodied in the practices, ways of being, and responses to clinical situations and where clinical and ethical judgments are inseparable.

Benner's original domains and competencies of nursing practice were derived inductively from clinical situation interviews and observations of nurses in actual practice. From these interviews and observations, 31 competencies and 7 domains were identified and described. The 7 domains are 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 healthcare practices, and organizational work role competencies (Benner, 1984/2001). Along with the identification of the competencies and domains of nursing, Benner identified five stages of skill acquisition based on the Dreyfus model of skill acquisition as applied to nursing along with characteristics of each stage. The stages identified included novice, advanced beginner, competent, proficient, and expert (Benner, 1984/2001).

Later, in an extension of her original work, Benner and her colleagues identified nine domains of critical care nursing. These domains are diagnosing and managing life-sustaining physiologic functions in unstable patients, using skilled know-how to manage a crisis, providing comfort measures for the critically ill, caring for patients' families, preventing hazards in a technological environment, facing death: end-of-life care and decision making, communicating and negotiating multiple perspectives, monitoring quality and managing breakdown, using the skilled know-how of clinical leadership and the coaching and mentoring of others (Benner, Hooper-Kyriakidis, & Stannard, 1999). In addition, the nine domains of critical care nursing practice are used as broad themes in data interpretation for the identification and description of six aspects of clinical judgment and skilled comportment. These six aspects are as follows:

- Reasoning-in-transition: Practical reasoning in an ongoing clinical situation
- Skilled know-how: Also known as embodied intelligent performance; knowing what to do, when to do it, and how to do it
- Response-based practice: Adapting interventions to meet the changing needs and expectations of patients
- Agency: One's sense of and ability to act on or influence a situation
- Perceptual acuity and the skill of involvement: The ability to tune into a situation and hone in on the salient issues by engaging with the problem and the person
- Links between clinical and ethical reasoning: The understanding that good clinical practice cannot be separated from ethical notions of good outcomes for patients and families (Benner et al., 1999).

Metapardigm Concepts as Defined in Benner's Philosophy	
Person Embodied person living in the world who is a "self-interpreting being, that is, the person does not come into the world pre-defined but gets defined in the course of living a life" (Benner & Wrubel, 1989, p. 41) **Environment (situation)** A social environment with social definition and meaningfulness	**Health** The human experiencee of health or wholeness **Nursing** A caring relationship that includes the care and study of the lived experience of health, illness, and disease

TABLE 2-4

Benner identifies and defines the four metaparadigm concepts of nursing in addition to the concepts previously discussed. The concepts of person, environment, health, and nursing as defined by Benner are summarized in Table 2-4.

■ Selected Conceptual Models and Grand Theories of Nursing

Conceptual models provide a comprehensive view and guide for nursing practice. They are organizing frameworks that guide the reasoning process in professional nursing practice (Alligood, 2006). At the level of the conceptual model, each metaparadigm concept is defined and described in a manner unique to the model, with the model providing an alternative way to view the concepts considered important to the discipline (Fawcett, 2005, pp. 17–18).

Martha Rogers's Science of Unitary Human Beings

According to Rogers (1994), nursing is a learned profession, both a science and an art. The art of nursing is the creative use of the science of nursing for human betterment.

Rogers's theory asserts that human beings are dynamic energy fields that are integrated with environmental energy fields so that the person and his or her environment form a single unit. Both human energy fields and environmental fields are open systems, pandimensional in nature and in a constant state of change. Pattern is the identifying characteristic of energy fields (Table 2-5).

Rogers identified the principles of helicy, resonancy, and integrality to describe the nature of change within human and environmental energy fields. Together, these principles are known as the principle of homeodynamics. The helicy principle describes the unpredictable but continuous, nonlinear evolution of energy fields, as evidenced by a spiral development that is a continuous, nonrepeating, and innovative patterning that reflects the nature

Metaparadigm Concepts as Defined in Rogers's Theory	
Person An irreducible, irreversible, pandimensional, negentropic energy field identified by pattern; a unitary human being develops through three principles: helicy, resonancy, and integrality (Rogers, 1992) **Environment** An irreducible, pandimensional, negentropic energy field, identified by pattern and manifesting characteristics different from those of the parts and encompassing all that is other than any given human field (Rogers, 1992)	**Health** Health and illness as part of a continuum (Rogers, 1970) **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 environmental fields for realization of maximum health potential (Rogers, 1970)

TABLE 2-5

of change. Resonancy is depicted as a wave frequency and an energy field pattern evolution from lower to higher frequency wave patterns and is reflective of the continuous variability of the human energy field as it changes. The principle of integrality emphasizes the continuous mutual process of person and environment (Rogers, 1970, 1992).

Rogers used two widely recognized toys to illustrate her theory and constant interaction of the human–environment process. The Slinky illustrates the openness, rhythm, motion, balance, and expanding nature of the human life process, which is continuously evolving (Rogers, 1970). The kaleidoscope illustrates the changing patterns that appear to be infinitely different (Johnson & Webber, 2010, p. 142).

Rogers (1970) identified five assumptions that support and connect the concepts in her conceptual model:

- Man is a unified whole possessing his own integrity and manifesting characteristics more than and different from the sum of his parts (p. 47).
- Man and environment are continuously exchanging matter and energy with one another (p. 54).
- The life process evolves irreversibly and unidirectionally along the space–time continuum (p. 59).
- Pattern and organization identify man and reflect his innovative wholeness (p. 65).
- Man is characterized by the capacity for abstraction and imagery, language and thought, sensation, and emotion (p. 73).

Rogers's model is an abstract system of ideas but is applicable to practice, with nursing care focused on pattern appraisal and patterning activities. Pattern appraisal involves a comprehensive assessment of environmental field

patterns and human field patterns of communication, exchange, rhythms, dissonance, and harmony through the use of cognitive input, sensory input, intuition, and language. Patterning activities can include interventions such as meditation, imagery, journaling, or modifying surroundings. Evaluation is ongoing and requires a repetition of the appraisal process (Gunther, 2006).

Dorothea Orem's Self-Care Deficit Theory of Nursing

Orem describes her theory as a general theory that is made up of three related theories, the Theory of Self-Care, the Theory of Self-Care Deficit, and the Theory of Nursing Systems. The Theory of Self-Care describes why and how people care for themselves. The Theory of Self-Care Deficit describes and explains why people can be helped through nursing. The Theory of Nursing Systems describes and explains relationships that must exist and be maintained for nursing to occur. These three theories in relationship constitute Orem's general theory of nursing known as the Self-Care Deficit Theory of Nursing (Berbiglia, 2010; Orem, 1990; Taylor, 2006).

Theory of Self-Care

The Theory of Self-Care describes why and how people care for themselves and suggests that nursing is required in case of inability to perform self-care as a result of limitations. This theory includes the concepts of self-care agency, therapeutic self-care demand, and basic conditioning factors.

Self-care agency is an acquired ability of mature and maturing persons to know and meet their requirements for deliberate and purposive action to regulate their own human functioning and development (Orem, 2001, p. 492). The concept of self-care agency has three dimensions: development, operability, and adequacy. According to Orem (2001, p. 491), therapeutic self-care demand consists of the summation of care measures necessary to meet all of an individual's known self-care requisites. *Basic conditioning factors* refer to those factors that affect the value of the therapeutic self-care demand or self-care agency of an individual. Ten factors are identified: age, gender, developmental state, health state, pattern of living, healthcare system factors, family system factors, sociocultural factors, availability of resources, and external environmental factors (Orem, 2001).

Orem identifies three types of self-care requisites that are integrated into the theory of self-care and provide the basis for self-care. These include universal self-care requisites, developmental self-care requisites, and health deviation self-care requisites.

Universal self-care requisites are those found in all human beings and are associated with life processes. These requisites include the following needs:

- Maintenance of sufficient intake of air
- Maintenance of sufficient intake of water
- Maintenance of sufficient intake of food
- Provision of care associated with elimination processes and excrements

- Maintenance of a balance of activity and rest
- Maintenance of a balance between solitude and social interaction
- Prevention of hazards to human life, human functioning, and human well-being
- Promotion of human functioning and development within social groups in accordance with human potential, known limitations, and the human desire to be normal (Orem, 1985, pp. 90–91)

Developmental self-care requisites are related to different stages in the human life cycle and might include events such attending college, marriage, and retirement. Broadly speaking, the development self-care requisites include the following needs:

- Bringing about and maintenance of living conditions that support life processes and promote the processes of development—that is, human progress toward higher levels of organization of human structures and toward maturation
- Provision of care either to prevent the occurrence of deleterious effects of conditions that can affect human development or to mitigate or overcome these effects from various conditions (Orem, 1985, p. 96)

Health-deviation self-care requisites are related to deviations in structure or function of a human being. There are six categories of health-deviation requisites:

- Seeking and securing appropriate medical assistance
- Being aware of and attending to the effects and results of illness states
- Effectively carrying out medically prescribed treatments
- Being aware of and attending to side effects of treatment
- Modifying self-concept in accepting oneself in a particular state of health
- Learning to live with the effects of illness and medical treatment (Orem, 1985, pp. 99–100)

Theory of Self-Care Deficit

The Theory of Self-Care Deficit explains that maturing or mature adults deliberately learn and perform actions to direct their survival, quality of life, and well-being; put more simply, it explains why people can be helped through nursing. According to Orem, nurses use five methods to help meet the self-care needs of patients:

- Acting for or doing for another
- Guiding and directing
- Providing physical or psychological support
- Providing and maintaining an environment that supports personal development
- Teaching (Johnson & Webber, 2010; Orem, 1995, 2001)

Theory of Nursing Systems

The Theory of Nursing Systems describes and explains relationships that must exist and be maintained for the product (nursing) to occur (Berbiglia, 2010; Taylor, 2006). Three systems can be used to meet the self-requisites of the patient: the wholly compensatory system, the partially compensatory system, and the supportive-educative system.

- In the *wholly compensatory system,* the patient is unable to perform any self-care activities and relies on the nurse to perform care.
- In the *partially compensatory system,* both the patient and the nurse participate in the patient's self-care activities, with the responsibility for care shifting from the nurse to the patient as the self-care demand changes.
- In the *supportive-educative system,* the patient has the ability for self-care but requires assistance from the nurse in decision making, knowledge, or skill acquisition. The nurse's role is to promote the patient as a self-care agent.

The system selected depends on the nurse's assessment of the patient's ability to perform self-care activities and self-care demands (Johnson & Webber, 2010; Orem, 1995, 2001).

There are eight general propositions for the Self-Care Deficit Theory of Nursing (although each of the three individual theories also has its own set of propositions) (Meleis, 2004):

- Human beings have capabilities to provide their own self-care or care for dependants to meet universal, developmental, and health-deviation self-care requisites. These capabilities are learned and recalled.
- Self-care abilities are influenced by age, developmental state, experiences, and sociocultural background.
- Self-care deficits should balance between self-care demands and self-care capabilities.
- Self-care or dependent care is mediated by age, developmental stage, life experience, sociocultural orientation, health, and resources.
- Therapeutic self-care includes actions of nurses, patients, and others that regulate self-care capabilities and meet self-care needs.
- Nurses assess the abilities of patients to meet their self-care needs and their potential of not performing their self-care.
- Nurses engage in selecting valid and reliable processes, technologies, or actions for meeting self-care needs.
- Components of therapeutic self-care are wholly compensatory, partly compensatory, and supportive-educative.

In addition to these other concepts, the four metaparadigm concepts of nursing are identified in Orem's theory (Table 2-6). Orem's theory clearly differentiates the focus of nursing and is one of the nursing theories that is most commonly used in practice.

Metaparadigm Concepts as Defined by Orem's Theory	
Person (patient) A person under the care of a nurse; a total being with universal, developmental needs, and capable of self-care **Environment** Physical, chemical, biologic, and social contexts within which human beings exist; environmental components include environmental factors, environmental elements, environmental conditions, and developmental environment (Orem, 1985)	**Health** "A state characterized by soundness or wholeness of developed human structures and of bodily and mental functioning" (Orem, 1995, p. 101) **Nursing** Therapeutic self-care designed to supplement self-care requisites. Nursing actions fall into one of three categories: wholly compensatory, partly compensatory, or supportive–educative system (Orem, 1985)

TABLE 2-6

Metaparadigm Concepts as Defined in Roy's Model	
Person "An adaptive system with cognator and regulator subsystems acting to maintain adaptation in the four adaptive modes" (Roy, 2009, p. 12) **Environment** "All conditions, circumstances, and influences surrounding and affecting the development and behavior of persons and groups, with particular consideration of mutuality of person and earth resources" (Roy, 2009, p. 12)	**Health** "A state and process of being and becoming an integrated and whole that reflects person and environment mutuality (Roy, 2009, p. 12) **Nursing** The goal of nursing is "to promote adaptation for individuals and groups in the four adaptive modes, thus contributing to health, quality of life, and dying with dignity by assessing behavior and factors that influence adaptive abilities and to enhance environmental factors (Roy, 2009, p.12)

TABLE 2-7

Callista Roy's Adaptation Model

The Roy Adaptation Model presents the person as an adaptive system in constant interaction with the internal and the external environments. The main task of the human system is to maintain integrity in the face of environmental stimuli (Phillips, 2006). The goal of nursing is to foster successful adaptation (Table 2-7).

According to Roy and Andrews (1999), adaptation refers to "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" (p. 54). Adaptation leads to optimum health and well-being, to quality of life, and to death with dignity (Andrews & Roy, 1991). The adaptation level represents the condition of the life processes. Roy describes three levels: integrated, compensatory, and compromised life processes. An integrated life process can change to a compensatory process, which attempts to reestablish adaptation. If the compensatory processes are not adequate, compromised processes result (Roy, 2009, p. 33).

The processes for coping in the Roy Adaptation Model are categorized as "the regulator and cognator subsystems as they apply to individuals, and the stabilizer and innovator subsystems as applied to groups" (p. 33). A basic type of adaptive process, the regulator subsystem responds through neural, chemical, and endocrine coping channels. Stimuli from the internal and external environments act as inputs through the senses to the nervous system, thereby affecting the fluid, electrolyte, and acid–base balance, as well as the endocrine system. This information is all channeled automatically, with the body producing an automatic, unconscious response to it (p. 41).

The second adaptive process, the cognator subsystem, responds through four cognitive-emotional channels: perceptual and information processing, learning, judgment, and emotion. Perceptual and information processing includes activities of selective attention, coding, and memory. Learning involves imitation, reinforcement, and insight. Judgment includes problem solving and decision making. Defenses are used to seek relief from anxiety and make affective appraisal and attachments through the emotions (p. 41).

The cognator–regulator and stabilizer–innovator subsystems function to maintain integrated life processes. These life processes—whether integrated, compensatory, or compromised—are manifested in behaviors of the individual or group. Behavior is viewed as an output of the human system and takes the form of either adaptive responses or ineffective responses. These responses serve as feedback to the system, with the human system using this information to decide whether to increase or decrease its efforts to cope with the stimuli (Roy, 2009, p. 34).

Behaviors can be observed in four categories, or adaptive modes: physiologic-physical mode, self-concept–group identify mode, role function mode, and interdependence mode. Behavior in the *physiologic-physical mode* is the manifestation of the physiologic activities of all cells, tissues, organs, and systems making up the body. The *self-concept–group identity mode* includes the components of the physical self, including body sensation and body image, and the personal self, including self-consistency, self-ideal, and moral-ethical-spiritual self. The *role function mode* focuses on the roles of the person in society and the roles within a group, and the *interdependence mode* is a category of behavior related to interdependent relationships. This mode focuses on interactions related to the giving and receiving of love, respect, and value (Roy, 2009).

In the Roy Adaptation Model, three classes of stimuli form the environment: the focal stimulus (internal or external stimulus most immediately in the awareness of the individual or group), contextual stimuli (all other stimuli present in the situation that contribute to the effect of the focal stimulus), and residual stimuli (environmental factors within or outside human systems, the effects of which are unclear in the situation) (Roy, 2009, pp. 35–36).

The propositions of Roy's theory include the following:

- Nursing actions promote a person's adaptive responses.
- Nursing actions can decrease a person's ineffective adaptive responses.
- People interact with the changing environment in an attempt to achieve adaptation and health.
- Nursing actions enhance the interaction of persons with the environment.
- Enhanced interactions of persons with the environment promote adaptation (Meleis, 2004).

The Roy Adaptation Model is commonly used in nursing practice. To use the model in practice, the nurse follows Roy's six-step nursing process, which is as follows (Phillips, 2006):

- Assessing the behaviors manifested from the four adaptive modes (physiologic-physical mode, self-concept–group identity mode, role function mode, and interdependence mode)
- Assessing and categorizing the stimuli for those behaviors
- Making a nursing diagnosis based on the person's adaptive state
- Setting goals to promote adaptation
- Implementing interventions aimed at managing stimuli to promote adaptation
- Evaluating achievement of adaptive goals

Andrews and Roy (1986) point out that by manipulating the stimuli rather than the patient, the nurse enhances "the interaction of the person with their environment, thereby promoting health" (p. 51).

Betty Neuman's Systems Model

The Neuman Systems Model is a wellness model based on general systems theory in which the client system is exposed to stressors from within and without the system. The focus of the model is on the client system in relationship to stressors. The client system is a composite of interacting variables that include the physiologic variable, the psychological variable, the sociocultural variable, the developmental variable, and the spiritual variable (Neuman, 2002, pp. 16–17). Stressors are classified as intrapersonal, interpersonal, or extrapersonal depending on their relationship to the client system (p. 22).

The client system is represented structurally in the model as a series of concentric rings or circles surrounding a basic structure. These flexible concentric circles represent normal lines of defense and lines of resistance that

function to preserve client system integrity by acting as protective mechanisms for the basic structure. The basic structure or central core consists of basic survival factors common to the species, innate or genetic features, and strengths and weaknesses of the system. The flexible line of defense forms the outer boundary of the defined client system; it protects the normal line of defense. The normal line of defense represents what the client has become or the usual wellness state. Adjustment of the five client system variables to environmental stressors determines its level of stability. The series of concentric broken circles surrounding the basic structure are known as lines of resistance. They become activated following invasion of the normal line of defense by environmental stressors (Neuman, 2002, pp. 16–18). The greater the quality of the client system's health, the greater protection is provided by the various lines of defense (Geib, 2006). An overview and diagram of the model are provided on the Neuman Systems Model website (neumansystemsmodel.org/NSMdocs/nsm_powerpoint_overview.htm). See also (Table 2-8).

Basic assumptions of the Neuman Systems Model include the following (Meleis, 2004; Neuman, 1995):

- Nursing clients have both unique and universal characteristics and are constantly exchanging energy with the environment.
- The relationships among client variables influence a client's protective mechanisms and determine the client's response.
- Clients present a normal range of responses to the environment that represent wellness and stability.
- Stressors attack flexible lines of defense and then normal lines of defense.
- Nurses' actions are focused on primary, secondary, and tertiary prevention.

The Neuman Systems Model is health oriented, with an emphasis on prevention as intervention, and has been used in a wide variety of settings. Perhaps one of the greatest attractions to this model is the ease with which it

Metaparadigm Concepts as Defined in Neuman's Model	
Person (client system) A composite of physiological, psychological, sociocultural, developmental, and spiritual variables in interaction with the internal and external environment; represented by central structure, lines of defense, and lines of resistance (Neuman, 2002). **Environment** All internal and external factors of influences surrounding the client system.	Three relevant enviornments identified are the internal environment, the external environment, and the created environmnet (Neuman, 2002, p. 18). **Health** A continuum of wellness to illness; equated with optimanl system stability (Neuman, 2002, p. 23).

TABLE 2-8

> **Nursing Prevention as intervention; concerned with all potential stressors.**

can be used for families, groups, and communities as well as the individual client. The use of the model in practice requires only moderate adaptation of the nursing process with a focus on assessment of stressors and client system perceptions.

Imogene King's Interacting Systems Framework and Theory of Goal Attainment

King, in her Interacting Systems Framework, conceptualizes three levels of dynamic interacting systems that include personal systems (individuals), interpersonal systems (groups), and social systems (society). Individuals exist within personal systems, and concepts relevant to this system include body image, growth and development, perception, self, space, and time. Interpersonal systems are formed when two or more individuals interact. The concepts important to understanding this system include communication, interaction, role, stress, and transaction. Examples of social systems include religious systems, educational systems, and healthcare systems. Concepts important to understanding the social system include authority, decision making, organization, power, and status (King, 1981; Sieloff, 2006).

King's Theory of Goal Attainment was derived from her Interacting Systems Framework (Sieloff, 2006) and addresses nursing as a process of human interaction (Norris & Frey, 2006). The theory focuses on the interpersonal system interactions in the nurse–client relationship (Table 2-9). During the nursing process, the nurse and the client each perceives one another, makes judgments, and takes action that results in reaction. Interaction results, and if perceptual congruence exists, transactions occur (Sieloff, 2006). Outcomes are defined in terms of goals obtained. If the goals are related to patient behaviors, then they become the criteria by which the effectiveness of nursing care can be measured (King, 1989, p. 156).

Metaparadigm Concepts as Defined in King's Model	
Person (human being) A personal system that interacts with interpersonal and social systems. **Environment** Can be both external and internal. The external environment Is the context "within which human beings grow, develop, and perform daily activities" (King, 1981, p. 18); the internal environment of human beings transforms energy to enable them to adjust to	continuous external environmental changes (King, 1981, p. 5). **Health** "Dynamic life experiences of a human being, which implies continuous adjustment to stressors in the internal and external environment through optimum use of one's resources to achieve maximum potential for daily living" (King, 1981, p. 5).

TABLE 2-9

The propositions of King's Theory of Goal Attainment are as follows (King, 1981):

> **Nursing**   A process of human interaction; the goal of nursing is to help patients achieve their goals.

- If perceptual accuracy is present in nurse–client interactions, transactions will occur.
- If the nurse and client make transactions, goals will be attained.
- If goals are attained, satisfactions will occur.
- If goals are attained, effective nursing care will occur.
- If transactions are made in the nurse–client interactions, growth and development will be enhanced.
- If role expectations and role performance as perceived by the nurse and client are congruent, transactions will occur.
- If role conflict is experienced by nurse or client or both, stress in nurse–client interactions will occur.
- If nurses with special knowledge and skills communicate appropriate information to clients, mutual goal setting and goal attainment will occur.

King's theory can be implemented in practice using the nursing process where assessment focuses on the perceptions of the nurse and client, communication of the nurse and client, and interaction of the nurse and client. Planning involves deciding on goals and agreeing on how to attain goals. Implementation focuses on transactions made, and evaluation focuses on goals attained using King's theory (King, 1992).

Johnson's Behavioral System Model

Johnson's model for nursing presents the client as a living open system that is a collection of behavioral subsystems that interrelate to form a behavioral system (Table 2-10). The seven subsystems of behavior proposed by Johnson include achievement, affiliative, aggressive, dependence, sexual, eliminative, and ingestive. Motivational drives direct the activities of the subsystems that are constantly changing because of maturation, experience, and learning (Johnson, 1980).

Metaparadigm Concepts as Defined in Johnson's Theory	
Person (human being) A biopsychosocial being who is a behavioral system with seven subsystems of behavior **Environment** Includes internal and external environment **Health** Efficient and effective functioning of system; behavioral system balance and stability	**Nursing** An external regulatory force that acts to preserve the organization and integrity 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 (Johnson, 1980, p. 214)

TABLE 2-10

The achievement subsystem functions to control or master an aspect of self or environment to achieve a standard. This subsystem encompasses intellectual, physical, creative, mechanical, and social skills. The affiliative or attachment subsystem forms the basis for social organization. Its consequences are social inclusion, intimacy, and the formation and maintenance of strong social bonds. The aggressive or protective subsystem functions to protect and preserve the system. The dependency subsystem promotes helping or nurturing behaviors. The consequences include approval, recognition, and physical assistance. The sexual subsystem has the function of procreation and gratification and includes development of gender role identity and gender role behaviors. The eliminative subsystem addresses "when, how, and under what conditions we eliminate," whereas the ingestive subsystem "has to do with when, how, what, how much, and under what conditions we eat" (Johnson, 1980, p. 213).

The nursing process for the behavioral system model is known as Johnson's nursing diagnostic and treatment process. The components of the process include the determination of the existence of a problem, diagnosis and classification of problems, management of problems, and evaluation of behavioral system balance and stability. When using Johnson's model in practice, the focus of the assessment process is obtaining information to evaluate current behavior in terms of past patterns, determining the impact of the current illness on behavioral patterns, and establishing the maximum level of health. The assessment is specifically related to gathering information related to the structure and function of the seven behavioral subsystems as well as the environmental factors that affect the behavioral subsystems (Holaday, 2006). The ultimate goals of nursing using the model are to maintain or restore behavioral system balance (Johnson, 1980).

■ Selected Theories and Middle-Range Theories of Nursing

Rosemary Parse's Humanbecoming Theory

Parse's theory was originally called man-living-health (Parse, 1981). In 1992, Parse changed the name to *human becoming,* and then in 2007 again changed the name to *humanbecoming* (Mitchell & Bournes, 2010) to coincide with Parse's evolution of thought. The Humanbecoming Theory consists of three major themes: meaning, rhythmicity, and transcendence (Parse, 1998). Meaning is the linguistic and imagined content of something and the interpretation that one gives to something. Rhythmicity is the cadent, paradoxical patterning of the human–universe mutual process. Transcendence is defined as reaching beyond with possibles or the "hopes and dreams envisioned in

multidimensional experiences powering the originating of transforming" (Parse, 1998, p. 29). The three major principles of the Humanbecoming Theory flow from these themes.

The first principle of the Humanbecoming Theory states, "Structuring meaning multidimensionally is cocreating reality through the languaging of valuing and imaging" (Parse, 1998, p. 35). This principle proposes that persons structure or choose the meaning of their realities and that the choosing occurs at levels that are not always known explicitly (Mitchell, 2006). This means that one person cannot decide the significance of something for another person and does not even understand the meaning of the event unless that person shares the meaning through the expression of his or her views, concerns, and dreams.

The second principle states, "Cocreating rhythmical patterns of relating is living the paradoxical unity of revealing–concealing and enabling–limiting while connecting–separating" (Parse, 1998, p. 42). This principle means that persons create patterns in life, and these patterns tell about personal meanings and values. The patterns of relating that persons create involve complex engagements and disengagements with other persons, ideas, and preferences (Mitchell, 2006). According to Parse (1998), persons change their patterns when they integrate new priorities, ideas, hopes, and dreams.

The third principle of the Humanbecoming Theory states, "Cotranscending with the possibles is powering unique ways of originating in the process of transforming" (Parse, 1998, p. 46). This principle means that persons are always engaging with and choosing from infinite possibilities. The choices reflect the person's ways of moving and changing in the process of becoming (Mitchell, 2006).

Three processes for practice have been developed from the concepts and principles in the Humanbecoming Theory, including the following (Parse, 1998, pp. 69, 70):

- Illuminating meaning is explicating what was, is, and will be. Explicating is making clear what is appearing now through language.
- Synchronizing rhythms is dwelling with the pitch, yaw, and roll of the human–universe process. Dwelling with is immersing with the flow of connecting–separating.
- Mobilizing transcendence is moving beyond the meaning moment with what is not yet. Moving beyond is propelling with envisioned possibles of transforming.

In practice, nurses guided by the Humanbecoming Theory prepare to be truly present (Table 2-11) with others through focused attentiveness on the moment at hand through immersion (Parse, 1998).

Metaparadigm Concepts as Defined in Parse's Theory	
Person An open being, more than and different than the sum of parts in mutual simultaneous interchange with the environment who chooses from options and bears responsibility for choices (Parse, 1987, p. 160) **Environment** Coexists in mutual process with the person	**Health** Continuously changing process of becoming **Nursing** A learned discipline; the nurse uses true presence to facilitate the becoming of the participant

TABLE 2-11

Madeleine Leininger's Cultural Diversity and Universality Theory

Leininger (1995) identified the main features of the Cultural Diversity and Universality Theory:

> Transcultural nursing is a substantive area of study and practice focused on comparative cultural care (caring) values, beliefs, and practices of individuals or groups of similar or different cultures with the goal of providing culture-specific and universal nursing care practices in promoting health or well-being or to help people face unfavorable human conditions, illness, or death in culturally meaningful ways. (p. 58)

Consistent with the focus of her theory, Leininger defined the metaparadigm concepts of nursing in a manner that causes the nurse to specifically consider culture in the delivery of competent nursing care (Table 2-12).

According to Leininger (2001), three modalities guide nursing judgments, decisions, and actions to provide culturally congruent care that is

Metaparadigm Concepts as Defined in Leininger's Theory	
Person Human being, family, group, community, or institution **Environment** Totality of an event, situation, or experience that gives meaning to human expressions, interpretations, and social interactions in physical, ecological, sociopolitical, and/or cultural settings (Leininger, 1991)	**Health** A state of well-being that is culturally defined, valued, and practiced (Leininger, 1991, p. 46) **Nursing** Activities directed toward assisting, supporting, or enabling with needs in ways that are congruent with the cultural values, beliefs, and lifeways of the recipient of care (Leininger, 1995)

TABLE 2-12

beneficial, satisfying, and meaningful to the persons the nurse serves. These three modes include cultural care preservation or maintenance, cultural care accommodation or negotiation, and cultural care repatterning or restructuring. Culture care preservation or maintenance refers to those assistive, supportive, facilitative, or enabling professional actions and decisions that help people of a specific culture to maintain meaningful care values for their well-being, recover from illness, or deal with a handicap or dying. Culture care accommodation or negotiation refers to those assistive, supportive, facilitative, or enabling professional actions and decisions that help people of a specific culture or subculture adapt to or negotiate with others for meaningful, beneficial, and congruent health outcomes. Culture care repatterning or restructuring refers to the assistive, supportive, facilitative, or enabling professional actions and decisions that help patients reorder, change, or modify their lifeways for new, different, and beneficial health outcomes (Leininger & McFarland, 2006).

The nurse using Leininger's theory plans and makes decisions with clients with respect to these three modes of action. All three care modalities require coparticipation of the nurse and client working together to identify, plan, implement, and evaluate nursing care with respect to the cultural congruence of the care (Leininger, 2001).

Leininger developed the sunrise model, which she revised in 2004. She labeled this model as "an enabler," to clarify that although it depicts the essential components of the Cultural Diversity and Universality Theory , it is a visual guide for exploration of cultures.

Hildegard Peplau's Theory of Interpersonal Relations

In her theory, Peplau addresses all of nursing's metaparadigm concepts (Table 2-13), but she is primarily concerned with one aspect of nursing: how persons relate to one another. According to Peplau, the nurse–patient relationship is the center of nursing (Young, Taylor, & McLaughlin-Renpenning, 2001).

Metaparadigm Concepts as Defined in Peplau's Theory
Person Encompasses the patient (one who has problems for which expert nursing services are needed or sought) and the nurse (a professional with particular expertise) (Peplau, 1992, p. 14) **Environment** Forces outside the organism within the context of culture (Peplau, 1952, p. 163).	**Health** "Implies forward movement of personality and other ongoing human processes in the direction of creative, constructive, productive, personal, and community living" (Peplau, 1992, p. 12) **Nursing** The therapeutic, interpersonal process between the nurse and the patient

TABLE 2-13

Peplau (1952) originally described four phases in nurse–patient relationships that overlap and occur over the time of the relationship: orientation, identification, exploitation, and resolution. In 1997, Peplau combined the phase of identification and exploitation, resulting in three phases: orientation, working, and termination. Nevertheless, most other theorists still consider the phases of identification and exploitation to be subphases of the working phase. During the orientation phase, a health problem has emerged that results in a "felt need," and professional assistance is sought (p. 18). In the working phase, the patient identifies those who can help, and the nurse permits exploration of feelings by the patient. During this phase, the nurse can begin to focus the patient on the achievement of new goals. The resolution (termination) phase is the time when the patient gradually adopts new goals and frees himself or herself from identification with the nurse (Peplau, 1952, 1997).

Peplau (1952) also describes six nursing roles that emerge during the phases of the nurse–patient relationship: the role of the stranger, the role of the resource person, the teaching role, the leadership role, the surrogate role, and the counseling role. Over the course of Peplau's career, the nursing roles were refined to include teacher, resource, counselor, leader, technical expert, and surrogate. As a teacher, the nurse provides knowledge about a need or problem. In the role of resource, the nurse provides information to understand a problem. In the role of counselor, the nurse helps recognize, face, accept, and resolve problems. As a leader, the nurse initiates and maintains group goals through interaction. As a technical expert, the nurse provides physical care using clinical skills. And, as a surrogate, the nurse may take the place of another (Johnson & Webber, 2010, p. 125).

Peplau (1952) also described four psychobiological experiences: needs, frustration, conflict, and anxiety. According to Peplau, these experiences "all provide energy that is transformed into some form of action" (p. 71) and provide a basis for goal formation and nursing interventions (Howk, 2002).

Peplau, as one of the first theorists since Nightingale to present a theory for nursing, is considered a pioneer in the area of theory development in nursing. Prior to Peplau's work, nursing practice involved acting on, to, or for the patient such that the patient was considered an object of nursing actions. Peplau's work was the force behind the conceptualization of the patient as a partner in the nursing process (Howk, 2002, pp. 379–380). Although Peplau's book was first published in 1952, her model continues to be used extensively by clinicians and continues to provide direction to educators and researchers (Howk, 2002).

Nola Pender's Health Promotion Model

The Health Promotion Model is an attempt to portray the multidimensionality of persons interacting with their interpersonal and physical environments as they pursue health while integrating constructs from expectancy-value theory and social cognitive theory with a nursing perspective of holistic human

functioning (Pender, 1996, p. 53). A summary of the metaparadigm concepts of nursing as defined by Pender are presented in Table 2-14.

There are three major categories to consider in Pender's health promotion model: (1) individual characteristics and experiences, (2) behavior-specific cognitions and affect, and (3) behavioral outcome. Personal factors include personal biological factors such as age, body mass index, pubertal status, menopausal status, aerobic capacity, strength, agility, or balance. Personal psychological factors include factors such as self-esteem, self-motivation, and perceived health status; personal sociocultural factors include factors such as race, ethnicity, acculturation, education, and socioeconomic status. Some personal factors are amenable to change, whereas others cannot be changed (Pender, Murdaugh, & Parsons, 2006, p. 52).

Behavior-specific cognitions and affect are behavior-specific variables within the Health Promotion Model. Such variables are considered to have motivational significance. In the Health Promotion Model, these variables are the target of nursing intervention because they are amenable to change. The behavior-specific cognitions and affect identified in the Health Promotion Model include (1) perceived benefits of action, (2) perceived barriers to action, (3) perceived self-efficacy, and (4) activity-related affect. Perceived benefits of action are the anticipated positive outcomes resulting from health behavior. Perceived barriers to action are the anticipated, imagined, or real blocks or personal costs of a behavior. Perceived self-efficacy refers to the judgment of personal capability to organize and execute a health-promoting behavior. It influences the perceived barriers to actions, such that higher efficacy results in lower perceptions of barriers. Activity-related affect refers to the subjective positive or negative feelings that occur before, during, and following behavior based on the stimulus properties of the behavior. Activity-related affect influences perceived self-efficacy, such that the more positive the subjective feeling, the greater the perceived efficacy (Pender et al., 2006; Sakraida, 2010, p. 438).

Commitment to a plan of action marks the beginning of a behavioral event. Interventions in the Health Promotion Model focus on raising consciousness related to health-promoting behaviors, promoting self-efficacy,

Metapradigm Concepts as Defined in Pender's Theory	
Person The individual, who is the primary focus of the model **Environment** The physical, interpersonal, and economic circumstances in which persons live **Health** A positive high-level state	**Nursing** The role of the nurse includes raising consciousness related to health-promoting behaviors, promoting self-efficacy, enhancing the benefits of change, controlling the environment to support behavior change, and managing barriers to change

TABLE 2-14

enhancing the benefits of change, controlling the environment to support behavior change, and managing the barriers to change. Health-promoting behavior, which is ultimately directed toward attaining positive health outcomes, is the product of the Health Promotion Model (Pender et al., 2006, pp. 56–63).

Kristen Swanson's Theory of Caring

Swanson's Theory of Caring (1991, 1993, 1999a, 1999b) offers an explanation of what it means to practice nursing in a caring manner. In this theory, *caring* is defined as a "nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility" (Swanson, 1991, p. 162). Swanson (1993) posits caring for a person's biopsychosocial and spiritual well-being is a fundamental and universal component of good nursing care.

Five additional concepts are integral to Swanson's Theory of Caring and represent the five basic processes of caring: maintaining belief, knowing, being with, doing for, and enabling.

- The concept of maintaining belief is sustaining faith in the other's capacity to get through an event or transition and face a future with meaning. This includes believing in the other's capacity and holding him or her in high esteem, maintaining a hope-filled attitude, offering realistic optimism, helping to find meaning, and standing by the one cared for, no matter what the situation (Swanson, 1991, p. 162).
- The concept of knowing refers to striving to understand the meaning of an event in the life of the other, avoiding assumptions, focusing on the person cared for, seeking cues, assessing meticulously, and engaging both the one caring and the one cared for in the process of knowing (Swanson, 1991, p. 162).
- The concept of being with refers to being emotionally present to the other. It includes being present in person, conveying availability, and sharing feelings without burdening the one cared for (Swanson, 1991, p. 162).
- The concept of doing for refers to doing for others what one would do for oneself, including anticipating needs, comforting, performing skillfully and competently, and protecting the one cared for while preserving his or her dignity (Swanson, 1991, p. 162).
- The concept of enabling refers to facilitating the other's passage through life transitions and unfamiliar events by focusing on the event, informing, explaining, supporting, validating feelings, generating alternatives, thinking things through, and giving feedback (Swanson, 1991, p. 162).

These caring processes are sequential and overlapping. In fact, they might not exist separate from one another because each is an integral component of the overarching structure of caring (Wojnar, 2010, p. 746). According to Swanson (1999b), knowing, being with, doing for, enabling, and maintaining

belief are essential components of the nurse–client relationship, regardless of the context. A summary of the metaparadigm concepts of nursing as defined by Swanson are included in Table 2-15.

Katharine Kolcaba's Theory of Comfort

Comfort, as described by Kolcaba (2004, p. 255) in the Theory of Comfort, is the immediate experience of being strengthened by having needs for relief, ease, and transcendence addressed in four contexts—physical, psychospiritual, sociocultural, and environmental; it is much more than simply the absence of pain or other physical discomfort. Physical comfort pertains to bodily sensations and homeostatic mechanisms. Psychospiritual comfort pertains to the internal awareness of self, including esteem, sexuality, meaning in one's life, and one's relationship to a higher order or being. Sociocultural comfort pertains to interpersonal, family, societal relationships, and cultural traditions. Environmental comfort pertains to the external background of the human experience, which includes light, noise, color, temperature, ambience, and natural versus synthetic elements (Kolcaba, 2004, p. 258).

According to Kolcaba, comfort care encompasses three components: an appropriate and timely intervention to meet the comfort needs of patients, a mode of delivery that projects caring and empathy, and the intent to comfort. Comfort needs include patients' or families' desire for or deficit in relief, ease, or transcendence in the physical, psychospiritual, sociocultural, or environmental contexts of human experience. Comfort measures refer to interventions that are intentionally designed to enhance patients' or families' comfort (Kolcaba, 2004, p. 255).

The Theory of Comfort also addresses intervening variables—negative or positive factors over which nurses and institutions have little control but that affect the direction and success of comfort care plans. Examples of intervening variables are the presence or absence of social support, poverty, prognosis, concurrent medical or psychological conditions, and health habits (Kolcaba, 2004, p. 255).

Metapradigm Concepts as Defined in Swanson's Theory of Caring	
Person "Unique beings who are in the midst of becoming and whose wholeness is made manifest in thoughts, feelings, and behaviors" (Swanson, 1993, p. 352)Environment "Any context that influences or is influenced by the designated client" (Swanson, 1993, p. 353)	**Health** Health and well-being is "to live the subjective, meaning-filled experience of wholeness. Wholeness involves a sense of integration and becoming wherein all facets of being are free to be expressed" (Swanson, 1993, p. 353) **Nursing** Informed caring for the well-being of others (Swanson, 1991, 1993)

TABLE 2-15

An additional concept within the theory comprises the health-seeking behaviors of patients and families. Health-seeking behaviors are those behaviors that patients and families engage in either consciously or unconsciously while moving toward well-being. Health-seeking behaviors can be either internal or external and can include dying peacefully. It is posited that enhanced comfort results in engagement in health-seeking behaviors (Kolcaba, 2004, p. 255).

The metaparadigm concepts of nursing as defined by Kolcaba are summarized in Table 2-16.

Pamela Reed's Self-Transcendence Theory

Three major concepts are central to the Theory of Self-Transcendence: self-transcendence, well-being, and vulnerability. Self-transcendence is the capacity to expand self-boundaries intrapersonally, interpersonally, temporally, and transpersonally (Reed, 2008, p. 107). The capacity to expand self-boundaries intrapersonally refers to a greater awareness of one's philosophy, values, and dreams. The capacity to expand interpersonally relates to others and one's environment. The capacity to expand temporally refers to integration of one's past and future in a way that has meaning for the present. Finally, the capacity to expand transpersonally refers to the capacity to connect with dimensions beyond the typically discernable world (p. 107). Self-transcendence is a characteristic of developmental maturity that is congruent with enhanced awareness of the environment and a broadened perspective on life. Self-transcendence is expressed through behaviors such as sharing wisdom with others, integrating physical changes of aging, accepting death as a part of life, and finding spiritual meaning in life (Reed, 2008, pp. 107–108).

Well-being is the second major concept of Reed's theory. Well-being is a sense of feeling whole and healthy, according to one's own criteria for wholeness and health. The definition of well-being depends on the individual

Metapardigm Concepts as Defined in Kolcaba's Theory of Comfort	
Person Recipients of care may be individuals, families, institutions, or communities in need of health care (Kolcaba, Tilton, & Drouin, 2006). **Environment** The environment includes any aspect of the patient, family, or institutional setting that can be manipulated by the nurse, a loved one, or the institution to enhance comfort (Dowd, 2010, p. 711).	**Health** Health is considered optimal functioning of the patient, the family, the healthcare provider, or the community (Dowd, 2010, p. 711). **Nuring** Nursing is the intentional assessment of comfort needs, design of comfort interventions to address those needs, and reassessment of comfort levels after implementation compared with baseline (Dowd, 2010, p. 711).

TABLE 2-16

or population. Indeed, indicators of well-being are as diverse as human perceptions of health and wellness. Examples of indicators of well-being are life satisfaction, positive self-concept, hopefulness, happiness, and having meaning in life. Well-being is viewed as a correlate and an outcome of self-transcendence (Reed, 2008).

The third major concept, vulnerability, is the awareness of personal mortality and the likelihood of experiencing difficult life situations. Self-transcendence emerges naturally in health experiences when a person is confronted with mortality and immortality. Life events such as illness, disability, aging, childbirth, or parenting—all of which heighten a person's sense of mortality, inadequacy, or vulnerability—can trigger developmental progress toward a renewed sense of identity and expanded self-boundaries. According to Reed (2008, pp. 108–109), self-transcendence is evoked through life events and can enhance well-being by transforming losses and difficulties into healing experiences.

Additional concepts in Reed's theory include moderating-mediating factors and points of intervention. Moderating-mediating factors are personal and contextual variables such as age, gender, life experiences, and social environment that can influence the relationships between vulnerability and self-transcendence and between self-transcendence and well-being. Nursing activities that facilitate self-transcendence are referred to as points of intervention (Coward, 2010, p. 623). Two points of intervention are intertwined with the process of self-transcendence: Nursing actions can focus either directly on a person's inner resource for self-transcendence or indirectly on the personal and contextual factors that affect the relationship between vulnerability and self-transcendence and the relationship between self-transcendence and well-being (p. 621). The metaparadigm concepts of nursing as defined by Reed are summarized in Table 2-17.

Metapradigm Concepts as Defined in Reed's Self-Transcendence Theory	
Person Persons are human beings who develop over the life span through interactions with other persons and within an environment (Coward, 2010, p. 622). **Environment** The environment is composed of family, social networks, physical surroundings, and community resources (Coward, 2010, p. 622).	**Health** Well-being is a sense of feeling whole and healthy, according to one's own criteria for wholeness and health (Reed, 2008). **Nursing** The role of nursing activity is to assist persons through interpersonal processes and therapeutic management of their environment to promote health and well-being (Coward, 2010, p. 622).

TABLE 2-17

The American Association of Critical-Care Nurse's Synergy Model for Patient Care

The Synergy Model is a conceptual framework for designing practice competencies to care for critically ill patients with a goal of optimizing outcomes for patients and families. Optimal outcomes are realized when the competencies of the nurse match the patient and family needs.

The Synergy Model for Patient Care is the result of the American Association of Critical-Care Nurses (AACN) envisioning a new paradigm for clinical practice. In 1993, the AACN Certification Corporation convened a think tank that included nationally recognized experts to develop a conceptual framework for certified practice. The initial work resulted in the description of 13 patient characteristics based on universal needs of patients and 9 characteristics required of nurses to meet patient needs. The patient characteristics identified were compensation, resiliency, margin of error, predictability, complexity, vulnerability, physiologic stability, risk of death, independence, self-determination, involvement in care decisions, engagement, and resource availability. The characteristics of nurses were engagement, skilled clinical practice, agency, caring practices, system management, teamwork, diversity responsiveness, experiential learning, and being an innovator–evaluator. The think tank suggested that the synergy emerging from the interaction between the patient needs and the nurse characteristics should result in optimal outcomes for the patient and that these characteristics of the nurse would determine competencies for certified practice (Hardin, 2005, pp. 3–4).

In 1995, the AACN Certification Corporation decided to refine this model, to conduct a study of practice and job analysis of critical care nurses, and to test the validity of the concepts in critical care nurses. The group refined the patient characteristics into eight concepts, merged the nurse characteristics into eight concepts, and delineated a continuum for the characteristics. The eight patient characteristics identified in the current model are resiliency, vulnerability, stability, complexity, resource availability, participation in care, participation in decision making, and predictability. The eight nurse characteristics are clinical judgment, advocacy, caring practices, collaboration, systems thinking, response to diversity, clinical inquiry, and facilitation of learning (Hardin, 2005, p. 4). Each patient characteristic is placed on a scale from one to five, with the level of each patient characteristic being critical in terms of the competency required of the nurse (Hardin, 2005, pp. 4–7). The eight nurse characteristics can be considered essential competencies for providing care for critically ill patients. All eight competencies reflect an integration of knowledge, skills, and experience of the nurse. Each nurse characteristic can be understood on a continuum from one to five (Hardin, 2005, pp. 5–6).

The Synergy Model delineates three levels of outcomes: outcomes derived from the patient, outcomes derived from the nurse, and outcomes derived from the healthcare system. Outcomes data derived from the patient include functional changes, behavioral changes, trust, satisfaction, comfort, and quality of life. Outcomes data derived from nursing competencies include physiologic changes, the presence or absence of complications, and the extent to which

treatment objectives are attained (Curley, 1998). Outcomes data derived from the healthcare system include readmission rates, length of stay, and cost utilization (Hardin, 2005, pp. 8–9). The metaparadigm concepts of nursing as defined in the Synergy Model for Patient Care are summarized in Table 2-18.

Nurse of the Future: Nursing Core Competencies

Although not a theory of nursing, the *Nurse of the Future: Nursing Core Competencies* (Massachusetts Department of Higher Education, 2010) document addresses the knowledge base and relationships among concepts important to the practice of nursing. In the context of nursing knowledge, the concepts of patient, environment, health, and nursing are defined and are presented in Table 2-19.

Metapardigm Concpets as Defined in The Synergy Model for Patient Care

Person   Persons are viewed in the context of patients who are biological, social, and spiritual entities who are present at a particular developmental stage.

Environment   The concept of environment is not explicitly defined. However, included in the assumptions is the idea that environment is created by the nurses for the care of the patient.

Health   The concept of health is not explicitly defined. An optimal level of wellness as defined by the patient is mentioned as a goal of nursing care.

Nursing   The purpose of nursing is to meet the needs of patients and families and to provide safe passage through the healthcare system during a time of crisis. (Hardin, 2005, p. 8).

TABLE 2-18

Metapardigm Concpets as Defined in The Nurse of The Future: Nursing Core Competencies

Human being/patients   The recipient of nursing care or services. Patients may be individuals, families, groups, communities, or populations (AACN, 1998, p. 2 as cited in Massachusetts Department of Higher Education, 2010, p. 7).

Environment   "The atmosphere, milieu, or conditions in which an individual lives, works or plays" (ANA, 2004, p. 47 as cited in Massachusetts Department of Higher Education, 2010, p. 7).

Health   "An experience that is often expressed in terms of wellness and illness, and may occur in the presence or absence of disease or injury" (ANA, 2004, p. 5 as cited in Massachusetts Department of Higher Education, 2010, p. 8).

Nursing   …"the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, groups, communities, and populations" (ANA, 2001, p. 5 as cited in Massachusetts Department of Higher Education, 2010, p. 8).

TABLE 2-19

There are 10 Nurse of the Future core competencies:

- Patient-centered care: "The Nurse of the Future will provide holistic care that recognizes an individual's preferences, values, and needs and respects the patient or designee as a full partner in providing compassionate, coordinated, age and culturally appropriate, safe and effective care" (Massachusetts Department of Higher Education, 2010, p. 9).
- Professionalism: "The Nurse of the Future will demonstrate accountability for the delivery of standard-based nursing care that is consistent with moral, altruistic, legal, ethical, regulatory, and humanistic principles" (Massachusetts Department of Higher Education, 2010, p. 13).
- Leadership: "The Nurse of the Future will influence the behavior of individuals or groups of individuals within their environment in a way that will facilitate the establishment and acquisition/achievement of shared goals" (Massachusetts Department of Higher Education, 2010, p. 17).
- Systems-based practice: "The Nurse of the Future will demonstrate an awareness of and responsiveness to the larger context of the health care system, and will demonstrate the ability to effectively call on microsystem resources to provide care that is of optimal quality and value" (Massachusetts Department of Higher Education, 2010, p. 19).
- Informatics and technology: "The Nurse of the Future will use information and technology to communicate, manage, knowledge, mitigate error, and support decision making" (Quality and Safety Education for Nursing [QSEN], 2007, as cited in Massachusetts Department of Higher Education, 2010, p. 22).
- Communication: "The Nurse of the Future will interact effectively with patients, families, and colleagues, fostering mutual respect and shared decision making to enhance patient satisfaction and health outcomes" (Massachusetts Department of Higher Education, 2010, p. 27).
- Teamwork and collaboration: "The Nurse of the Future will function effectively within nursing and interdisciplinary teams, fostering open communication, mutual respect, shared decision making, team learning, and development" (adapted from QSEN, 2007, as cited in Massachusetts Department of Higher Education, 2010, p. 31).
- Safety: "The Nurse of the Future will minimize risk of harm to patients and providers through both system effectiveness and individual performance" (QSEN, 2007, as cited in Massachusetts Department of Higher Education, 2010, p. 34).
- Quality improvement: "The Nurse of the Future uses data to monitor the outcomes of care processes, and uses improvement methods to design and test changes to continuously improve the quality and safety of health care systems" (QSEN, 2007, as cited in Massachusetts Department of Higher Education, 2010, p. 36).

- Evidence-based practice: "The Nurse of the Future will identify, evaluate, and use the best current evidence coupled with clinical expertise and consideration of patients' preferences, experience and values to make practice decisions" (adapted from QSEN, 2007, as cited in Massachusetts Department of Higher Education, 2010, p. 37).

The committee that designed the *Nurse of the Future: Nursing Core Competencies* also identified several assumptions and principles to serve as a framework. The assumptions include: (1) education and practice partnerships are key in developing an effective model, (2) it is imperative that leaders in nursing education and practice develop collaborative models to facilitate a minimum of a baccalaureate degree in nursing for all nurses, (3) a more effective education system must be created that will allow preparation of the nursing workforce to respond to the current and future healthcare needs of populations, (4) the nurse of the future will be proficient in a core set of competencies, and (5) nurse educators in education and practice settings will need to use different teaching strategies to integrate Nurse of the Future core competencies into the curriculum (Massachusetts Department of Higher Education, 2010, pp. 3-4).

The art and science of nursing are based on a framework of caring and respect for human dignity. A compassionate approach to patient care mandates that nurses provide care in a competent manner. The *Nurse of the Future: Nursing Core Competencies* provides a framework for the provision of competent nursing care (Massachusetts Department of Higher Education, 2010, p. 7).

> **www. CRITICAL THINKING QUESTION ✷**
>
> Think about the definitions of the metaparadigm concepts and the assumptions or propositions of each of the theories presented. Which of the theories most closely matches your beliefs? ✷

Relationship of Theory to Professional Nursing Practice

How will theory affect your nursing practice? Using a theoretical framework to guide your nursing practice assists you as you organize patient data, understand and analyze patient data, make decisions related to nursing interventions, plan patient care, predict outcomes of care, and evaluate patient outcomes (Alligood & Tomey, 2002). Why? The use of a theoretical framework provides a systematic and knowledgeable approach to nursing practice. The framework also becomes a tool that assists you to think critically as you plan and provide nursing care.

How do you begin? Now that you know why nursing theory is important to your nursing practice, it is time to identify a theoretical framework that fits you and your practice.

> **The use of a theoretical framework provides a systematic and knowledgeable approach to your nursing practice.**

Alligood (2006) presented guidelines for selecting a framework for theory-based nursing practice. Following are the steps:

1. Consider the values and beliefs in nursing that you truly hold.
2. Write a philosophy of nursing that clarifies your beliefs related to person, environment, health, and nursing.
3. Survey definitions of person, environment, health, and nursing in nursing models.
4. Select two or three frameworks that best fit with your beliefs related to the concepts of person, environment, health, and nursing.
5. Review the assumptions of the frameworks that you have selected.
6. Apply those frameworks in a selected area of nursing practice.
7. Compare the frameworks on client focus, nursing action, and client outcome.
8. Review the nursing literature written by persons who have used the frameworks.
9. Select a framework and develop its use in your nursing practice.

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www **CASE STUDY 2-1**

Mr. M. is 34-year-old Caucasian male who presents to the mental health clinic with depression and complaints of fatigue. An interview reveals that his wife and both of his children were killed in a traffic accident 6 months ago. The nurse knows that Mr. M. is vulnerable as a result of the loss of his family, but that self-transcendence is evoked through life events and that well-being can be enhanced by transforming losses and difficulties into healing experiences.

1. The nurse using Reed's Self-Transcendence Theory focuses nursing activity for Mr. M. on facilitating self-transcendence. Based on the assessment, what intrapersonal strategies might be appropriate?

2. Which interpersonal strategies might be appropriate during follow-up visits to facilitate connecting to others?


Conclusion

As demonstrated by the descriptions of the philosophies, conceptual models, and theories presented in this chapter, there is a wide variety of perspectives and frameworks from which to practice nursing. There is no one right or wrong answer. Various nursing theories represent different realities and address different aspects of nursing (Meleis, 2007). For this reason, the multiplicity of nursing theories presented in this chapter should not be viewed as competing theories, but rather as complementary theories that can provide insight into different ways to describe, explain, and predict nursing concepts and/or prescribe nursing care. Curley (2007, p. 3) describes this understanding in an interesting way by comparing the multiplicity of nursing theories to a collection of maps of the same region. Each map might display a different

characteristic of the region, such as rainfall, topography, or air currents. Although all of the maps are accurate, the best map for use depends on the information needed or the question being asked. This is precisely the case with the nurse's choice of nursing theories for practice.

So, begin with whichever theoretical framework seems to "fit," and then practice using it as you provide nursing care. "The full realization of nursing theory–guided practice is perhaps the greatest challenge that nursing as a scholarly discipline has ever faced" (Cody, 2006). So, be patient; developing your nursing practice guided by nursing theory takes time and practice. All nursing theories require in-depth study over time to master them fully (this chapter provides only a brief introduction), but the incorporation of theory into your practice can transform your nursing practice. The end result of this process will be seen in the excellent nursing care that you can provide to patients over the course of your professional nursing career.

Classroom Activity 1

Divide into small groups and give each group a copy of the same case study. Assign a different nursing theory to each group, and ask the groups to develop a plan of care using the assigned nursing theory as the basis for practice. Each group should share its plan of care with the class. Discuss the differences and similarities in the foci of care based on each of the selected theories. www

Classroom Activity 2

Think about the metaparadigm concepts of nursing. Draw each of the concepts in relation to the other concepts to show your ideas of how each of the concepts interfaces with the others. Present your "conceptual model" to the class, and discuss your ideas about each of the concepts represented.

This activity works best if you use colored pencils, crayons, or markers and a large piece of paper or newsprint. Actual student examples are presented in Figure 2-1 and Figure 2-2. www
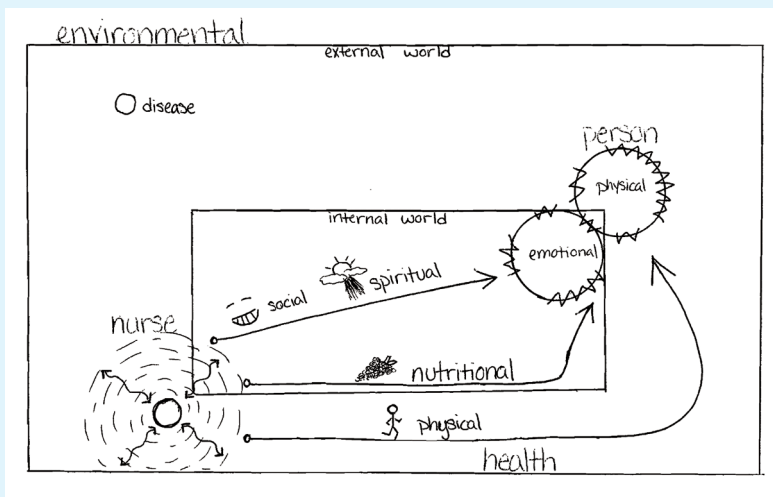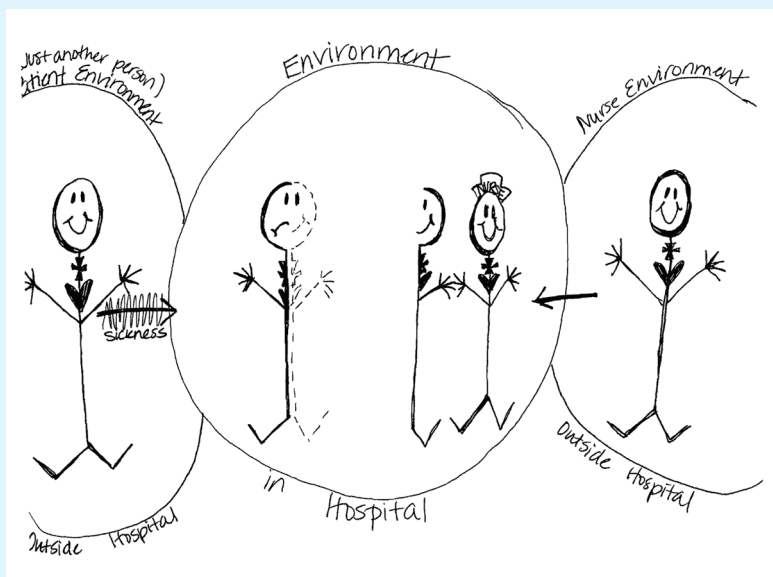
Figure 2-1

Figure 2-2

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Critical Thinking Question ❖

What are the specific competencies for nurses in relation to theoretical knowledge? ✳