Self-Care Science, Nursing Theory, and Evidence-Based Practice
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Preface

To our knowledge, this book is the first of its kind. It clearly establishes the link between evidence-based nursing practice, nursing theory, and the foundational nursing sciences, including the science of self-care. There are two international trends in health care that led to our deciding to write this book—self-care and evidence-based practices. We have been committed to self-care as it relates to nursing for decades. Interest in the concept of self-care is taking on broader appeal, so much so that there is not at present a clear understanding of what it is.

The sciences of self-care and nursing as presented in this text have their origin in work done by the nursing theorist Dorothea Orem. For more than 40 years Orem has recognized, spoken, and written of the need for nursing to develop the science base of nursing practice. In 1993, Orem invited a small international group of nurses, which became known as the Orem Study Group, to meet with her to further the development of self-care deficit nursing theory. We began the work with discussion about the discipline of nursing and nursing science. Two major products of the group activity, which have guided development of this text, are the structure of the discipline (Figure 1.4) and a schematic representation of the nursing practice sciences (Figure 1.5).

There is a science of self-care that goes beyond people doing things for themselves. The current movement toward evidence-based nursing is leading to serious discourse regarding the meaning of knowledge and evidence in nursing. To have an evidence-based view of practice, the professional nurse needs to have a clear frame of reference regarding the proper object of nursing and the structure of the discipline in order to frame the problem. The science of self-care and the related sciences, including the nursing-specific knowledge as expressed in the self-care deficit nursing theory developed and promulgated by Dorothea Orem and others, provides the structure
Preface

and content for understanding self-care. In this book, we consider the science of self-care, the constituent foundational nursing sciences, and the practical nursing sciences as the basis for evidence-based practice and education.

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Katherine Renpenning, MScN
Acknowledgments

First, we would like to recognize 25 stimulating and exciting years of working with Dorothea Orem without whose guidance, inspiration, and contributions this book would never have come about. We want to acknowledge the contributions of the following to the continuing development of self-care deficit nursing theory: the Nursing Development Conference Group, the Orem Study Group, and the International Orem Society. We would be remiss in not recognizing the ongoing work of faculties of schools of nursing, and the individual scholars and practitioners around the world who continue to make significant contributions to theory development and related nursing practice.

We are grateful to Barbara Banfield for reading drafts as the book took shape. Her knowledge of the theory makes her a leading expert. We appreciate Elizabeth Geden for sharing her practical wisdom.

Thank you to all who have made this book a reality.

Susan and Kathie
This book is concerned with two themes that are prominent in today’s nursing literature: evidence-based practice and self-care. The purpose of the book is to explore new ways of looking at the inter-relationship of these topics from the perspective of nursing practice. Theory and science are necessary and linked parts of the development of the discipline of nursing.

Section I begins with a discussion of the proper object or focus of the discipline of nursing (the reason for the existence of the nursing profession). This focus is identified as persons who are unable to provide for themselves the amount and quality of self-care required to maintain life, health, and promote development. Accepting this leads to exploring the question: if this is the proper object of the discipline, what are the questions of concern to nursing and what constitutes evidence for nursing purposes? Through identification of variables associated with the performance of self-care operations and hypothesizing about the relationships of those variables, a foundation for a science of self-care has evolved.

The science of self-care and the nursing practice sciences are linked in the production of nursing action by providing a theoretical framework derived from a science of self-care for clinical decision making by the nurse. Furthermore, the nursing theory uses a science of self-care...
that is interdisciplinary and is used internationally. Persons interested in health-related self-care regardless of their specific discipline need to know how to determine efficacy of actions taken or proposed, and how to assist clients in developing capabilities in relation to self-care. Development of these professions and disciplines rely on a science of self-care which goes beyond the common sense view or the medically related view of self-care.

The science of self-care identifies what a person requires to be healthy, the complexity of factors that change or modify these requirements, the actions a person takes to maintain their health and well-being, and limitations in the individual’s ability to take action. It also includes the self-care systems used or needed by persons experiencing a change in health-state or environment. Though the initial focus is on explicating a science of self-care that is individually based, the science also presents components that explain the relationship of self-care to dependents, family, community, and culture.

Chapter 1 focuses on the development of the self-care deficit theory of nursing as the basis for the discipline of nursing and the conceptual elements of the nursing theory, including the science of self-care. This is further explored in Chapter 2. The following chapters continue to develop and expand the concepts presented in the theory of nursing and the science of self-care. Section II then describes the practice science of nursing derived from, or associated with, the science and theory of self-care and nursing.
Self-care is work. It is work required by or for every person to maintain life and health as well as to promote development. When persons are unable to provide the quantity and quality of self-care required, they need assistance. If this assistance is beyond the common sense knowledge acquired by the family or other lay caregivers in any society, the assistance of specially prepared caregivers is required. These categories of specialized caregivers are known by the specialized services they provide. From the self-care deficit nursing theory perspective, the care or assistance provided by the nurse is associated with health-related actual or potential self-care deficits of persons, individually or collectively.

An explicit relationship between nursing and self-care was first made by Orem in 1956. Since then, under her leadership and guidance, that connection has been developed into a general theory of nursing, the _self-care deficit nursing theory_. The theory explains why people require nursing care, the processes for the production of the required care, and a structure for the development of the sciences of self-care, the practical sciences of nursing, and the related knowledge associated with these sciences.
A NURSING PRACTICE THEORY WITH FOUR PARTS

The self-care deficit nursing theory is a nursing practice theory with four parts. The first and major component is the theory of nursing systems. The theory of nursing systems encompasses both the theory of self-care and the theory of self-care deficits. The theory of self-care refers to the requirements for self-care and the powers and capabilities of the person to provide this care. The theory of self-care deficits reflects an imbalance between the required self-care and ability to perform the care. The identification of the existence or potential for a self-care deficit associated with health is the basis for establishing the nursing system. The fourth and last part is the corollary theory of dependent care which presents elements related to caring for persons who are socially dependent. Figure 1.1 shows the relationship among the four parts of this nursing practice theory.

The variables of concern for nursing practice are the components of the theories, defined in Exhibit 1.1 and elaborated further in the book.

What is the condition that exists in a person when judgments are made that a nurse(s) should be brought into the situation? It is obvious that not every one is in need of the services of a nurse all the time. Nurses possess knowledge and skills that any person can benefit from at some time, but are not required, or even desirable, all the time. So what is the basis for judgments about a need for nursing? It is “the inability of persons to provide continuously for themselves the amount and quality of required self-care because of situations of personal health” (Orem, 2001, p. 20). This statement is elegant, each word is significant.

FIGURE 1.1 Relationship of the Four Parts of Self-Care Deficit Nursing Theory

Chapter 1  The Proper Object of Nursing and a Theory of Nursing Practice

EXHIBIT 1.1
Variables of Concern for Practice and the Definitions

**Therapeutic self-care demand** summarizes all of the action required over time to meet known self-care requisites. A self-care requisite expresses the goals of action necessary for regulating an aspect(s) of human functioning and development. There are three categories of self-care requisites or goals of self-care: *universal*, which are common to all persons; *developmental*, which are particular to the person's developmental stage; and *health deviation*, which address particular health states.

**Self-care agency** is persons' ability to know and meet their continuing requirements for self-care in order to regulate their own human functioning and development. It is a threefold construct that includes:

1. Self-care operations of knowing, decision making, and acting with the abilities associated with each operation.
2. The operations are derived from action theory.
3. The 10 power components, which are abilities specific to self-care.

Capabilities and dispositions are foundational to deliberate action.

**Dependent-care agency** is the “capabilities of persons to know and meet the therapeutic self-care demands of persons socially dependent on them or to regulate the development or exercise of these persons' self-care ability” (Orem, 1995, p. 457).

**Dependent-care deficit** is a relational statement and describes the relationship between the self-care deficit of the dependent (the required assistance) and dependent-care agency (the capabilities of the care provider). Identification of a dependent-care deficit indicates a need for further assistance.

**Nursing agency** is “the developed capabilities of persons educated as nurses that empowered them to represent themselves as nurses and within the frame of a legitimate interpersonal relationship to act, to know, and to help persons in such relationships to meet their therapeutic self-care demands and regulate the development or exercise of their self-care agency” (Orem, 2001, p. 518).

**Nursing systems** are series and sequences of deliberate practical actions of nurses performed at times in coordination with actions of their patients . . . (Orem, 2001, p. 519).

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Definitions used with permission of Orem's estate administrator.

and it expresses the whole of nursing. It leads to many insights and questions, all of which give direction to the foundation of practice, research, and knowledge development. For example, “inability” moves us to ask what are the expected abilities a person needs to be able to care for self; what is the level, degree, or nature of these limitations? How might one develop these abilities? What factors could
Section I  Self-Care Science and Nursing Theory

FIGURE 1.2  A Conceptual Framework for Nursing


influence or affect the person’s ability to care for self or for others, for example, infants, children, elderly, and the chronically ill? As Orem and others worked to answer these kinds of questions, the basic structure of the self-care deficit nursing theory was made known as a nursing practice theory with four parts. The basic conceptual elements are shown in Figure 1.2, a conceptual framework for nursing (Orem, 2001, p. 491). The self-care deficit nursing theory is comprised of the patient variables of self-care/dependent-care agency and therapeutic self-care demand/dependent-care demand; the nurse variable, that is, nursing agency, and the relationships between them. All of these are described in detail in the later chapters.

NURSING: A PROFESSION AND A DISCIPLINE

Nursing is both a profession and a discipline. Nursing as a field of practice is a profession; as a field of knowledge, nursing is a discipline. Although distinct entities, in a practice discipline they are in reality inseparable—as the saying goes “you can’t have one without the other.”
The profession of nursing relies on the discipline of nursing to inform the practice, to provide the knowledge that is transformed into practice, useful in designing systems of nursing for individual persons or groups, and for developing institutional systems for delivery of care. And while the discipline of nursing provides the knowledge base for practice, ever expanding or clarifying the understanding of the theoretical or science base for practice, practice experiences give direction to the development of theoretical knowledge. There is knowledge needed for the profession that is outside the disciplinary knowledge, such as knowledge of specific political systems affecting the work environment (Figure 1.3).

A profession is an occupationally related social institution established and maintained as a means of providing essential services to the individual and the society. Some commonly accepted characteristics of a profession include the following. Each profession is concerned with an identified area of need or function, for example, maintenance of physical and emotional health, preservation of rights and freedom, enhancing the opportunity to learn. Professionals are assumed to have extensive theoretical knowledge and to possess skills based on that knowledge that they are able to apply in practice. The profession collectively, and the professional individually, possesses a body of knowledge and a repertoire of behaviors and skills (professional culture) needed in the practice of the profession; such knowledge, behavior, and skills normally are not possessed by the nonprofessional. In some professions, the body of knowledge is relatively inaccessible to the
uninitiated. Nursing has as one of its goals making the knowledge and skills of the profession more accessible.

Professional knowledge contains elements that cannot be communicated in the form of rules and can only be acquired through experience. Members of the profession are involved in decision making in the service of the client. These decisions are made in accordance with the most valid knowledge available, against a background of principles and theories, and within the context of possible impact on other related conditions or decisions. The current movement toward evidence-based practice is an effort to meet this professional characteristic. A profession is based on one or more undergirding disciplines from which it builds its own basic and applied knowledge and skills (Wikipedia, http://www.adprima.com/profession.htm).

The body of nursing knowledge referred to in the characteristics of profession is the discipline of nursing. A discipline is a structured body of knowledge about a particular segment of reality. “Each discipline has a unique focus for knowledge development that directs its inquiry and distinguishes it from other fields” (Smith & Liehr, 2008, p. 1). The structure of that knowledge serves as a matrix for examining relationships between theoretical and practical concepts and propositions. It presents to the scholar/researcher/practitioner a view of gaps in knowledge within the field and areas where new knowledge, developed through various accepted methods, articulates with current knowledge.

The discipline of nursing is seen by some scholars (Fawcett, 2000) as having an over-arching structure or metaparadigm comprised of four major elements: person, environment, health, and nursing. The particular definition of each element gives room for variation in general theories or models of nursing. These elements were derived in the 1970–1980s from existing theories of nursing and did not influence the initial direction of development of self-care deficit nursing theory though they are evident in the theory. The definitions presented here are congruent with self-care deficit nursing theory conceptualizations.

Person, or human being, refers to both the recipient of care and the giver of care. Detailed in Chapters 1 and 2, human beings are unitary beings who exist in their environments. Self-care deficit nursing theory includes the whole reality of human beings, singly and in social units as the material object of nursing. This includes individuals, dependent units, and multi-person units such as families and communities and their relationship to nursing as a profession and as a discipline.
It includes persons who occupy the position or fill the role of nurse. “A nurse is one who knows nursing and can and does produce it” (Orem, 2001, p. 40).

The person and environment within which persons exist are inseparable but factors about the environment and human relationship can be isolated and described. From the view of self-care deficit nursing theory, a significant meaning of environment is as a basic conditioning factor, the meaning of which is described in Chapter 2. Environment conditions the persons’ need for self-care, the actions selected and the setting within which care is given, the opportunity to engage in those actions, and the restricting influences which interfere with that engagement. There are physical, chemical, biologic, social, and political features. Culture is an element of environment. Further references are made to the meaning of environment throughout the text.

Health refers to the state of wholeness of structure and function of a living person. There are two dominant themes in the many definitions of health that have meaning for self-care deficit nursing theory. The first is that evidence of holistic integrated functioning and evaluative judgments about health or not-health can be made by the self or others. Much of this evidence can be objectively measured; others can be identified by observation or self-report. Second, individuals have their own sense of health and well-being, their own definitions of health formed within a cultural context. Orem distinguishes between health and well-being. Well-being relates to the second theme, that of the individual’s subjective views, whereas health is the more objective determination based on evidence of integrated structure and functioning. What persons understand as health and what they value as to the functioning and integrity of the self affects the persons’ self-care as much as does the evidence of integrated functioning. This is further explored in Chapter 4.

Nursing is an essential human service; the definitive characterizing structure of nursing is made known through a general theory of nursing. Nursing is produced in a particular time and a particular place through discrete deliberate actions or sequences of actions. Nursing exists through relationship of nurse and patient and what they choose to do. The self-care deficit nursing theory is a theory about the variables of concern when the service of nursing is required as nurses and patient interact, and about the variations in relationships among those variables. The basic conceptual elements are shown in Figure 1.2, a conceptual framework for nursing as described previously. At its most
elemental, self-care deficit nursing theory is comprised of two patient variables—self-care agency and therapeutic self-care demand, one nurse variable, nursing agency, and the relationship between the nurse and patient.

THE STRUCTURE OF NURSING SCIENCE

Originally, science was synonymous with knowledge (from the Latin scientia, meaning knowledge). As knowledge expanded and ways of thinking and generalizing about us and the world around us became more elaborate and expansive, science took on a more specific meaning. Science, in its broadest sense, is “any systematic knowledge that is capable of resulting in a correct prediction or reliable outcome. This comes about through observation, study, and experimentation carried on to determine the nature or principles of what is being studied. In its more restricted sense, science is a system of acquiring knowledge based on scientific method, and the organized body of knowledge gained through such research. In this sense science is a systematic enterprise of gathering knowledge about the world and organizing and condensing that knowledge into testable laws and theories” (Wikipedia, http://en.wikipedia.org/wiki/Science). Referred to as natural or empirical sciences, this knowledge must be based on observable phenomena and capable of being tested for its validity by other researchers working under the same conditions.

In recent years the category “human science” has emerged, referring to “a philosophy and approach to science that seeks to understand human experience in deeply subjective, personal, historical, contextual, cross-cultural, political, and spiritual terms. Human science is the science of qualities rather than of quantities and closes the subject-object split in science. It is interpretive, reflective, and appreciative” (Wikipedia, http://en.Wikipedia.org/wiki/human_science). Others classify sciences as basic and applied. Basic sciences are empirical, theoretical sciences, whereas applied sciences take the findings of the basic sciences and, literally, apply them in a practical manner to solve a problem. All of these descriptions or categories of science have validity and utility for nursing knowledge development.

Nursing is a practical science. In 1969, Simon proposed the science of the artificial. He stated that “certain phenomena are ‘artificial’ in a very specific sense: They are as they are only because of a system’s being molded, by goals or purposes, to the environment in which it
lives . . . artificial phenomena have an air of ‘contingency’ in their malleability by environment” (p. ix). Viewing nursing as an “artificial” science helped Orem and the Nursing Development Conference Group (NDCG) develop the self-care deficit theory of nursing. Artificial, meaning produced by art rather than nature, refers to things made by persons, not necessarily material, characterized in terms of functions, goals, and adaptations. Simon found the artificial to be “interesting principally when it concerns complex systems that live in complex environments” (Simon, 1969, p. xi). Simon provided NDCG with that and many other insights that aided them in their development of the theory of nursing systems and the science of design which he called “the core of all professional training.” At that same time, Argyris and colleagues were developing theories of practice and actions science (Argyris, Putnam, & Smith, 1985; Argyris & Schön, 1974). They presented ideas related to problem framing or setting, that is, when one “select[s] the problem, we select what we will treat as the ‘things’ of the situation, we set the boundaries of our attention to it, and we impose upon it a coherence which allows us to say what is wrong and in what directions the situation needs to be changed” (Schön, 1983, p. 40). Other important concepts introduced were that of the interrelationship of scientist and practitioner and reflection and learning. Though these ideas were overshadowed by the increasing favor of the empirical sciences related to the natural, leading to a focus on the relevant nonnursing sciences as identified in Figure 1.4, the structures of the disciplines such as physiology and sociology are emerging amid the discourse regarding evidence and evidence-based nursing.

Early in the process of developing self-care deficit nursing theory, the NDCG identified nursing as a practical science, that is, one of action, behavior and conduct with speculative and practical knowledge (NDCG, 1979, 2nd ed., p. 105). A practical science seeks to produce or construct its object and needs scientific knowledge to do so. Practical science has theoretic and speculative parts, as well as parts that give direction to what to do or what not to do in distinct situations. Practical sciences include speculatively practical knowledge and practically practical knowledge, whereas the theories and conceptual elements of self-care deficit nursing theory are speculative in mode (Orem, 2001, p. 164).

Within the discipline of nursing there are categories of nursing science. These are named and the relationships shown in Figure 1.4. This figure indicates points at which knowledge from other disciplines can inform nursing knowledge and vice versa.
FIGURE 1.4 The Structure of the Discipline of Nursing

Source: Reprinted with permission from K. Renpenning, G. Bekel, M. Denyes, and S. G. Taylor, The Structure of The Discipline of Nursing (Germany, Ulm, 2004).
THE PROPER OBJECT OF NURSING

The critical issue regarding the development of the body of knowledge of nursing is identification and explication of the object of nursing, material and proper. As noted above, a discipline is a structured body of knowledge about a particular segment of reality. Paley (2010) described a network of theories, evidence, and models connected to adjacent nodes of the network, with each consequently reinforcing the whole structure. He described the ideas in a single location as having ramifications in all directions, and proposed that substantive changes a location can have repercussions even in distantly connected regions of the network.

This view of discipline moves from that of a hierarchical or pyramidal structure to one of a web with nodes and interconnections. Although models presenting the structures and substructures of the self-care deficit nursing theory are shown as two dimensional, they are best thought of as at least three-dimensional models.

The focus of a discipline is constituted by its object, which is a theoretical concept. The object of nursing is the human person. The proper or specific object of a discipline defines it; it designates the particular aspect of reality that is the subject of the discipline as it can be known and expressed. Though initially the boundaries and matrices of the discipline may be lacking in detail and the relationships of substance to matrix not yet established; over time the details become clearer and the design takes shape. Like creating a patchwork quilt, you begin with little pieces, sewing them together into blocks, eventually joining those separate blocks with sashing. As the sewer goes on, the design of the quilt becomes visible to others. Different sewers can add to the quilt or change and improve the design.

KNOWLEDGE DEVELOPMENT WITHIN A DISCIPLINE

The methods of developing the substantive knowledge of nursing include philosophical and scientific as well as other ways of knowing as described by scholars (Carper, 1978; Chinn & Kramer, 1999). Though many disciplines share the common object of the human person, they vary as to the aspect of person that forms the proper object and the different ways of knowing and types of knowledge accepted by the discipline. Differences and similarities in disciplines are necessary
because each discipline does not cover all of reality; it is not global (Bekel, 1998, pp. 1–4). Recognizing boundaries and limitations for a discipline does not mean closed systems but does provide for identification of overlaps, areas where integrated knowledge may develop. It facilitates discourse between disciplines as well as within each discipline. The description of the object builds the center of professional endeavor of a discipline. The use of proper object to designate the focus of nursing was first used by Orem in 1958 (Orem, 2001, p. 20). The whole reality of human beings cared for, either singly or in social units, constitutes the material object of the activities of all the human services. Identification of the proper object, what distinguishes one field from another, includes “specification of various aspects of object domains as a way of describing how sciences use the identified object in the development of scientific disciplines, notably (a) problem domain, (b) application domain, (c) proper object domain, and (d) universe of discourse” (Weingartner, 1999, pp. 2–3). The proper object domain of nursing is found in the answer to the question as to what condition exists in a person when judgments are made that a nurse(s) should be brought into the situation, that is, those persons should be under nursing care. Orem asked the questions “Why do people need nursing, or what human condition brings about a need for nursing? What is nursing? What is the structure of the entity, that service we refer to as nursing?” (Orem, 1996, p. 302). For Orem, the answer was “the inability of persons to provide continuously for themselves the amount and quality of required self-care because of situations of personal health” (Orem, 2001, p. 20). Further responses to this question in the form of clarification, insights, formulations, and expressions provide the conceptual foundation for the body of work known as the self-care deficit nursing theory. Through the years there has been further development, clarification, elaboration, and verification in all levels of abstraction, including specific situation theory for practice.

HISTORY OF NURSING THEORY

What Is Past Is Prologue

The work done by nurses through the centuries is all essential work and is linked to contemporary nursing knowledge. Theorizing is a matter of proposing solutions, parameters, limitations. The natural
inquisitiveness of humans leads them to ask questions and to seek solutions to situations encountered, to try to explain the reality they perceive within the limits of what is known, and to speculate about possibilities.

There has been theorizing about self-care and nursing since social groups first assigned specific persons the responsibility of taking care of members of the group who might be in need of assistance with daily care. The leaders of the group had to consider questions as to what personal actions are to be taken, for example, what to eat, how to do bodily care, where and when to sleep, what are acceptable activities? What is to be done for the injured hunter or warrior, ill children, elderly members? Who are the persons to whom the responsibility of assisting others is given? What are they expected to do? What are they allowed to do to another to meet the expectations? What are the consequences if they don’t meet these expectations? The answers to these questions are found in the traditions and rules of the various groups. This kind of thinking laid the foundation for the evolution and development of organized care, both medicine and nursing. Select persons are assigned social tasks for caring for others, maintaining health. They begin to work out ways of doing things, reasons for taking a certain action over another. Special locations for caring for the ill were established, for example, Hospital Hotel Dieu, 660 A.D. in Paris. Like many early hospitals, it started as a general institution catering to the poor and sick, offering food and shelter in addition to medical care. In 1633 in France, Louise de Marillac began a systematic training of women, particularly for the care of the sick. In 1833 in Germany, Pastor Theodore Fleidner founded an order of deaconesses at Kaiserswerth to train nurses for hospital work. The content of the training programs identified the knowledge and skills believed at that time to be necessary for providing care to those sick and needy. Further comments on the history of nursing theory development are in Appendix A.

The efforts of these and other nurses led, inevitably, to the development of theoretical systems of nursing knowledge and practice. For what is theorizing but contemplation and offering explanations that eventually lead to a coherent group of propositions, a particular conception or view of something to be done and the method of doing it? And what is the purpose of theorizing in practice disciplines but the development of knowledge and science leading to practice based in empirical and personal evidence.
Self-care deficit nursing theory is an important component of nursing’s theoretical knowledge. This theory was first articulated in the 1950s, formalized and first published in 1972 for the purpose of laying out the structure of nursing knowledge and explicating the domains of nursing knowledge. Self-care deficit nursing theory was one of the first models of nursing developed. (Detailed presentations of the history of self-care deficit nursing theory can be found in Orem, 2001, Appendix B, 6th edition; Renpenning & Taylor, 2003, pp. 254–266; Taylor, 1997, pp. 7–10). Scholars wishing to learn more about the early work can access the Orem Archives at The Alan Mason Chesney Medical Archives of the Johns Hopkins Medical Institutions.

Orem identified two phases in the development of the theory. The first ended in 1972 when the essential ideas were identified, relationships described, and the first book was published: Nursing: Concepts of Practice. The second phase began in 1972, when the focus was on diffusion and refinement, and ended with her death in 2007. A new phase, or a continuation of the second phase, now focuses on research to validate theoretical relationships and the use of the theory in practice.

Dorothea Orem: The Person

Knowing some personal history lays the foundation for understanding her work. Orem, born in 1914, was one of two sisters who grew up in Baltimore, Maryland. In a personal interview in 1997, Orem described herself as early in her life having “a natural talent for seeing order and relationships especially with ideas and concepts and meanings” (Taylor, 1997). Reading was important to her from early on. Dorothea attended Seton High School in Baltimore. She recalls as most helpful the courses in English “We did a lot of analysis. We took things apart; we searched for meaning.”

Her early exposure to nursing through her family made it a viable career choice for her. Nursing was chosen because of “practical reasons.” When Orem decided to apply for nursing school, she chose Providence School of Nursing at Providence Hospital, Washington, DC, where her aunt was then supervisor of the operating room.

Orem did her preservice education at Providence Hospital during the depression. She received her diploma in nursing in 1934. She described some of her experiences in nursing school as helping to
conceptualize order and relationships. She described two experiences that were a motivating force in developing and being able to express a concept of nursing, in both instances she saw what to her was “good nursing.”

After receiving her diploma, Orem worked in the operating room, for 1 year. Experiences in the operating room helped her see the “whole picture” especially in terms of organization and administration. She did private duty nursing, in home and hospital, (there were no ICUs in those days) and staff nursing in pediatrics and adult medical/surgical units. She was evening supervisor in the emergency room, where she saw the articulations between nursing and practically everything else.

Physicians and nurses worked together but the nurse was not under the physician in any sense of the word. There was collaborating with orders, but even with orders you had to know what you could and couldn’t do. I think sometimes the burden on nurses is extreme because they have to know what’s within limits of both fields—nursing and medicine. (Taylor, personal interview, 1997)

During this time she was going to The Catholic University of America (CUA) where she received her baccalaureate degree in 1939. She moved to Detroit in 1940 where she taught biological sciences at Providence Hospital School of Nursing. She returned to DC and took a position at Providence School of Nursing as assistant to the director of the program—then a combination of the old Providence program and CUA—where she taught a microbiology class. Orem received a master’s degree in 1946. At that time the degree required a foreign language, German, and a thesis. Orem did her thesis work in the area of guidance. “It took me a long time to do that thesis, to find something to do.” She returned to Detroit in 1945 as director of nursing service and director of the school of nursing. While there, she took a course in metaphysics at University of Detroit, a Jesuit university, a course that was important as a broad general tool in dealing with the matter of sorting and structuring the content of nursing, in reaching understanding, and in understanding both the parts and the whole as such. At that point she recognized that without a conceptualization of nursing, there are certain questions that can’t be answered and one is therefore oriented to doing.

In 1949, Orem went to the Indiana State Board of Health, Hospital Division, to help in upgrading of nursing services in general hospitals.
There she noted that nurses had difficulty representing their needs to hospital administrators because they didn’t know how to talk about nursing. She became focused on expressing what nursing is.

The mid-1950s was a time when there was beginning to be a focus on planning nursing care. Orem became aware that the “point of departure for planning care had to be the patient” not the nurses’ tasks. “Then, another experience was when in the profession they put all this emphasis on planning your nursing care. The question that I asked is ‘what is the basis for planning? What are you planning?’ To me, there wasn’t anything.”

Following this time in Indiana, Orem returned to DC and took a position with the Office of Education, Vocational Section of the Technical division, where there was an on-going project to upgrade practical nurse training. It was at this time that the more formal work of structuring nursing knowledge began. “In my thinking that started at that time, I came to the conclusion that the question that had to be answered was ‘why do people need nursing?’ and her answer was that it is the inability of the person to maintain self-care in health situation.” “From that time onward, the knowledge I had about nursing began to structure itself; the pieces started to come together” albeit with considerable work, alone and with others. Some of the elements of what is now known as self-care deficit nursing theory emerged and are recorded in *Guides for Developing Curricula for the Education of Practical Nurses* where she expressed the object of nursing.

After the publication of the guidelines, Orem returned to a faculty position at CUA in 1959. While there she began working on a book, *Foundations of Nursing* which was later self-published. Orem provided the intellectual leadership in developing self-care deficit nursing theory throughout the collaborative endeavors with members of the Nursing Models Committee at Catholic University of America, and the “Improvement in Nursing (IN) group,” later the Nursing Development Conference Group (NDCG) comprised of nurses from all fields, including educators, administrators, and clinicians. After the publication of the first edition of *Nursing: Concepts of Practice* in 1971, Orem continued to work on the development of the theory. She consulted extensively and did many presentations at conferences. These often brought together the major theorists; however, there was little substantive interaction among them. Later Orem gathered a group of scholars, the Orem Study Group, to work with her in the development of the theory. Much of the work of this group is included in this book.
ROLE OF THEORY IN THE DEVELOPMENT
OF NURSING KNOWLEDGE

The relationship of nursing theory, research and practice is described in detail by many. Of note is the work of Young, Taylor, and Renpenning (2001). They identified two major outcomes of nursing theoretical systems. First, there is scientific, systematized knowledge for nursing practice that can also be used in designing research and curriculum. The second is a formalized statement of a philosophical worldview on which to base further understanding of nursing theory. Theory instructs the nurse in focus and content of that practice as well as guides nursing action. Theory informs practice and practice informs theory (Alligood & Tomey, 2002, p. 3). The same can be said about theory and research. In fact, the theoretical system provides a unifying focus for approaching a wide range of nursing concerns (Neuman & Fawcett, 2011). A conceptual model, such as self-care deficit nursing theory, can unify a number of middle-range theories and give direction to areas for further development. “Results from atheoretical studies or those that have no nursing theoretical link cannot be easily incorporated into the structure of nursing knowledge, and are at risk for losing their identity as nursing studies” (Kolcaba & Kolcaba, 2011, p. 307). Sieloff and Frey (2007) commented that

Developing and testing propositions and formulations from nursing theory are critical for the development of nursing science. This process is also one of the most difficult approaches to knowledge building to establish and maintain. A primary reason for this may be the lack of support for nursing theories within the discipline . . . doctoral programs rarely require the use of an explicit nursing theory for dissertation work. (2007, p. xv)

Orem believed that general theories are not static but rather guide the work of scholars, practitioners, and researchers leading to refinement and further understandings. The more developed the conceptual model, the more meaningful the translation to specific situations recognizing that this knowledge is most useful when generalizations can be made within the context of the broader theory. Using self-care deficit nursing theory generates a style of thinking and a way of communicating nursing. A deeper way of thinking and interacting occurs
when there is a shared language. It is both more effective and efficient; fewer misunderstandings and errors occur and less time is spent in clarifying meaning.

THE STRUCTURE OF THE DISCIPLINE OF NURSING

In designing the structure of the discipline of nursing, the Orem Study Group worked from the premise that all knowledge is ultimately related; though each discipline has a particular proper object, knowledge has meaning across boundaries. Knowledge development for the discipline and the practice of nursing is, or should be, built upon existing knowledge and integrated into existing bodies of knowledge. A broader view of nursing places it in the context of the world of human endeavor. Given the proper object of nursing as described, the Study Group examined the nature of persons and persons in relations. Nursing specific knowledge is framed within an action frame of reference as shown in Figure 1.4. The relevant non-nursing sciences provide the content for that frame of reference. It is the foundational nursing sciences and the nursing practice sciences that constitute nursing’s unique body of knowledge. Though not specifically identified, Orem anticipated the development of a number of nursing applied sciences.

The philosophical view of human beings underlying the self-care deficit nursing theory is that human beings are unitary beings who exist in their environments. They are in a developmental process, striving to achieve their human potential and self-ideal through these processes. They possess free will and are capable of maintaining an awareness of self and environment. Human beings attach meaning to what is experienced, reflect upon their experiences, and possess the ability to engage in deliberate action. In addition to freedom, other essential qualities of human beings include bonding together with others through human love, the unrestricted desire to know, the appreciation of beauty and goodness, the joy of creative endeavor, the love of God, and the desire for happiness (Banfield, 1997, p. 51).

The object of nursing includes the whole reality of human beings, singly and in social units. This includes individuals, dependent units, and multi-person units such as families and communities.
Chapter 1  The Proper Object of Nursing and a Theory of Nursing Practice

THE FOUR CONSTITUENT THEORIES OF SELF-CARE DEFICIT NURSING THEORY

The Theory of Nursing Systems

The nursing system was first conceptualized as a complex action system formed by linking one or a combination of the ways of assisting to a patient self-care system or to some component part of the system (Nursing Development Conference Group, 1973). Nursing systems are designed: (a) to achieve patient health or health-related goals through self-care which is therapeutic, (b) overcome self-care deficits, and (c) foster and preserve self-care abilities of the patient. It establishes the structure and the content of nursing practice. A nursing system is an action system designed by nurses. Inherent in this approach is the position that the nursing system and the self-care system are action systems and that they are open, self-organizing systems, in the sense described by Ashby (1968) and Buckley (1967). These systems have the qualities of conditionality, constraint, and freedom of variation. As open systems become more complex, there develop within them complex mediating processes. These intervene between external forces and behavior and perform the operations of: (1) temporarily adjusting the system to external contingencies; (2) directing the system toward more congenial environments; and (3) permanently reorganizing aspects of the system itself to deal perhaps more effectively with the environment (Backscheider, 1974, p. 1139). The term self, as in “self-regulation,” “self-direction,” and “self-organizing” points to these mediating processes on the human level.

The power to take action to achieve various goals is known as agency. When that power is developed and activated toward care of self it is called self-care agency. When it is developed and activated to design and produce nursing systems, it is nursing agency. Agency is essential for deliberate action, that is, action that is purposeful, goal directed, thought-out and carried out, or produced. Without question nursing is deliberate action. Nursing agency is developed in nursing education programs, influenced by the many personal, social, cultural, and environmental factors. This agency is refined and further developed through time with reflective experience and additional education. An unreflected experience does little to change nursing agency.
The nursing system was originally conceptualized as a hierarchy of interlocking systems (Orem, 1971, p. 76) as shown in Figure 1.5. This is useful in understanding the many dimensions of nursing situations, the complexity of which should not be underestimated. A nursing situation begins with an interpersonal relationship and interaction within social, contractual, and legal dimensions. The articulations between
self-care, therapeutic self-care demand, and nursing agency constitute the unique nursing aspects of the situation. These ideas are further considered in chapters on nursing practice.

The Theory of Self-Care

The theory of self-care is the second of the constituent theories that form the self-care deficit nursing theory. The concept of self-care was foundational to Orem’s work in defining and further developing the self-care deficit nursing theory. The idea of self-care was first used in her 1956 definition and in 1959 description of why persons require and can be helped through nursing. This has been the major focus of theory development and research throughout the years.

The theory of self-care expresses the view of human beings attending to and dealing with themselves. The individual is both the agent of the action (the one acting) and the object of action (the one acted upon). The conceptual elements of the theory are self-care, self-care agency, and self-care requisites. Self-care is an enduring system of actions produced by or for persons from birth to death through the performance of care actions and action sequences. The persons’ powers and capabilities for action are referred to collectively as their agency. Self-care agency includes (a) operational powers specific to performing estimative, transitional, and productive result-seeking operations of self-care; and (b) the capabilities and dispositions essential to performing these. The capabilities for self-care are developed over time with assistance and experience in social groups as well as through education and training. Important parts of self-care are self-appraisal and self-management, the effectiveness of which affects the performance of other types of endeavors. Self-care occurs within the broad life situation of the individual, such as family, occupation, education, household, and care and guidance of dependent family members and others. The content related to self-care agency is further developed in Chapter 3.

Self-care requisites are those actions that are required to maintain human functioning and human development and give rise to the development and activation of self-care agency. Requisite refers not just to what is needed for a particular condition, not imposed from the outside (as in required), but is a factor judged necessary according to the nature of things or the circumstances of the case. These requisites may be essential (universal), enduring, or situation specific. The totality of
Section I  Self-Care Science and Nursing Theory

requisites is known as the therapeutic self-care demand. These ideas are developed in Chapter 2.

The Theory of Self-Care Deficit

Deficit expresses a relationship between two or more elements where there is not enough resource to meet the essential requisite. It is not a defect in the person’s nature or character, though those may be considered in assessing and making judgments about the self-care deficit. In self-care, the essential is identified as the therapeutic self-care demand and the resource as the self-care agency. At any point in time, a person experiences some limitation in ability to meet existing requirements. These may be transitory, short term, easily overcome by gaining information, developing motivation, or seeking assistance. Or the requisites may be more enduring, related to health state or other personal factors including lack of resources. Determination of the nature and extent of the self-care deficit needs to be made before appropriate assistance can be provided. This is an essential part in the development of a nursing system. Nurses may have to use all their skills and knowledge just to diagnose or determine the nature of the self-care deficit, let alone take action working with the person or a designated person, such as a family member, to manage or overcome the deficit. Chapter 4 presents the content of self-care deficit and human assistance.

The Theory of Dependent Care

The theory of dependent care explains how the self-care system is modified when it is directed toward a person who is socially dependent and needs assistance in meeting his or her self-care requisites. This is an area of great interest to many nursing scholars. There are many situations where there are needs for dependent care. In addition to the obvious infant and child care, there are persons with chronic illness or multiple debilitating conditions who are dependent on others for help in meeting self-care requisites. The general structure is analogous to that of self-care. In self-care, the agent and the object are the same individual, whereas in dependent care there are at least two agents only one of whom is the object of the action. This increases the complexity of the situation as it includes capabilities to focus on meeting another’s needs and, in many instances, working with the bodily parts of another.
In Chapter 5, dependent-care agency and dependent-care system are examined, as well as the meaning of this for nursing.

**SUMMARY**

The discipline and profession of nursing are continuing to develop amidst the many changes occurring in the work of health care and higher education, in fact, in the world in general. Within the discipline there is a focus on developing science, philosophy, and other ways of knowing. The profession is concerned about the use of this knowledge to improve patient care through movements such as evidence-based practice. The self-care deficit nursing theory provides a platform for organizing all of these foci and concerns. The self-care deficit nursing theory serves to give direction, meaning, and structure to nursing practice, as well as to emerging theoretic nursing sciences.

**REFERENCES**


Chapter 1  The Proper Object of Nursing and a Theory of Nursing Practice


