Contents

Editorial

3 Parting shot
   Michael J. Morgan

3 Foreword by Guest Editor
   Violeta A. Berbiglia

Original manuscripts

4 A Self-Care Deficit Nursing Theory practice model for advanced practice psychiatric/mental health nursing
   Victoria T. Grando

9 Development and examination of psychometric properties of Self-Care instruments to measure nutrition practices for English and Spanish-speaking adolescents
   Jean Moore, Lisa Pawloski, Heibatollah Baghi, Karen Whitt, Claudia Rodriguez, Laura Lumbi, and Adel Bashatah

17 Teaching practically practical nursing science
   Anna J. Biggs

22 Development and application of the Community Care Deficit Nursing Model (CCDNM) in two populations
   Serey Shum, Rebecca McGonigal, Barbara Biehler

Teaching Strategy Column

26 Show me how
   Violeta A. Berbiglia

IOS News

27 From the president
   Barbara Banfield

28 In memory of Margarethe Lorensen

29 Concept Formalization in Nursing reprint offer

30 New IOS Web Presentation
Author guidelines

Self-care, Dependent-care, & Nursing is the official journal of the International Orem Society for Nursing Science and Scholarship. The editor welcomes manuscripts that address the mission of the Journal.

MANUSCRIPT PREPARATION

Use Standard English. The cover page must include the author’s full name, title, mailing address, telephone number, and eMail address. So that we may use masked peer review, no identifying information is to be found on subsequent pages. Include a brief abstract (purpose, methods, results, discussion) followed by MeSH key words to facilitate indexing.

The use of metric and International Units is encouraged. Titles should be descriptive but short. Full-length articles should not exceed 15 double-spaced pages. Use of the Publication Manual of the American Psychological Association (5th ed.) is strongly encouraged but not mandatory. When required by national legal or ethical regulations, research-based manuscripts should contain a statement regarding protection of human subjects.

Mission:
To disseminate information related to the development of nursing science and its articulation with the science of self-care.

Vision:
To be the venue of choice for interdisciplinary scholarship regarding self-care.

Values:
We value scholarly debate, the exchange of ideas, knowledge utilization, and development of health policy that supports self- and dependent-care.

REVIEW PROCESS

Manuscripts are reviewed anonymously. One author must be clearly identified as the lead, or contact, author who must have eMail access. The lead author will be notified by eMail of the editor’s decision regarding publication.

INTELLECTUAL PROPERTY

Authors submit manuscripts for consideration solely by SCDCN. Accepted manuscripts become the property of SCDCN, which retains exclusive rights to articles, their reproduction, and sale. It is the intention of the editor to facilitate the flow of information and ideas. Authors are responsible for checking the accuracy of the final draft.

SUBMISSION

Manuscripts are to be submitted in MS Word format as an eMail attachment to the editor, Karen Cox, RN, PhD coxk@health.missouri.edu. Submissions will be immediately acknowledged. It is assumed that a manuscript is sent for consideration solely by SCDCN until the editor sends a decision to the lead author.
Parting shots

I do not know how well the title of my final editorial will be perceived by the non-North American readership, so I will translate: a parting shot is a statement, often acerbic and over the shoulder, as a person leaves a situation (or tries to get the last word in during an argument). While I am not engaged in an argument with anyone in particular, I do have a parting shot and hope it stimulates discussion, not ends it.

It has been 5 years since Kathie McLaughlin Renpenning turned the IOS Newsletter over to me with the sage/rueful advice, “You can’t publish what you don’t receive.” I wish I could say that Self-care scholarship has flourished in those 5 years, but I would be hard pressed to find the evidence. Biennial Congresses notwithstanding, our scholarship is not being presented to the discipline of nursing. One barrier is the dearth of scholarship; another is ongoing intradisciplinary hostility to nursing theory. I believe it is up to the IOS to fund the development of scholarship, as few others will do it. I implore readers to become part of the process. We have few researchers funded at significant levels to produce the type of scholarship necessary to improve, extend, and even refute some of the theorized relationships among various aspects of Self-care Deficit Nursing Theory. What can we do about that?

We can continue to volunteer to be reviewers for grant applications. We can pressure such deep-pocket funding sources (National Institute for Nursing Research) to fund theory-based investigations. We can pressure our colleagues by asking, “What is the contribution of our discipline in that effort?” I am still dismayed that NINR continues to fund proposals with the phrase “self-care” yet give cursory mention of SCDNT. The traditional big grant winners continue to supply the reviewers who continue to fund non-nursing research—all under the umbrella of nursing! NINR continues to fund “nurses who research” rather than nurses doing “nursing research.” The same thing goes for Sigma Theta Tau, International. I have given up bothering to read their journal for nursing research, yet it claims to be the journal of nursing research. (See what I mean about a parting shot?) To paraphrase what I have asked before, “Who is the keeper of the disciplinary flame?”

EBSCO has received all the back issues of this Journal, and the articles therein should be available via EBSCO products in the very near future. Our scholarship can now be accessed by people whose library subscribes to EBSCO, which is nearly every university library in North America and dozens across the globe. Self-care, Dependent-care & Nursing continues to be an on-ramp to the information highway. Please join me in wishing the new editor, Karen Cox, RN, PhD as she gets behind the wheel. Give her the fuel (manuscripts) as she heads the journal into the future. (Please forgive the metaphors, but I do live in Detroit, Michigan, “the Motor City.”)

Best wishes,
Michael J. Morgan,
Editor

About this issue

Dr. Violeta Berbiglia volunteered to be Guest Editor for an SCDCN devoted to education. She solicited and edited all of the articles contained in this issue. Her enthusiasm for SCDNT and dedication to excellence in nursing education shines through.

FOREWORD FROM THE GUEST EDITOR

It has been a pleasure to serve as your guest editor for this issue. This special issue on SCDNT-based education includes 3 contributors from the USA and 1 from Canada. All are known for their contributions to the IOS and their excellence in nursing education. Also, they are interested in your response to their conceptualizations and in creating a dialog with you. I have included a Teaching Strategy Column that I hope will continue in future issues. Enjoy your reading and plan to attend my Educators’ Meeting in Johannesburg.

Violeta A. Berbiglia, RN, EdD
Abstract
Because advanced practice nurses often use treatment strategies in common with other healthcare providers, controversy continues concerning their role within the health care delivery system. This is particularly true for psychiatric/mental health nurse practitioners whose practice overlaps with that of psychiatrists, psycholinguists, social workers, and counselors. To address this issue, a practice model based on Orem's Self-Care Deficit Nursing Theory was developed as part of a family psychiatric/mental health nurse practitioner master's specialty program. The practice model focuses on minimizing the self-care deficits of patients with mental health issues by improving their self-care agency, meeting their therapeutic self-care demands, and establishing therapeutic self-care systems. This paper provides a valuable and timely contribution to the literature on the advancement of nursing discipline-specific knowledge and practice activities by presenting a practice model grounded in a nursing conceptual model: Orem's S-CDNT. Key words: Self-care, Orem, Psychiatric/Mental Health Nursing; Advanced Practice Nursing; practice models

Nursing leaders continue to wrestle with the parameters that define the scope of advanced nursing practice. A review of nursing literature reveals the ongoing dialogue regarding whether nurse practitioners are engaged in advanced nursing or delegated medicine (Cody, 2003; Fawcett, Newman, & McAllister, 2004; Geden & Taylor, 1997; Geden, 2001; Grando, 1998; Watson, 1995). These leaders hold that the role of advanced practice nurses needs to be differentiated from the role of other health care professionals by clearly delineating nursing's proper object that is the unique focus of nursing. Indeed, Fawcett (2003) argues that nursing's future rests in the advancement of nursing discipline-specific knowledge and practice activities grounded in nursing conceptual models that provide nursing's distinct perspective on phenomena of interest to the profession: human beings, environment, health, and nursing. Although an important issue for all advanced practice nurses, it is especially so for advanced practice psychiatric/mental health nurses who have recently experienced a major shift in their practice environment. The purpose of this paper is twofold. First, it traces the historical background of nurses' concern for their patients' ability to care for themselves. And, second, it describes a practice model based on Orem's S-CDNT that was developed to educate family psychiatric/mental health nurse practitioners.

Psychiatric/Mental Health Nursing in Transition
Prior to the decline of inpatient psychiatric services brought about by managed care, the role of psychiatric nurses was unique: managing the round-the-clock therapeutic milieu of psychiatric units. This included, among other things, engaging patients in therapeutic communication, assisting patients in learning new behaviors and identifying feelings, teaching patients to deal with stress, improving patients' social skills, managing medications, helping patients develop and manage their self-care systems, running psychoeducational groups, and performing psychotherapy. Their role was clearly defined whether they based their care on nursing conceptual models or not.

Today, however, many advanced psychiatric/mental health nurses work in primary care as psychiatric/mental health nurse practitioners. In these settings, their practice overlaps that of other mental health professionals. For example, psychiatric/mental health nurse practitioners and psychiatrists share prescriptive authority while psychiatric/mental health nurse practitioners, psychiatrists, psychologists, social workers, and counselors use psychotherapy as their primary treatment strategy. Moreover, the theoretical frameworks that are the basis for psychotherapy are derived from other disciplines. These factors underscore the critical need for psychiatric/mental health nurse practitioners to base their practice on conceptual models of nursing if they are to have a distinct role. I believe that Orem's Self-Care Deficit Nursing Theory (S-CDNT) provides a nursing framework for today's advanced practice psychiatric/mental health nurses. However, there is a void in the recent
literature on the topic of advanced practice psychiatric/mental health nursing and the use of S-CDNT as a guiding framework. This paper fills this void by providing a valuable and timely contribution to the literature on the advancement of nursing discipline-specific knowledge and practice activities by presenting a practice model grounded in a nursing conceptual model: Orem’s S-CDNT.

**Historical Background**

Since the inception of modern nursing in the mid-nineteenth century, nurses have assisted their patients’ achieve health by providing nursing care that promotes both the body’s healing process and the patients’ ability to care for their health related needs. Florence Nightingale articulated these views in, *Notes on Nursing: What it is and What it is not* (1859, 1946). In this landmark book, she delineates the nature of nursing while making the following three points.

First, the role of nursing is distinct from the role of medicine. Nightingale believed that the aim of both physicians and nurses was to enhance the body’s ability to heal itself. Physicians achieved this by intervening surgically and prescribing medications. Nurses achieved this by preventing complications of poor sanitation, inadequate nutrition, prolonged confinements to sick beds, and unnecessary emotional stress as well as carefully observing the patient’s condition.

Second, she held that patients and their environment were the focus of nurses rather than physician’s orders. This view was clearly stated in *Notes on Nursing* by the following:

> It (nursing) has been limited to signify little more than the administration of medicines and the application of poultices. It ought to signify the proper use of fresh air, light, warmth, cleanliness, quiet, and the proper selection and administration of diet—all at the least expense of vital power of the patient. (Nightingale, p. 6)

Lastly, Nightingale believed that nurses’ role was not only to care for the sick, but to teach the proper methods of caring to those who care for the health of others. The fact that *Notes on Nursing* was not a manual of nursing, but a guide for women on how to care for their family’s health needs shows her commitment to this belief.

Nursing strategies advocated by Nightingale were highly effective. The phenomenal success of Nightingale’s nurses in reducing the mortality rate in military hospitals during the Crimean war and the rapid growth of American hospitals after the introduction of trained nurses (Ashley, 1976; Grando, 1994) provides evidence of the effectiveness of these nursing interventions.

The writings of another influential nursing leader, Virginia Henderson, echo Nightingale’s views on nursing. Henderson believed that the focus of nursing was to help patients achieve health by assisting them to perform health related activities and gain independence. Furthermore, she believed that nurses should focus on daily activities such as breathing normally, eating adequately, getting sufficient rest and sleep, avoiding dangers, communicating with others, and learning how to achieve normal development. In her book, *The Nature of Nursing* (1966), she provides the following definition of nursing:

> 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. (p. 15)

Orem’s (2001) beliefs about nursing are similar to those of Nightingale and Henderson, but she advanced their views by placing greater emphasis on achieving health by focusing on patients’ ability to care for themselves. According to Orem, nursing’s proper object is self-care. The following excerpt from her book, *Nursing: Concepts for Practice* (2001), illustrates her views:

> Nursing has as its special concern man’s need for self-care action and the provision and maintenance of it on a continuous basis in order to sustain life and health, recover from disease and injury, and cope with their effects. The condition that validates the existence of a requirement for nursing in an adult is the absence of the ability to maintain for himself continuously that amount and quality of self-care which is therapeutic in sustaining life and health, in recovering from disease or injury or in coping with their effects. (p. 22)

**Orem’s S-CDNT and Advanced Practice Psychiatric/Mental Health Nursing**

It is evident from the writings of these influential nursing leaders that promoting health and the ability to care for self are nurses’ unique contributions to health care. Inspired by this tradition, I developed a practice model: *Treating*
Self-Care Deficits Related to Mental Health Functioning. It is based on Orem’s S-CDNT and is the foundation of a new family psychiatric/mental health nurse practitioner master’s specialty program. The following assumptions guided the development of the practice model: (a) nurses have an important role in the process of healing, (b) psychiatric/mental health nurse practitioners play a distinct role in mental health, (c) self-care is the proper object of psychiatric/mental health nursing, and (d) Orem’s S-CDNT (Orem, 1979, 2001) is an excellent model on which to base the practice of psychiatric/mental health nurse practitioners.

From the perspective of this practice model based on S-CDNT (Orem, 1979, 2001), the proper object of psychiatric/mental health nurse practitioners is those persons whose inability to manage their self-care requirements is related to their mental health functioning. As primary psychiatric/mental health care providers, this means that they treat patients with actual or potential self-care deficits related to psychiatric/mental health issues. Accordingly, their focus is on assessing their patients’ basic conditioning factors, identifying their patients’ therapeutic self-care demands, improving their patients’ self-care agency, and helping their patients’ establish therapeutic self-care systems (see Figure 1).

The following examples demonstrate how common psychiatric/mental health problems are viewed from the perspective of this practice model. Personal crisis: people experience a crisis when their established self-care systems are inadequate to cope with a stressful event and they are unable to develop new ones that would address the crisis. Relationship abuse: physical and psychological abuse result in low-self esteem and shame that clouds the abused person’s judgment of their ability to engage in self-care actions needed to protect themselves. Psychosis – people with schizophrenia have limitations in self-care agency resulting from disordered thoughts that hinders their ability to make decisions about appropriate self-care actions needed to meet universal self-care requisites.

Using this practice model, the focus of psychiatric/mental health nurse practitioners is not on the presenting problem, but on finding solutions to self-care deficits. They accomplish this by helping patients identify self-care actions necessary to restore mental health and by helping patients enhance their ability to engage in these actions.

Figure 1. Practice Model: Treating Self-Care Deficits Related to Mental Health Functioning.
therapeutic self-care actions. The goals of treatment include the following: (a) enhancing self-care agency by strengthening capabilities and minimizing limitations, (b) determining self-care actions necessary to change behaviors, reframing beliefs, and managing feelings; and (c) establishing therapeutic self-care systems.

Achieving these goals is often difficult because patients frequently have long established dysfunctional self-care patterns. However, engaging patients in treatment planning facilitates the achievement of their goals. The first step in this process is a comprehensive psychiatric/mental health history and assessment that focuses on strengths as well as limitations. It begins by evaluating the patient’s Basic Conditioning Factors that influence the current situation such as family dynamics; neurobiological factors; peer relations; social support systems; developmental milestones; current behaviors, beliefs, and feelings; and on what routine self-care actions are working and those that are not. 

Next it focuses on determining the patient’s Therapeutic Self-Care Requisites (Universal, Developmental, and Health Deviation) and the self-care actions necessary to meet these requisites. And lastly, it involves determining the adequacy of the patient’s Self-Care Agency by assessing the following: (a) the patient’s knowledge about self-care (empirical, experiential, or technical), (b) the patient’s ability to make sound judgments and decisions about self-care, and (c) the status of the patient’s foundational capabilities (such as learning ability, priority systems, attention, perception, and self-understanding), which are necessary to engage in deliberate action.

After assessing the pertinent patient information, psychiatric/mental health nurse practitioners work with their patients to resolve the current situation. Treatment goals are directed at solutions and not dissecting the perceived problem. From a S-CDNT perspective (Orem, 1979, 2001), the solution is achieved by determining therapeutic self-care demands, establishing therapeutic self-care action system, and enhancing self-care agency.

The following two case examples demonstrate how the practice model can be applied to persons having difficulty meeting the therapeutic self-care demands. A young adult comes to see the psychiatric/mental health nurse practitioner because she has been cautioned that her continued tardiness at work will result in her losing her job. She states that she has always had trouble getting up in the morning, but recently she is unable to get up on time because she is tired in the mornings. Moreover, she feels “down” and has lost enjoyment in being at work. The problem started a few months after her best friend was killed in a car accident. The assessment reveals that the patient’s recent loss has lead to depression, which has exacerbating her chronic problem of getting up in the morning. The focus of treatment is to meet her therapeutic self-care demand, which is to get to work on time. The treatment goals include treating the depression that interferes with her ability to perform self-care, helping her identify what actions she is currently performing that help her get-up, guiding her identifying new actions needed to get her get-up, and assisting her develop a system of self-care actions that will effectively get her to work on time. Treatment strategies might include antidepressants, teaching the patient cognitive reframing skills, and exploring actions that effectively wake get her up.

A middle aged man has come in to be seen because he is afraid that he has an “alcohol problem”. The assessment reveals that his intake of alcohol has been steadily increasing over the past year and that he is not eating a sufficient quantity of protein because of his high alcohol consumption. The focus of treatment would be to meet the patient’s self-care demands: to reduce his alcohol intake and to eat a balanced diet. The treatment plan would address the addictive behaviors, his eating patterns, and the connections between the two. Treatment strategies would include joining a treatment group focused on reducing his alcohol dependency, identifying the positive aspects of his current diet, and guiding him to develop a balanced eating plan.

The Practice Model for Treating Self-care Deficits Related to Mental Health Functioning provides a treatment orientation that differentiates psychiatric/mental health nurse practitioners’ care from that of other mental health professionals by focusing on patients’ self-care requisites, identifying patients’ therapeutic self-care demands, improving patients’ self-care agency, and assisting patients develop self-care systems. A self-care orientation is especially appropriate for mental health patients because it focuses on their ability to solve their mental health problems. Moreover, helping patients achieve health by managing their own care needs is a longstanding nursing challenge.

Victoria T. Grando, PhD, APRN, BC, is Associate Professor, University of Arkansas for Medical Sciences College of Nursing, Little Rock, AR. Contact Dr. Grando at: GrandoVictoria@uams.edu
References


Development and examination of psychometric properties of Self-Care instruments to measure nutrition practices for English and Spanish-speaking adolescents

Jean Burley Moore, Lisa Pawloski, Heibatollah Baghi, Karen Whitt, Claudia Rodriguez, Laura Lumbi and Adel Bashatah

Although the researchers had been conducting nutrition education classes and collecting qualitative dietary information such as 24-hour dietary recall and usual meal content on girls in Nicaragua for several years, determining dietary change and, therefore, program effectiveness, from such information was very difficult. First, it was not possible to identify specific nutrition behavior, particularly intellectual behavior, from such information. Further, when changes in the diet occurred, it was unclear whether it was due to a girl’s or her mother’s influence. To resolve these issues, the researchers decided to develop a quantitative, self-report approach to measure behavior change for both girls and mothers asking for typical self-care activities before and after the nutrition education classes. The following paper relates the process of development of these instruments.

V. Berbiglia, Guest Editor

Abstract

There is a need for health professionals to develop nutrition education programs that inspire good self-care nutrition practices among adolescents and their caregivers, as well as instruments to measure the effectiveness of these programs. The purpose of this study was to develop and assess the validity and reliability of two self-care instruments to measure nutrition practices in English and Spanish-speaking adolescents and their parents. One instrument, the Adolescent Nutrition Self-Care Questionnaire (ANSCQ), was designed to measure adolescents’ nutrition self-care practices and the second, the Parent Nutrition Dependent-Care Questionnaire (PNDCQ), was created to measure parents’ nutrition dependent-care behavior for their children. The questionnaires were developed and tested first in English and then translated into Spanish, back-translated, and tested. Orem’s self-care deficit nursing theory was used as the theoretical framework for this study. Specifically, Orem’s (2001) estimative, transitional, and production self-care operations were used as the structure for instrument development. The researchers developed and tested the instruments using methodology suggested by Evers and by Nunnally and Bernstein. The researchers examined the psychometric properties of the instruments including content validity, item analysis, and reliability. In general, the experts agreed that the items were clear, represented the nutrition content, and were unbiased. The Adolescent Nutrition Self-Care Questionnaire (ANSCQ) and the Parent Nutrition Dependent-Care Questionnaire (PNDCQ) can be valuable instruments for various investigations, such as describing nutrition practices, comparing adolescents and parents’ behavior, comparing practices in English- and Spanish-speaking populations, examining adolescents’ and parents’ self-care operations, and determining the effectiveness of a nutrition intervention.

Key words: nutrition, measurement instruments, self-care, dependent-care, adolescents, Spanish, self-care operations

The development of healthy nutritional behaviors in childhood and adolescence contributes to lifelong health and well-being. Eating a healthy diet reduces the risk for cardiovascular disease, some cancers, diabetes, and other diseases (U.S. Department of Health and Human Services, 1998). Worldwide, many children and adolescents do not meet health guidelines for adequate nutrition. For example, research from Latin America has shown that while many countries within this region of the world are improving economically, a transition has occurred in which fewer children suffer from lack of food, but many are now at risk of overconsumption of high fat, high calorie, carbohydrate rich foods. Further, their consumption of nutrient dense fruits and vegetables has decreased (Pena and Bacallao, 2000). A survey of eating trends in the United States reported that fewer than 15% of families with children eat the recommended 5 or more servings of fruit and vegetables per day (Produce for Better Health Foundation, 2003). In the United States, the nutritional problems of adolescents and children are due mainly to poor food choices such that children are consuming high calorie and low nutrient dense foods. For many United States’ families convenience outranks price or nutrition in the importance of selecting food (Guthrie, Lin, & Frazao, 2002). In developing countries malnutrition among adolescents and children is a major public health problem and the World Health Organization has called for the development of nutrition programs to lower the incidence of malnutrition in these countries (de Onis, Frongillo, & Blossner, 2000).

Parents and guardians play a critical role in establishing healthy eating behaviors in their children. Parents and caregivers are traditionally the gatekeepers of a child’s food supply and serve as role models for food consumption. Positive parental modeling and involvement significantly influence healthy eating behaviors in children and adolescents (Norton, 2003).

There is a need for health professionals to
develop nutrition education programs that inspire good self-care nutrition practices among adolescents and their parents, as well as instruments to measure the effectiveness of these programs. The intent of this study was to develop and examine the psychometric properties of two self-care instruments to measure nutrition practices in English- and Spanish-speaking adolescents and their parents.

**Theoretical Framework**

Orem’s self-care deficit nursing theory (2001; Orem Study Group, 2004) was used as the theoretical framework for this study. Specifically, Orem’s (2001) estimative, transitional, and production self-care operations were used as the structure for instrument development. Dennis (1997) defines an operation as “an intellectual or psychomotor action directed toward a goal” (p.21). So operations are practices, activities, or behaviors enacted to perform self-care for oneself or dependent-care for one’s dependent. Estimative operations are defined as activities that involve gathering information, acquiring knowledge, and identifying alternatives (Orem, 2001; Dennis, 1997). Transitional operations are behaviors such as considering various options, making decisions, and planning what action needs to be taken (Orem, 2001; Dennis, 1997). Production operations involve taking action, identifying resources, and evaluating the results of the action to meet the need for self-care or dependent-care (Orem, 2001; Dennis, 1997). Dennis (1997) describes estimative and transitional operations as primarily cognitive activities and production as primarily psychomotor.

Orem’s discussion of operations is instructive when examining self-care practices. Self-care practices related to the universal self-care requisite “maintenance of a sufficient intake of food”, for example, involve more than just eating activities, according to Orem. Acquiring information about foods containing specific nutrients, identifying alternative healthier food, making food-buying decisions, and planning healthy meals can be among the important cognitive antecedent activities for meeting this requisite. Since the researchers’ goal in this study was to design instruments to measure both cognitive and psychomotor nutrition-related behaviors of adolescents and parents, they used Orem’s operations as a framework for writing items. Examples of items appear in Table 1. They reasoned that measurement of nutrition-related operations, both cognitive and psychosocial, is necessary to determine current behaviors, design effective education interventions, or measure outcomes.

**Literature Review**

Since formal publication of Orem’s Self-Care Deficit Nursing Theory in 1971, a number of instruments have been developed to measure the concepts and aspects of self-care (Dodd, 2004). Most of the self-care instruments that have been developed to date are for use in adults. Several self-care instruments have been developed for use with children, adolescents, and their dependent caregivers. The Denyes Self-Care Agency Instrument (1981) is a 35-item Likert scale instrument that measures the ability of adolescents to manage self-care. Deynes (1988) also developed a 17-item self-response instrument to measure general self-care actions in adolescents. The Dependent Care Agent Questionnaire (DCAQ) was developed to study mother’s performances of self-care activities for children (Moore & Gaffney, 1989). The Child and

<table>
<thead>
<tr>
<th>Table 1 Operations identified in Self-Care nutrition questionnaires</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Examples of Operation from Instrument Item</strong></td>
</tr>
<tr>
<td><strong>Adolescents</strong></td>
</tr>
<tr>
<td><strong>Parents</strong></td>
</tr>
<tr>
<td><strong>Estimative:</strong></td>
</tr>
<tr>
<td>- Identify Alternatives</td>
</tr>
<tr>
<td>I suggest healthy foods for my family to buy</td>
</tr>
<tr>
<td>suggest healthy foods for the family to buy</td>
</tr>
<tr>
<td><strong>Transitional:</strong></td>
</tr>
<tr>
<td>- Make Decisions</td>
</tr>
<tr>
<td>I eat a variety of food</td>
</tr>
<tr>
<td>eat a variety of food</td>
</tr>
<tr>
<td>- Choose Among Alternatives</td>
</tr>
<tr>
<td>I choose to drink soda instead of water</td>
</tr>
<tr>
<td>choose to drink soda instead of water</td>
</tr>
<tr>
<td>- Plan</td>
</tr>
<tr>
<td>I plan my meals so that they are healthy</td>
</tr>
<tr>
<td>plan her meals so that they are healthy</td>
</tr>
<tr>
<td><strong>Productive:</strong></td>
</tr>
<tr>
<td>- Take Action</td>
</tr>
<tr>
<td>I eat breakfast every day</td>
</tr>
<tr>
<td>eat breakfast every day</td>
</tr>
<tr>
<td>- Evaluate Action</td>
</tr>
<tr>
<td>I think about whether my diet has enough protein</td>
</tr>
<tr>
<td>think about whether her diet has enough protein</td>
</tr>
</tbody>
</table>
A search for nutrition self-care instruments based on Orem's theory in the CINAHL database identified only two studies that used nutrition self-care instruments. One study used an instrument to measure self-care/dependent care nutrition knowledge and practices of dependent older adults and their caregivers (Biggs & Freed, 2000). Another study used an instrument to measure nutrition self-care behavior of myocardial infarction patients (Aish & Isenberg, 1996). No studies were identified that used instruments based on Orem's Self-Care Theory to measure adolescent nutrition self-care behaviors or parents' nutrition dependent-care behavior for their children.

Regarding the performance of Orem's self-care operations, only one study has been reported. Moore and Beckwitt (in press) examined children's and parents' performance of operations in a qualitative study, finding that both children and parents reported performing operations in all three categories.

A variety of methods have been used to measure nutrition behavior in children and adolescents. In some studies, the measurement of nutrition behavior in adolescents has been incorporated into multidimensional instruments that measure many variables, such as health perceptions, safety, lifestyle practices, and dental health with only a few questions related to nutrition behavior (Graham & Uphold, 1992; McCaleb & Cull, 2004). The Youth Risk Behavior Survey is an example of a multidimensional instrument that includes a brief section on dietary behaviors (Centers for Disease Control, 2000). Neumark-Sztainer, Story, Hannan, & Croll (2002) noted that instruments used in large, comprehensive, population-based studies of adolescent health include very few questions assessing eating behaviors and these questions have been limited in scope and not adequately tested for reliability and validity. The majority of instruments used to measure child and adolescent nutrition behavior in studies published within the past ten years have examined food consumption only, such as food frequency questionnaires, 24-hour food recalls, or 3-day food diaries (Birnbaum, et al, 2002; Frenn, 2003; Hawks, Merrill, & Madanat, 2004; Lytle, Siefert, Greenstein, & McGovern, 2000; Middleman, Vasquez, & Durant, 1998; National Institutes of Health, 2002; Neumark, et al., 2004; Prochaska & Sallis, 2004; Rhiderknecht & Smith, 2004; Siega-Riz, Carson, & Popkin, 1998; Stanton, Fries, & Danish, 2003).

Contento, Randell, & Basch, (2002) reviewed instruments used in 265 nutrition education studies conducted between 1980 and 1999 in six population groups: preschool children, school aged children, adults, pregnant women, older adults, and professionals. This review noted that there were a wide variety of instruments and methods used to evaluate nutrition education effectiveness. Measures evaluating nutrition knowledge and skills were used to evaluate nutrition education effectiveness in 85% of the studies of school-aged children. Instruments measuring nutrition attitudes, diet self-efficacy, and intentions to change nutrition behavior were also used to evaluate nutrition education effectiveness in studies of school-aged children. With regard to measuring behavioral outcomes of nutrition education in school-aged children, Contento et al. (2002) reports that direct observation of actual consumption of school lunch and snacking practices has been used, as well as, 24 hour dietary recall, 3-day food records, and food selection inventories.

The outcome of choice in measuring the effectiveness of nutrition education programs is change in dietary behavior (Contento et al, 2002). There is no standard definition of nutrition behavior in dietary studies, however, and measurement of behaviors can range from actual intake of specific nutrients to actual food related behaviors. Contento et al. (2002) suggests that food related behaviors and eating patterns are more likely to be correlated with health, rather than specific nutrients or foods and thus, instruments that measure food-related behaviors and eating patterns are a more effective evaluation of nutrition education. Contento et al. (2002) identified 10 studies that used instruments to measure food-related behaviors and eating patterns in adults, but no studies were mentioned that used food-related behavior or eating pattern instruments in school-aged children.

In general, there is a scarcity of Spanish language instruments available for research with Hispanic populations (Carlson, 2000). A search of the Health and Psychosocial Instruments database from 1985 to 2005 revealed no Spanish instruments that measure nutrition self-care behaviors in adolescents and their parents and very few Spanish instruments that measure nutrition-related variables. Most nutrition-related Spanish instruments are designed for adults and...
include only a small number of nutrition questions embedded in large, multidimensional health questionnaires. For example, the Correlates of Compliance Measure (Frack, Candelaria, Woodruff, & Elder, 1997) is a Spanish instrument, developed for adults, that contains a nutrition-related psychological measure section that includes 3-items on nutritional beliefs, 3-items on intention to change nutritional habits, 5-items on nutrition self-efficacy, and a 12-item nutrition knowledge test. A few nutrition instruments have been designed for use with Spanish-speaking mothers of preschool children. The Nutrition Knowledge Questionnaire (Sherman & Alexander, 1991) is a multiple choice, true-false instrument designed to assess nutrition knowledge of Spanish-speaking mothers of preschool-age children with questions that focus on elements of a well-balanced diet, food sources for vitamins and nutrients, consequences of a poor diet, and the four food groups. Contenko et al. (1993) reported the Mother’s Food Choice Criteria and 24-Hour Dietary Recall Measure, which are Spanish instruments that measure mothers’ attitudes about food choices for preschool-age children that can be correlated with children’s food intake from the 24-hour food recall.

In conclusion, although many measurement instruments exist that determine either nutrition intake or knowledge, few exist that measure such practices for adolescents. None of these are designed to quantify change in behavior. There are no reported English/Spanish equivalent instruments for measuring and comparing nutrition self-care behavior in adolescents and their parents. Likewise, no instruments measure both intellectual and physical nutrition-related activities. Finally, no existing instruments base items on Orem’s (2001, pp. 273-277) estimative, transitional, and production self-care operations.

**Purpose**

The purpose of this study was to develop and assess the validity and reliability of two self-care instruments to measure nutrition practices in English- and Spanish-speaking adolescents and their parents. One instrument, the Adolescent Nutrition Self-Care Questionnaire (ANSCQ), was designed to measure adolescents’ nutrition self-care practices and the second, the Parent Nutrition Dependent-Care Questionnaire (PNDHQ), was created to measure parents’ nutrition dependent-care behavior for their children. The questionnaires were developed and tested first in English and then translated into Spanish, back-translated, and tested. These self-care measurement instruments can enable researchers to identify specific nutrition behavior, particularly intellectual, as well as describe dietary intake, determine dietary change, compare adolescents’ and parents’ behaviors, and evaluate nutrition intervention effectiveness.

**Method**

**Sample**

The instruments were tested with girls ages 10-18 years old and their mothers. The English versions of the instrument were tested on 32 girls and 29 mothers. The Spanish versions were tested first in the United States on a group of 7 girls and 18 mothers who were native Spanish-speakers with English as their second language. Then the Spanish versions of the questionnaires were given to 88 girls and 29 mothers in Nicaragua, to provide a more homogeneous group of Spanish-speakers. Girls and mothers were recruited from community groups, including churches, in the U.S. and from a nursing clinic in Nicaragua.

**Procedure**

This study was reviewed and approved by a university human subjects review committee in the United States and a school of nursing committee in Nicaragua. The girls and their mothers gave informed assent and consent respectively. The researchers developed and tested the instruments in this study using methodology suggested by Evers (2000) and Nunnally and Bernstein (1994) in the following stages. After each stage the researchers revised the instrument.

1. **Operationally defined variable to be measured.** The researchers defined nutrition practices as self-care operations related to diet.

2. **Generated nutrition-related items.** All researchers developed items based on (a) recommended nutrition content (U.S. Department of Agriculture, 2005) and (b) Orem’s (2001) operations.

3. **Developed the format for the questionnaire.** Items were written in a five-choice, Likert-type scale format to measure frequency of activities.

4. **Submitted the questionnaire to a group of experts to determine content validity.** Various content experts evaluated the instruments for nutrition content, clarity, format, lack of bias, and cultural sensitivity. Five researchers determined separately the operation that each item represented, and then compared findings until they reached consensus.

5. **Pilot tested the questionnaire on a small group of English-speaking girls and mothers.** The girls and their mothers
evaluated the instruments for directions, clarity, format, and time for administration.

6. **Translated the questionnaire into Spanish.** Guidelines for translation, as discussed by Carlson (2000), were followed. These include selection of an expert translator, back-translation, pretesting in a field test, and pilot testing.

7. **Pretested the questionnaire on a small group of Spanish-speaking girls and mothers.** Spanish-speaking girls and mothers in the U.S. suggested many revisions in the Spanish translation.

8. **Consulted a nursing faculty member in Nicaragua to translate the items into Nicaraguan Spanish.** The Nicaraguan researcher and another native Spanish-speaker suggested changes in the Spanish translation based on the language and culture of Nicaragua.

9. **Pilot tested the questionnaire with girls and their mothers in Nicaragua.** The Spanish versions of the questionnaires were used with girls and mothers in Nicaragua.

10. **Conducted item analysis on the questionnaire.** Item analyses were calculated on both English and Spanish versions for girls and mothers.

11. **Calculated reliability.** Reliabilities were calculated for both English and Spanish versions for girls and mothers.

12. **Performed an additional check for evidence of validity.** Participants were asked whether they could answer the before and after questions accurately.

**Instruments**

The Adolescent Nutrition Self-Care Questionnaire (ANSCQ), designed by the researchers, is a 37-item questionnaire to measure nutrition self-care practices based on Orem’s operations (2001). The questionnaire measures frequency of behavior in a 5-choice Likert-type scale format with choices of never, rarely, sometimes, most of the time, and always with higher scores indicating better nutrition practices. Eleven of the items are reversed.

The Parent Nutrition Dependent-Care Questionnaire (PNDCQ) was developed by the researchers to measure nutrition dependent-care operations that parents perform for their daughters. It is a 37-item instrument that measures frequency of behavior in a 5-choice Likert-type scale format with the same choices ranging from never to always. All items are prefaced with the statement, “I encourage my daughter to...” Its items correspond with the same topics in the same order as the girl’s questionnaire. For example, item #6 on the girl’s questionnaire is, “I suggest healthy foods for my family to buy.” Item #6 on the parents’ questionnaire is, with the preface, “Suggest healthy foods for the family to buy.” The same 11 items are reversed. See Table 1 for additional examples of items.

The questionnaires are designed to measure before and after behaviors on the same form at the same time. For other research they could be divided into tools that measure behaviors at one time only.

**Content validity**

Content validity is defined in the Standards for Education and Psychological Testing (American Educational Research Association, 1999) as a logical analysis of the adequacy with which the test content represents the content domain. The researchers developed the items based on the U.S. Department of Agriculture guidelines (2005) and Orem’s (2001) operations. To provide further content validity evidence, the questionnaires were reviewed by a panel of 11 experts including a pediatric nurse researcher, a nutritional anthropologist, a psychometrician, a nurse anthropologist, a nutritionist, two native Spanish speakers, and four nursing doctoral students. Of these experts, four had been conducting a nutrition intervention study in Nicaragua for four years, one was a native of Nicaragua and a faculty member at a school of nursing in Nicaragua, two had been involved in various nursing projects in Nicaragua, and one was conducting dissertation research on pediatric nutrition.

The experts made several suggestions for changes in substance, wording, and format for the questionnaires that were implemented. One expert questioned whether participants could remember previous dietary behavior and the researchers investigated that issue during the pilot study. As a check for memory of before and after behavior, the researchers asked both English and Spanish-speaking groups if they could accurately answer the questions. Participants reported that they could do so successfully. In general, the experts agreed that the items were clear, represented the nutrition content, and were unbiased. When the researchers assigned each item to an operational category, they reached consensus that items represented the three operational categories as shown in Table 1.

**Findings**

The researchers examined the psychometric properties of the instruments including content validity, item analysis, and reliability. The content validity was established using Orem’s (2001) operations, U.S. Department of Agriculture
guidelines (2005), and content expert evaluation. The results indicated that there was a correspondence between the questionnaire items and the intended content domain.

Researchers conducted item analysis on the items, examined the item-total correlations, found them to be acceptable, and estimated the internal consistency reliability of the instruments. The internal consistency method of estimating reliability focuses on the shared content of the items or whether the items are homogeneous. In this study, estimates of internal consistency were determined using coefficient alpha. Methods for estimating reliability differ with respect to the sources of error being addressed. The present study used coefficient alpha because it addresses errors due to sampling of content or domain, that is the degree to which the items are representative of the content being measured (Pedhazur & Schmelkin, 1991). The coefficients alpha were estimated and reported for the English and Spanish versions of the before and after data for both instruments. Although the minimum recommended standard for coefficient alpha varies among psychometricians, Nunnally and Bernstein (1994) recommend a threshold of .70. The reliability coefficients for the instruments in this study are shown in Table 2. The coefficients alpha are above the threshold for all versions, except for the English version of the parents' posttest at .67. If one specific item in that version were dropped, the coefficient alpha would be .72.

Table 2 Reliability Coefficients for the Nutrition Behavior Questionnaires

<table>
<thead>
<tr>
<th>Girls: Nutrition Self-Care Behavior Questionnaire</th>
<th>Coefficient Alpha</th>
<th>Coefficient Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before</td>
<td>English Version</td>
<td>.8258</td>
</tr>
<tr>
<td>After</td>
<td>Spanish Version</td>
<td>.9096</td>
</tr>
<tr>
<td>Before</td>
<td>English Version</td>
<td>.8132</td>
</tr>
<tr>
<td>After</td>
<td>Spanish Version</td>
<td>.9053</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mothers: Nutrition Dependent-Care Behavior Questionnaire</th>
<th>Coefficient Alpha</th>
<th>Coefficient Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before</td>
<td>English Version</td>
<td>.7500</td>
</tr>
<tr>
<td>After</td>
<td>Spanish Version</td>
<td>.8156</td>
</tr>
<tr>
<td>Before</td>
<td>English Version</td>
<td>.6694</td>
</tr>
<tr>
<td>After</td>
<td>Spanish Version</td>
<td>.9419</td>
</tr>
</tbody>
</table>

Discussion

Both the Adolescent Nutrition Self-Care Questionnaire and the Parent Nutrition Dependent-Care Questionnaire are instruments that were created to measure nutrition behaviors in English- or Spanish-speaking populations. Validity and reliability have been examined and established for these instruments. For construct validity, factor analysis will be conducted in the future on the instruments when sample sizes in each group are sufficient.

Orem’s (2001) theory was useful in developing items to measure both cognitive and psychomotor activities. At present the majority of items measure operations in the “take action” category, rather than being evenly distributed among various operations. More items should be added to the instruments reflecting the operations “acquiring knowledge”, “making decisions”, and “planning actions.” When compared to other nutrition measurement instruments in the literature, these instruments target areas previously unaddressed: matching adolescents and their parents, English/Spanish equivalent forms, comparison of before and after behaviors, and inclusion of both cognitive and psychomotor behaviors. So far these instruments have been tested only on girls and mothers and only in the United States and Nicaragua. Nicaraguan Spanish may be somewhat different than Spanish spoken in other countries.

The Adolescent Nutrition Self-Care Questionnaire (ANSCQ) and the Parent Nutrition Dependent-Care Questionnaire (PNDCQ) can be valuable instruments for various future research investigations, such as describing nutrition practices, comparing adolescents and parents’ behavior, comparing practices in English- and Spanish-speaking populations, examining adolescents and parents’ self-care operations, and determining the effectiveness of a nutrition intervention.

We will be pleased to share the questionnaires with other researchers. We would appreciate those researchers sharing their results with us so that we can perform further analysis on the questionnaires in the future.

Jean Burley Moore, RN, PhD, is Associate Professor, College of Nursing, Lisa Pawloski, PhD, Heibatollah Baghi, PhD, Karen Whitt, MSN, Doctoral Candidate, Claudia Rodriguez, BS and Adel Bashatah, MS, Doctoral candidate, all with George Mason University, Fairfax, Virginia. Laura Lumbi, MSN, is with Universidad Politecnica de Nicaragua, Managua, Nicaragua. Contact Dr. Moore: Email: jmoore@gmu.edu.

References


Frenn, M. (2003). Peer leaders and adolescents participating in a multicomponent school-based nutrition intervention had dietary improvements. Evidence-Based Nursing, 6(2), 44.


Teaching Practically Practical Nursing Science, Part I

Anna J. Biggs

We are fortunate to have one of our experienced educators relate to us her Self-Care Deficit Nursing Theory (SCDNT)-based curriculum experiences. Part I features the initial hermeneutic journey and teaching nursing using Orem’s SCDNT in a baccalaureate degree completion program. Part II will follow in our next issue on Education. The focus of Part II will be on teaching nursing assessment and fundamental skills and clinical courses for traditional baccalaureate nursing students, including application of SCDNT in a theoretical nursing assessment and nursing care plan forms used by the program and graduate nursing theory, again emphasizing application and use of Orem’s SCDNT.

V. Berbiglia, Guest Editor

Background

Having taught nursing in two associate degree programs in Southwestern and Western United States, I began preparations for entering a doctor of philosophy (PhD) in a nursing program. I believed I needed further education as the program where I was teaching developed a two-plus-two baccalaureate nursing program. This was at a time when physical assessment was becoming a nursing buzzword; and I wanted to understand better what a nursing assessment was.

Doctoral Studies

Early in my doctoral studies, the director of the doctoral program invited newly admitted students to her home to meet a visiting nurse philosopher and theorist, Martha Rogers. I, admittedly, did not know much about any nursing theory or nursing theorist, so decided I had better read a book that had come to my office as a desk copy for review and possible course adoption. The book (Nursing Theories Conference Group, 1980) was a synopsis of several nursing theories, including Martha Rogers’ Science of Unitary Man (before the change to Human Being) and Dorothea Orem’s Self-Care Deficit Nursing Theory, among others. While this first encounter with Orem’s theory was in a secondary source, it was the beginning of my hermeneutic journey.

I am a scribbler in books, making marginal notes and underlining or highlighting passages of the text that stand out to me. A few years later, when I was working on my dissertation on metaphors of nursing in Orem’s work, I needed to go back to this first source on Orem, and, to my surprise, found many marginal notes and underlining and a picture of my infant daughter as a bookmark in the chapter on Orem’s theory. There were fewer marks in the chapter on Rogers’ theory, which I had thought I should read before meeting Martha Rogers! I was surprised because I had no real recollection of having read and marked up the chapter on Orem’s theory! In hermeneutics, this is spoken of as being grasped by the theory rather than grasping it (Bleicher, 1980; Ricoeur 1975, 1976, and 1981).

During the PhD Program there was, of course, the required course on theory construction, development, analysis and evaluation. I read, studied and used a variety of articles and books on analyzing and evaluating theory (Ellis, 1968; Duffey & Mulhenkamp, 1974; Stevens, 1979; Fawcett, 1978; Fawcett, 1980; Meleis, 1985; Chinn & Jacobs, 1983). Finally, I focused my attention on Orem’s SCDNT, feeling drawn to the philosophy and theory. Still there was dissatisfaction with knowing what the Self-Care Deficit Nursing Theory says using the aforementioned traditional methods of theory analysis and evaluation which put questions (sometimes more than 60 questions!) to the theory, looking for the hidden meaning of the theory. I began searching for understanding the meaning of the theory using hermeneutic interpretation method (Ricoeur, 1975). This led to identifying the metaphors of nursing in Orem’s work: Nursing as a Practice Discipline; Nursing as Deliberate Action; Nursing as a Helping, Human Health Service and Science; and Nursing as Care—Self-Care of Another Self (Biggs, 1999). Metaphors carry the meaning of a text or theory and are projected upfront and not hidden in the text or the mind of the author. The identification of these metaphors of nursing and the nexus of metaphors connected with them and with the concepts of the General Theory of Nursing
Teaching in a SCDNT-Based Curriculum

After completing my doctorate, I began teaching in a baccalaureate completion program (RN to BSN) in a mid-western United States public university in a major metropolitan area, where Orem’s theory was the conceptual framework for the curriculum. I was delighted to be assigned to teach an introductory course on the dimensions of professional nursing where I would be introducing undergraduate nursing students (formerly diploma and associate degree registered nurses) to Dorothea Orem’s theory. I recall one semester where, as usual, I had asked students why they became a nurse and jotted their responses of wanting to help people on the blackboard. I then used that notion of helping people to begin talking about Dorothea Orem’s theory and the metaphors of nursing that had helped me better understand nursing. One student had her arms crossed and took no notes during the entire introduction to the course, assignments, and requirements. When I moved on into talking about helping as one of the metaphors of nursing in SCDNT and how we would use a practice model (see Figure 1) to examine the dimensions of professional nursing, I noticed this student writing notes as rapidly as possible. She came up during a break and asked for some additional references and I thought, “you’ve been caught as I was!” In fact, she later served as a research assistant on some of my research to test the Biggs’ Elderly Self-Care Assessment Tool (BESCAT) (Biggs, 1990).

One of the activities in this course was to critically analyze the kardexes and nursing care plans in use in students’ current employment situations. Students were challenged to see if there could be connections made to Orem’s SCDNT. I was impressed with their efforts. Some examples of their applications of SCDNT included:

- Connecting orders for pulse oximetry readings and oxygen administration to “maintaining an adequate intake of air”
- Changing the wording regarding parenteral (IV) fluid administration to “maintaining an adequate intake of water”
- Altering standardized nursing care plans for fall prevention to address “prevention of hazards”

Students were able to reconceptualize kardexes and nursing care plans in terms of universal self-care requisites. This new found ability may not seem tremendous or impressive to those who have been using Orem’s theory, but, for nurses prepared at a technical level, returning for their baccalaureate degree, this is an eye opening or gestalt experience. Most were delighted to have a better appreciation for all the things they did to care for patients. They felt that the nursing care they gave, using Orem’s theory, was actually moving them from a technical level of nursing to a more professional level.

Students working in pediatrics and obstetrics also used maturational and situational developmental self-care requisites, respectively, in developing appropriate nursing care plans, along with universal self-care requisites. There was a diabetes nurse educator in one of the classes who exclaimed, regarding the health deviation self-care requisites, “Now, I have a more comprehensive way of looking at and teaching diabetes self-care management. With Orem’s theory to help my patients understand their pathological condition, be aware of and attend to the effects of their diabetes and carry out the prescribed therapy and regulate their functioning, modify their self-concept by accepting themselves as having a pathologic condition and needing specific forms of health care, all the while learning to live with their condition in a life-style that promotes their continued personal development! This is just what I have needed for a long time!”

Dorothea Orem (1985) noted that nurses often start at the level of universal and developmental self-care requisites and basic conditioning factors. However, she concluded that there is a need for closer examination of the health deviation self-care requisites and a thorough description and discussion of “nursing cases” concerning the health deviation self-care requisites and the power components of self-care agency. For these beginning professional nurses, I believed their strides toward a more comprehensive nursing approach to be note-worthy.

When we examined currently used nursing history forms, students were distressed to see how much of the nursing history was really a repetition of the medical history and physical examination. That led to discussions of the proper object of nursing and the domain of nursing (Orem, 1980, 1985, 1995, 2001) as well as how the initial nursing history forms could be more relevant to nursing care. As we moved into examining the basic conditioning factors (BCF’s) (see Figure 1) to individualize the universal, developmental and health deviation self-care requisites, most of these registered nurses began seeing the need for
Figure 1. Practice Model of Orem’s Self-Care Deficit Nursing Theory

The Universal, Developmental, and Health-Deviation Self-Care Requisites (SCR's) are individualized by the Basic Conditioning Factors (BCF's) to determine the person's (patient's) Therapeutic Self-Care Demand (TSCD), the total care needed at this point in time. When we compare the Self-Care Agency (SCA, ability to care for self) or the Dependent-Care Agency (DCA, one's ability to care for one's dependents) with the TSCD, we find whether or not the person has a Self-Care Deficit (SCD, inability to care for one's self) or a Dependent-Care Deficit (DCD, inability to care for one's dependents) because of the situation of personal health. A Self-Care Deficit (or Dependent-Care Deficit) is what legitimizes the need for nursing. If there is an SCD or DCD due to the person's or dependent's health state, then a Nursing System is needed and designed. The Nursing System is prescribed as Wholly Compensatory, Partly Compensatory, or Supportive-Educative. The designed Nursing System is implemented by means of the five Methods of Assisting, and is further specified by the nursing actions to be taken within the general method of assisting. The designed Nursing System is evaluated in terms of the development of regained ability to exercise and regulate Self-Care Agency (or Dependent-Care Agency). Reassessment, replanning or redesigning results from this evaluation in the management of nursing care.
altering their employer’s nursing history forms to address more of the items in the BCF’s because that was truly the information nurses needed to provide nursing care.

Discussions of which nursing system was applicable in certain nursing situations were likewise very stimulating. Students posed questions such as:

- When is a patient in need of a wholly compensatory nursing system?
- What if there were family members who could make decisions for needed care and participate in care?
- If patients could do nothing for themselves, such as in an intensive care unit of sedated-ventilated patients, were the patients in a wholly compensatory nursing system?
- How did family involvement in decision-making and care fit with definitions of dependent care agency?
- How did nursing agency link with self-care agency and/or dependent-care agency?

Students who were in home health care agencies or who were patient educators in hospital settings were very interested in the concepts of “multi-person units” of families and populations of patients. They recognized that the ultimate basic unit of care was the individual, the “Another Self” (Orem, 1980, 1985, 1995, 2001), who needed self-care; but, because of the situation of personal health, was unable to provide care for self.

Students were also able to classify nursing interventions from the standardized care plans used in their employment situations with the categories of the methods of assisting. They found that much of the focus at that time was on teaching patients, with much less attention to acting for/doing for another, guiding another, supporting another, and providing an environment in which patients could develop their self-care agency. Seeing that nursing was so much more than only teaching helped many of them to work on expanding the care plans that were in use and to join practice committees at their employing institutions to try to make some of these changes. I believe this change in attitude of technical nurses in a baccalaureate completion program, as they examined the focus, nature and structure of nursing in preparation for becoming professional nurses, is an example of what Orem discussed in a recent article on Nursing Practice Science:

Nurses who have or are achieving professional status have responsibility for the development of nursing science. Becoming and being professional requires understanding of the focus, the nature, the structure, the content, and the domain of nursing science in relationship to the focus of and the realities that define the domain of nursing practice (Orem, 2004, p. 4).

These positive reflections should not be construed to mean that there were never groans or murmuring and complaining about “having to study Orem.” There was plenty of that, too. Students who did not want to have to read, study and think/reflect about their nursing practice were vocal in their preference for continuing their atheoretical nursing practice. They preferred their reflexive knee-jerk responses to situations like an empty IV or a patient’s request for pain medication, or a critical situation such as internal bleeding or wound dehiscence and evisceration. My intent was to foster a reflective (deliberate) nursing practice where:

- The IV might have been ready before the current bag was empty (to maintain an adequate intake of water).
- The patient’s pain might be anticipated and medications offered to manage pain before it became severe (promoting normalcy).
- Internal bleeding might have been thought of as a possibility and assessments made before it became a critical situation (maintaining an adequate intake of air as oxygen at the cellular level and the impact of bleeding and shock on air and oxygenation).
- A fragile wound might be managed by nursing care to prevent or at least find the earliest signs before there was evisceration (prevention of hazards).

Students who did not want to have to challenge their supervisors and colleagues to a higher level of practice were also among those who didn’t want to use a theory that might cause them to have to rock the boat. It is probably apparent which group of nurses would be preferred for caring for family members of those ascribing to the use of Orem’s Self-Care Deficit Nursing Theory! The challenge to faculty was to try to find the message that would hook the more resistant students or to acknowledge that not every student would be able to move into that level of professional thinking and practice.

Change from Teaching in a SCDNT-Based Curriculum to a Self-Care Systems Model-Based Curriculum

Sadly, at a curriculum workday in this college, a part-time clinical instructor, who rarely attended faculty committees or workdays, asked why we had to keep using Orem’s theory because she
had not read it and did not plan to and thought we ought to just drop it. I was nearly speechless and spent the lunch time writing about what using Orem’s theory did in terms of helping to structure and organize the curriculum and nursing practice, using an analogy of lemonade made from powder, or frozen concentrate with lemonade made from fresh lemons. However, I was one lone voice; and the vote was to change to an undefined (and undefinable without using Orem’s SCDNT!) “self-care systems model”. The courses were subsequently changed and re-titled, so there was no longer a course entitled “Designing Nursing Systems for Families and Groups”, nor a course on “Teaching and Supporting Individuals and Groups” and so forth. The entire curriculum lost its structure, cohesiveness and organization and became a listing of required courses for obtaining a bachelor’s degree in nursing.

Because Orem’s SCDNT pervaded my nursing practice or my own structure and organization as an educator, I was able to continue teaching in this program. My teaching assignment was changed to teaching a course on computers in nursing, where students used word processing to write essays about “self-care nursing systems” after reading a description of wholly compensatory, partly compensatory and supportive-educative nursing systems. Students devised databases to collect information on basic conditioning factors. They created spreadsheets with narrative and numerical data on maintaining an adequate intake of oxygen and hemodynamic monitoring data; or maintaining an adequate intake of water and food with IV fluid and total parenteral nutrition (TPN) ingredients or oral food intake. When students would ask where I got the ideas for their assignments, I would smile and then give them the reference to the current edition of Orem’s work. Some would respond with “Wow, that is really interesting that all this could come from a nursing theory!” So, even a computer course could be used to fulfill my need to continue to use Orem’s theory in teaching and practice.

When a nursing educator is committed to a theory-based nursing practice using SCDNT, teaching nursing students to know and perhaps even understand and appreciate Orem’s SCDNT, will be natural, even in the face of curricular and teaching assignment changes. The second article (Part II) will continue the discussion of using Orem’s SCDNT in a traditional baccalaureate program in a variety of courses: nursing assessment, fundamental skills, clinical practice, and graduate nursing.

Anna J. Biggs, RN, PhD, is Assistant Professor at St. Louis University, St. Louis, MO. Contact Dr. Biggs at: biggsaj@slu.edu

References


Abstract
The purposes of this paper are to describe the Community Care Deficit Nursing Model (CCDNM) and two case applications using the CCDNM in the education of graduate students. The students were able to apply the model to benefit the communities studied. Students derived a holistic understanding of the communities and the actual Community Deficits from the perspective of the community members.

Key terms: Theory, CCDNM, Orem, Community, Public Health, Teaching, Graduate Education

Orem’s Self-Care Deficit Nursing Theory (S-CDNT) has been applied extensively to individuals. Fewer applications have been accomplished in community care when a population is the multiperson unit of care. The Community Care Deficit Model (CCDM) and Diagnosis of Community Care Deficit Instrument (DCCDI) were developed by faculty and graduate students at West Texas A&M University (WTAMU). Orem’s (2001) Self-Care Deficit Nursing Theory (S-CDNT) is the foundation for all graduate nursing courses, as well as the practice theory for faculty and students at WTAMU. The development of this framework and its utilization were integral parts of the teaching methodology used in a master’s level community health nursing course.

Process
Students began the community health course with a review of the community health nursing literature. Notably lacking was a full extension of S-CDNT to the population as the multiperson unit of care. The Community Care Deficit Model (CCDM) and Diagnosis of Community Care Deficit Instrument (DCCDI) were developed by faculty and graduate students at West Texas A&M University (WTAMU). Orem’s (2001) Self-Care Deficit Nursing Theory (S-CDNT) is the foundation for all graduate nursing courses, as well as the practice theory for faculty and students at WTAMU. The development of this framework and its utilization were integral parts of the teaching methodology used in a master’s level community health nursing course.

A Community Care Deficit Instrument was developed based on the Community Care Deficit Model. Both the model and the instrument were compared to community health nursing theories and community assessment models in terms of philosophical underpinnings, assumptions, concepts and propositions. Specifically, Helvie’s Energy Theory of Communities (1991) and Anderson and McFarlane’s Community as Partner (2004) were chosen to confirm the accuracy and comprehensiveness of the new model and instrument in relation to current community diagnosis, population health management and community health nursing practice.

The term community is used to indicate the multiperson unit of service. In this model community, as the unit of service, is different from community as a setting for providing care to an individual, exemplified by a community primary care clinic, or a community based home health agency. It is also different from community as a conditioning factor for the individual. As the unit of service, the community is the care agent and has conditioning factors that are unique and affect the unit’s agency and demands.

Community is the type of multiperson unit described by Taylor and Renpenning (cited in Orem 2001) as a group of persons impersonally related who come together for shared purposes, and shared problem resolution. It fits the category of a type 2 multiperson care system in that members are of a “structured, enduring social
group" who have common requisites and work together to meet these requisites. As a type two care system, a community is a formally organized system and may be a part of a suprasystem. While there may exist subsystems within the community devoted to the care of individuals, there must exist subsystems designed to address common requisites that contribute to the maintenance of the health, integrity and future of the whole, and the diagnosis and solution of common problems. The public health department, sanitation departments and police department are examples of community care subsystems. Problems, which affect individuals, are addressed by community care systems only if their magnitude threatens the existence, health, safety and/or productivity of the community as a unit. Communities, as conceptualized by this model, are defined by geographic boundaries and the majority of relationships are impersonal. The structure is formal, with formal governance.

Figure 1 represents the conceptual model of Community Care Deficit Nursing.

Community conditioning factors are an extension of individual conditioning factors. Examples of these comparisons are listed in Table 1. These factors condition the agency, demands and deficits of the community.

Community care agency is viewed as the

<table>
<thead>
<tr>
<th>Individual Conditioning Factors</th>
<th>Community Conditioning Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age and gender</td>
<td>Age and gender distribution</td>
</tr>
<tr>
<td>Residence and its environment</td>
<td>Distribution of types and condition of residences. Location of environmental risks and hazards.</td>
</tr>
<tr>
<td>Family system factors</td>
<td>Distribution of family types. Marriage rates, divorce rates, fertility rates.</td>
</tr>
<tr>
<td>Health State</td>
<td>Morbidity and mortality rates</td>
</tr>
<tr>
<td>Developmental state</td>
<td>Community history &amp; current status as a unit</td>
</tr>
<tr>
<td>Pattern of living</td>
<td>General living patterns of unit and subunits</td>
</tr>
<tr>
<td>Health care system factors</td>
<td>Suprasystem factors, economic, political, health</td>
</tr>
<tr>
<td>Socioculture factors</td>
<td>Distribution of socioeconomic groups, cultural and ethnic groups</td>
</tr>
<tr>
<td>External environmental factors</td>
<td>Suprasystem environmental factors</td>
</tr>
</tbody>
</table>
ability of the community system and subsystems to evaluate and perform the functions needed to maintain the health, integrity and growth of the community. The power for community care lies within its governmental subsystems such as departments of health, sanitation, recreation, and public safety. Such power can also be exercised by less formal subsystems such as volunteer groups, non-profit agencies, religious groups, political groups and influential citizens and citizen groups.

The individual has self-care requisites. An extension of this construct is to think of the community as a multiperson unit which has unit care requisites. For example, individual universal self-care requisites include air, water and food. A community requires a safe water source, pollution free air and adequate corporate food supplies. Other examples of community requisites are control and regulation of communicable disease, control of safety hazards, reduction of preventable morbidity and premature death. These requisites place demands on the community and its subsystems; demands, which must be met to maintain a functional, integrated unit. The methods and strategies to meet community care requisites are population based with restoration of population health as the goal rather than individual care based with recovery of the individual as the goal.

When community care demands exceed community care agency, a deficit occurs. This deficit may be diagnosed through the routine monitoring of requisites and demands by community care subsystems or by a formal process of community assessment and diagnosis or a combination of the two methods. The diagnosis of a deficit concurrently diagnoses a deficit in community care agency. For example, an increase in sexually transmitted disease rates among adolescents is a community care deficit indicating also an agency deficit for those subsystems charged with the management and control of sexually transmitted diseases. When such a deficit exists there is a need for intervention.

Population based community care is of such a complex nature that nursing care agency may require partners, e.g., other disciplines both within and outside the community as well as individual members of the community, to address the deficit. The outcome of such intervention may result in adjustments or augmentation of existing community care subsystems or the planning and implementation of new population-based community care interventions. These interventions are population-based programs with the goal of restoring community care.

Nursing agency may be required in the diagnosis of community deficits as well as the planning, implementation and evaluation of community care interventions. To the extent that the community care deficit falls within the scope of nursing practice, nursing agency may be all that is required to address the community care deficit. More commonly nursing partners with care agents to address the community deficits.

The Diagnosis of Community Care Deficit
Instrument based on this model was developed to guide the student in defining the community according to geographic and system boundaries. The suprasystem(s) are identified, as well as the formal subsystems, which exist to maintain the health, functioning and integrity of the community.

Community conditioning factors are described as well as community requisites and demands. From these data, an analysis is made as to whether or not requisites and demands are met or not met. From those that are not met, a formal diagnosis is derived. Following this, students can use the program planning process to define agency requirements for addressing the community care deficit. Nursing agency requirements are specified as well as the agency requirements of partners of nursing from other disciplines and care systems.

**Community Care Deficit Nursing Model (CCDNM) Application**

To describe the teaching of the CCDNM in a master’s program, we will first describe the course, then course procedures and experiences using the model in two clinical settings. The course is a required core course in the master’s program and is designed to teach public health material according to various accreditation criteria. It is a didactic/clinical course that builds on undergraduate community health concepts.

Course Requirements include texts and public health resources, two papers, participation in classroom discourse, community assessment done in small clinical groups, and a formal presentation to their respective communities. Required materials have included Orem, epidemiology reference, public health resources, and Healthy People 2010. The first or second week of the semester students divide themselves into small groups for the clinical components. The small group determines the general population they want to work with.

The focus of the first of the two papers is global analysis of a population using the CCDNM. The second paper focuses on refinement of the Community Care Deficit. Resources for the first paper are more generic public health than the second in which students refer to information...
about the specific community deficit. Required classroom participation continues throughout the semester. Discourse focus moves from general public health information to a later specific clinical application focus. During the semester students will have reviewed S-CDNT in general, the CCDNM, public health concepts and epidemiology. Once students have begun to work with and study their selected populations they bring these data for class discussion.

These classroom discussions become the heart of learning public health concepts within the model. Each student brings information about a particular Community Care Requisite thinking her/his studied requisite is of major importance. Then, through faculty-student debate students come to recognize that all requisites are important to a community, but that Community Agency is the determining factor in identifying the Community Deficit. Because this is an academic experience, student must also consider what is doable within a semester’s time and within the realm of public health nursing. These discussions focus on a dialectic that involves concepts such as population, setting, multiperson units, and communities. Taylor and Renpenning’s work provides the basis for these discussions (cited in Orem, 2001).

For example, students recently studied two southwest communities: one an air force base and another, a low-income community served by a nurse practitioner clinic. With discussion of community care requisites, the community care demands and community agencies, students discovered that the Community Care Deficit was different than their initial impressions.

Discussions related to the air force base began with students’ thinking that the closing of the base hospital forcing patients to use community resources could be the problem. Students also reviewed one year’ retrospective record of emergency room use and interviewed with base parents. These data demonstrated a lack of primary care resources for pediatric patients. Using the model and focusing their literature review based on the refinement of data, students then looked at available resources for parenting, anticipatory guidance and emergency care for pediatric families, thus addressing this specific Community Care Deficit.

In the case of the low-income clinic population, students began with a concern for the ageing population. What the model led them to was that their specific population’s deficit related to grandparents raising grandchildren. This analysis led them to seeking specific resources for aging grandparents with low incomes raising their grandchildren.

Up to this point the clinical component has included: 1) data gathering from public documents; 2) survey of the selected communities with analysis and discussion at each point using the CCDNM; and 3) interviewing the multi-person units within their selected communities. The final clinical experience is the student feedback presentations to the selected communities. This is the high point of the semester. Students use radio spots and flyers to invite the community to the forums. They invite community members they have just surveyed and interviewed as well as the community stakeholders, and any professionals they can prevail upon to share their expertise to help with problem solving. In some cases students had family members that are CPA and attorneys who participated in the forum. Also invited are members of the class, faculty and other students.

Each small group selects a time of the day most appropriate to its population and prepares presentation media for the event. Information is shared and discussion follows. The dialogues have resulted in eye opening experiences for the clients, the stakeholders and professionals. There were often resources available that were not being accessed because of lack of information. Some stakeholders expressed an interest in continuing the dialogue. Both graduate students and community members learned that nursing agency has an important role in the health of a community. Teaching public health concepts within the CCDNM enables graduate students to see that nursing can make a positive difference to the health of a community.

Serey Shum PhD, RN, CNS is with West Texas A&M University, Division of Nursing, Canyon, TX. Rebecca McGonigal PhD RN, is with Brenau University Dept. of Nursing, Gainesville, GA; and : Barbara Biehler, EdD RN PNP lives in Amarillo, TX. Contact Dr. Shum at sshum@mail.wtamu.edu

References


Teaching Strategy Column

SCDNT – Tell Me About It

Game Design: Violeta A. Berbiglia

The Game

Purpose: To accomplish formative and summative evaluation on concept attainment of the SCDNT concepts.

Game Content: The questions come directly from classroom content (lecture, discussion, handouts, etc.). Only content that students have been exposed to in class is used for questions. Categories of questions are: history, concepts, rationales, trivia, and student-generated questions. The teacher develops all of the questions (except the student-generated questions) prior to class time.

Rules of the Game

1. Create 2 or more groups (not over 4 to 6 per group).
2. Each group selects a leader.
3. Only the group leader can answer questions.
4. Groups sit together at a distance from other groups. All course materials must be put away.
5. Select 1 individual to assist the teacher in recognizing group leaders when they stand.
6. Explain the rules and scoring to the groups.
7. Request each group to develop and answer 2 to 3 questions, write them on separate sheets of paper, and give them to the teacher.

Rules for Play

1. The teacher chooses the 1st category for a question.
2. The teacher announces the category.
3. The teacher asks a question from that category.
4. Groups confer within the group and agree on an answer.
5. The group leader stands, is recognized and provides the answer.
6. If several leaders stand, they are recognized in the order of standing. If the 1st standing answers incorrectly, the next standing is recognized, etc.

7. The group answering the question correctly selects the next category and another question is asked by the teacher.

Scoring

1. The scoreboard is posted on a blackboard, poster, flip chart, etc. Also, the categories are posted separate from the scoreboard. When correct answers are given, groups receive a letter (letters are given sequentially under the SCDNT Dorothea E. Orem.) If the answer is incomplete, the group will be given a part of a letter. The following scoreboard shows that all 3 groups have answered questions. If groups are tied at the end of the game, ask a complex question to break the tie. Upon completion of the game, the group with the most correct answers receives a prize.

   S C D N T D o r o t h e a E. O r e m

   Group 1     S N
   Group 2     C D
   Group 3     T D

Suggestions for a Fun Game Process:

1. Just after explaining the rules, ask the groups if they have any “handicaps” (for example: no males in group, no females in the group, 1 less group member than in other groups, too many younger (or older members), etc. If a group determines they have a handicap, award the group a letter on the scoreboard.
2. Request the groups to use their own words to paraphrase content – not memorized words. This gives them increased ownership of the theory.
3. Include humor.
4. Refrain from criticizing individuals/groups.
5. Don’t play the game too long. The interest will lag and fun decreases.

Violeta A. Berbiglia, RN, EdD lives in Helotes, TX. Contact Dr. Berbiglia:
violetaberbiglia@hotmail.com
From the president

Dear Members of IOS,

What a year it has been. The devastation and suffering resulting from so many natural disasters have been overwhelming. Yet, in all the tragedy and sadness, there is evidence of the tremendous capability of human beings to persevere and to strive to do good.

The IOS web site has been moved. The new address is www.scndt.com. There is still more work to be done on the web site. If you have any expertise with web site development, please consider volunteering to help with this ongoing work. If interested, send me an e-mail. A big Thank You to Gerd Bekel for his work on getting the new web site going.

At the end of this year, Michael Morgan will be stepping down as Editor of the journal. During his time as editor, Dr. Morgan has contributed a great deal, including moving the format of the journal from print to electronic format. Thank You Dr. Morgan for all the work you have done.

Karen Cox has been appointed by the Board of Directors of IOS to serve as Editor for the remainder of the term, ending Dec. 2006. Please see Dr. Cox’s announcement in this journal regarding the submission deadlines for next year.

The term for office for the Board of Directors was changed from 4 years to 2 years in the revised bylaws. Beginning in 2006, elections will be held yearly. The positions to be filled will alternate from year to year so that there is some continuity on the board. Think about running for an office or for chairperson of one of the committees (see below).

The 9th World Congress of SCDNT is scheduled for July 20-22 in Johannesburg, South Africa. I encourage you all to attend. Check out the web site at www.worldcongress-scdnt.com for specific details regarding the conference. Also, think about submitting an abstract for the conference. Information regarding the call for abstracts can be found on the web site.

I am asking each member to take a few minutes to look at the mission statement of the IOS as well as the mission statement of the journal. The accomplishment of the IOS mission is dependent on the contributions of individual members. As you think about your New Year’s resolutions, please make a commitment to do something that helps the IOS move toward accomplishment of its mission. There are a number of ways you can contribute; submit an article for publication in the journal, submit an abstract for the 9th World Congress, volunteer to serve on a committee, volunteer to help with further development of the web site, and/or consider running for an office or for chairperson of a committee.

May you all have a meaningful holiday season and a Happy New Year.

Barbara Banfield, President

For your information:

The composition of the Board of Directors is:

- Founding Members
- President-Banfield-term expires 12/2007
- VP-Beth Geden-term expires 12/2006
- Secretary-Connie Dennis-term expires 12/2007
- At Large Members-Violeta Berbiglia-term expires 12/2006
  Kathie Renpenning-term expires 12/2007
  Marcel Sailer-term expires 12/2007
- Nominating Committee-Barbara Biehler-term expires 12/2006
  Sheila Jesek-Hale-term expires 12/2006
  Monika Lovgren-term expires 12/2006
  Jacqueline Fawcett-term expires 12/2007
  Jane Ransom-term expires 12/2007
- Program Chair-Gerd Bekel-term expires 12/2006
- Public Affairs Chair-Andrea Hintze-term expires 12/2006
- Public Relations Chair-Andrea Hintze-term expires 12/2006
- Scholarly Endeavor Chair-Margarethe Lorensen-term expires 12/2006

Mission Statement:

The mission of the International Orem Society is to advance nursing science and scholarship through the use of Dorothea E. Orem's nursing conceptualizations in nursing education, practice, and research.
Memorial to Dr. Margarethe Lorensen, Institute of Nursing Science, Oslo University, Norway

Professor Margarethe Lorensen 1942-2005

Professor Margarethe Lorensen died October 30th 2005, at the age of 63, in her home in Denmark with her two sons beside her.

Dr. Lorensen’s colleague, Dr. Monika Lovgren, expresses the loss she feels and provides a translation of the information concerning Margarethe’s life:

Doctor Lorensen began her nursing career in 1964 as registered nurse at Sonderjyske Sygeplejeskole (Nursing College); and in 1969, she continued her nursing education at Denmark’s School of Nursing, Aarhus University.

Margarethe’s early interest was nursing research. She was awarded a scholarship for studies in USA. There, she received a Masters Degree of Arts in Education (Northern Arizona University, 1972) and a Masters Degree in Nursing (University of Colorado, 1973). Margarethe was the first Danish nurse to complete a PhD (Arizona State University, 1976). When she returned to Denmark, she worked as Research Consultant on the Danish Nursing Council (1978). She established the Danish Council’s Nursing Research. Margarethe served as supervisor for 25 years and as the publisher of the journal for Nursing Research for 21 years.

In 1983, Margarethe was appointed Vice Director for the Deaconess Foundation (Copenhagen). In 1986, she became the Director. She developed a Somatic Hospital into a Geriatric Center. This was the first time in Denmark that a PhD prepared nurse was appointed a supervisor. She used Orem’s Self-Care Deficit Nursing Theory in her practice in the care of the elderly.

Dr. Lorensen was the first nurse to receive a research award in health and nursing care from the Danish Medical Research Council. The award made it possible for her to conduct her project, “Elderly and Self-Care”.

From 1987 until her death, Margarethe was a Professor in Nursing Science at Oslo University. She worked very hard to define an autonomous and independent nursing science, nursing research and nursing practice.

The International Orem Society for Nursing Science and Scholarship celebrates the life of Margarethe and pays tribute to her contributions to the IOS and to the nursing profession. Dorothea Orem recalls the early contributions of Margarethe and comments: “Her research concerned women and their recovery under certain conditions. She was very active in that she had the research instruments she developed over time to study women who were hospitalized or in rehabilitation. She was an interesting woman. Walene and I enjoyed our time with her in Washington. Walene called her ‘the statue of liberty’.”

Vi Berbiglia also recalls Margarethe’s stature and strong leadership qualities. She served on IOS committees and fostered the use of the SCDNT in many parts of the world. The IOS and the faculty of the Institute of Nursing Science, Oslo University feel a great loss. Margarethe continued to meet with her university colleagues until a few days before her death. We all share a great appreciation for Dr. Margarethe Lorensen’s contributions and express our sympathy to her family.

Memorial prepared by: Drs. Monika Lovgren, Dorothea Orem, and Violeta Berbiglia
Concept Formalization in Nursing reprint offer

Reprint of Concept Formalization in Nursing is now available

The IOS has supported the reprint of the 2nd edition of Concept Formalization in Nursing: Process and Product. The book was one of the most selling nursing theory books in 1979.

The second edition of CONCEPT FORMALIZATION IN NURSING: PROCESS AND PRODUCT reflects the progress made till 1979. This volume refines previous conclusions and moves on to descriptions of the individual or group dynamics associated with formulation, expression, and acceptance of nursing’s conceptual structure. Orem’s general theory of nursing is used to provide the conceptual framework for research and the structuring of nursing knowledge. Research carried out by Conference members Melba Anger Malatesta, Louise Hartnett Rauckhorst, and the late Joan Backscheider is also presented.

Throughout the text, drawings, tables, charts, and graphs are used to illustrate key points. The book is divided into two parts.

Part I focuses on nursing as a practice discipline, explains the position of the profession in the world of human affairs, and analyzes 14 concepts of nursing. Part II delves into the Nursing Development Conference Group’s work on the structure of nursing knowledge and applies insights into the conclusions of the first edition. Two chapters explore the implications of the self-care agency. Throughout the text, the skillful integration of a substantial amount of new material serves to provide a complete update of the initial concerns.

For more information visit www.scdnt.com/pub/pub.html or for any order information contact Gerd Bekel (gerd.bekel@gbconcept.de).
New IOS Web Presentation

- The new IOS Webpage is available to the public.
- You will find new information related to S-CDNT and IOS.
- Please bookmark our domain and give notice to your colleagues, students and friends.
- You’ll find the webpage at www.scdnt.com
- Please feel free to send us comments and information you’d like to be presented.
- We would like to develop two more sections on SCDNT Research and on International affairs.
- If you or your students would like to report on your current research work, please contact Gerd Bekel (gerd.bekel@gbconcept.de).

Self-Care Deficit Nursing Theory -SCDNT-
International Orem Society for Nursing Science and Scholarship

Welcome to the International Orem Society for Nursing Science and Scholarship web site. It is for the discussion and dissemination of information related to Orem’s Self-Care Deficit Nursing Theory.


Research Grant Opportunities.
The International Orem Society is pleased to offer funding to support projects for the Advancement of Nursing Science and Scholarship. Read about the research grant here.

Thanks for browsing with us and we hope you will come visit again!!

Start >