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THEORETICAL PAPER/ESSAY

Self-care: Orem's theoretical contribution to the Nursing discipline and profession

Autocuidado: o contributo teórico de Orem para a disciplina e profissão de Enfermagem

Autocuidado: la contribución teórica de Orem para la disciplina y profesión de Enfermería

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Abstract

Background: As a practical human science, Nursing creates and uses an exclusive body of knowledge, affirming itself as a scientific discipline with its own characteristics. Theoretical thinking has evolved in a journey of major conceptual richness, thus generating theories and concepts with interpretative value of nurses' performance. One of the most often cited theories is the Self-Care Deficit Nursing Theory (SCDNT) of Dorothea Orem, which was developed between 1959 and 1985 and incorporated the nursing model proposed by the author.
Objective: To critically address the SCDNT through a theoretical study, which implied the reading, analysis and discussion of different bibliographic materials.
Main topics under analysis: The SCDNT and associated conceptual terms.
Conclusion: As a particular combination of conceptual properties common to all nursing circumstances, the SCDNT is relevant to guide nursing knowledge, clinical practice, education and management, as well as create structures from which other theories and concepts are developed.

Keywords: Nursing Theory; self-care; nursing science.

Resumo

Enquadramento: A enfermagem, enquanto ciência humana prática, cria e utiliza um corpo de conhecimento exclusivo, afirmando-se como uma disciplina científica com características próprias. O pensamento teórico tem evoluído num percurso de grande riqueza conceptual, gerando teorias e conceitos com valor interpretativo daquilo que os enfermeiros fazem. Uma das teorias mais citadas é a Teoria do Défice de Autocuidado de Enfermagem de Dorothea de Orem (TDAE), desenvolvida entre 1959 e 1985, que incorpora o modelo de enfermagem proposto pela mesma.
Objetivo: Abordar criticamente a TDAE através de um estudo de natureza teórica, que para a sua execução exigiu a leitura, análise e reflexão de diferentes materiais bibliográficos.
Principais tópicos em análise: A TDAE e os termos conceptuais que lhe estão associados.
Conclusão: A TDAE, sendo uma combinação particular de propriedades conceptuais comuns a todas as circunstâncias de enfermagem, revela-se pertinente na orientação do conhecimento e na prática clínica, ensino e gestão de enfermagem, assim como na criação de estruturas a partir das quais se desenvolvem outras teorias e conceito

Palavras-chave: Teoria de Enfermagem; autocuidado; ciência de enfermagem.

Resumen

Contexto: La enfermería, como ciencia humana práctica, crea y utiliza un cuerpo de conocimiento exclusivo, afirmándose como una disciplina científica con características propias. El pensamiento teórico ha evolucionado en un trayecto de gran riqueza conceptual, generando teorías y conceptos con valor interpretativo de aquello que los enfermeros realizan. Una de las teorías más citadas es la Teoría del Déficit de Autocuidado de Enfermería de Dorothea de Orem (TDAE), desarrollada entre 1959 y 1985, que incorpora el modelo de enfermería propuesto por la misma.
Objetivo: Abordar críticamente la TDAE a través de un estudio de naturaleza teórica, que para su ejecución exigió la lectura, el análisis y la reflexión de diferentes materiales bibliográficos.
Principales temas en análisis: La TDAE y los términos conceptuales que se le asocian.
Conclusión: La TDAE, al ser una combinación particular de propiedades conceptuales comunes a todas las circunstancias de enfermería, resulta pertinente en la orientación del conocimiento y en la práctica clínica, enseñanza y gestión de enfermería, así como en la creación de estructuras a partir de las cuales se desarrollan otras teorías y conceptos.

Palabras clave: Teoría de Enfermería; autocuidado; ciencia de enfermería.

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Introduction

The nursing theory has been a dominant topic in nursing literature over the past 40 years, thus contributing to nursing development as a profession. The era of theory, together with the awareness of nursing as a profession and academic discipline, emerged from the debates and discussions occurred in the 1960s. The transition from vocation to profession in the 1970s was decisive for nursing as it questioned the discipline on which it should be based, the answer being nursing science (Tomey & Alligood, 2002). According to Meleis (2011), this progress in nursing theory is a significant aspect of the scholarly evolution and the cornerstone of the nursing discipline.

Compared to other sciences, the nursing science is in the early stages of its development. It is considered a body of knowledge specific to the discipline of nursing, which focuses on the human-universe-health process integrated into the nursing structures and theories. Its goal is to represent the nature of nursing and use it for the benefit of humanity (Barrett, 2002). To think philosophically about nursing science helps to establish the meaning of science through the analysis and understanding of nursing concepts, theories and goals as they relate to care practice (Tomey & Alligood, 2002). For knowledge and its evolution to be addressed, it is necessary to take into account its ontology, epistemology and methodology. Ontology refers to what exists and its nature; epistemology relates to the forms of knowledge; and methodology refers to the mean(s) used for the acquisition of knowledge (Tomey & Alligood, 2002). More specifically, the epistemology of nursing may be defined as the study of the origins of its knowledge, its structure and methods, the patterns of knowing created and used by its members, and the criteria for validating its knowledge claims (Schultz & Meleis, 1988).

Carper (2006) first identified four fundamental patterns of knowing in nursing: empiric, aesthetic, ethical, and personal. The author later added reflective knowing and socio-political knowing. Other authors proposed new patterns or suggested reformulations, namely: experiential, intuitive and interpersonal knowing (Moch, 1990); context (White, 2006); procedural, cultural and tacit patterns (Abreu, 2008); and clinical and conceptual patterns (Schultz & Meleis, 1998). Clinical knowledge is manifested in the act of caring and results from combining empirical knowledge with the knowledge drawn by nurses from practice; conceptual knowledge is abstract and generalised, and goes beyond personal experience, allowing to explain all patterns manifested in multiple care experiences and articulate them with the various models and theories (Schultz & Meleis, 1998).

As a whole, these patterns of knowing constitute the ontological and epistemological foundations of the nursing discipline. Therefore, Fawcett, Watson, Betty, Walker and Fitzpatrick (2001) argue that the integration of all patterns is essential for the practice of professional nursing and that none can be used independently. Similarly to most disciplines, especially those that exist only if they are associated with a given professional practice, nursing is endowed with both scientific knowledge and conventional knowledge, that is, knowledge that was not empirically tested (McEwen & Wills, 2009).

This notion that the nursing discipline is composed of patterns of knowing that go beyond the empirical pattern allows us to rethink nursing as a science and an art (Queirós, 2013). According to Meleis (2011), the art of nursing may be used as a synonym for caring, which, for Johnson, mentioned by the same author, is only possible when nurses are able to grasp the meaning of the encounter with the patients and when they conduct their practice based on moral criteria. Thus, nursing cannot be considered an exact science, but rather a science that fits into the disciplinary group of human sciences, more specifically into the group of practical human sciences (Queirós, 2013). As a scientific discipline, nursing should outline its nature as a practical human science, distinguishing itself from not only the natural and social sciences, but also the human sciences (Kim, 2010). Nursing knowledge is then a knowledge that creates, structures and restructures itself in a dialogical dynamics between conception (theory) and action (caring), in a constant to-and-fro translational movement (Queirós, 2013).

Scientific disciplines have their own communication structure expressed by concepts and terms. Due to their interpretative, explanatory and symbolic power, some concepts become critical to define the nature of a discipline and identify its conceptual matrix (Queirós, 2014). According to Fourez (2008), a scientific discipline is what is called in philosophy of science a disciplinary matrix or paradigm, that is, a mental structure, whether conscious or not, that

is used to classify the world with the purpose of tackling it.

Theoretical thinking in nursing evolves and has evolved in a journey of great conceptual richness. This conceptual richness ought to be appropriately adapted by nurses in a plural form (both theoretically and methodologically) (Queirós, 2014).

To be useful, a theory ought to be meaningful, relevant and, above all, understandable. Theory has been defined as the systematic explanation of a given event in which components and concepts are identified, relationships are proposed and forecasts are made (Streubert-Speziale & Carpenter, 2003). Conceptual and theoretical models create mechanisms by which nurses may convey their own professional convictions, provide a moral/ethic structure to guide their actions, and promote a systematic way of thinking about nursing and its practice (Chinn & Kramer, 2004). Young, Taylor and Renpenning (2001) argue that conceptual models or structures describe a network of concepts and their relationships, thus explaining broad phenomena in nursing. In addition, nurses realise what they are doing and shall be able to explain it to others. Therefore, the theory in nursing leads to professional autonomy, guiding care, education and research practices within the profession (Tomey & Alligood, 2002).

One of the most often cited theories in nursing is the Self-Care Deficit Nursing Theory (SCDNT) of Dorothea Orem, which was developed between 1959 and 1985 and incorporated the nursing model proposed by the author. On the assumption that any theory has the capacity to expand the discipline and science of nursing, the purpose of this study was to critically address the SCDNT.

This study is theoretical in nature which implied the reading of Orem's SCDNT, using different bibliographic sources, and further analysis and critical discussion of the most crucial components. Given the emerging conceptual richness, whenever possible, concepts proposed by other theorists and authors shall also be discussed.

Development

Orem denied any kind of philosophical contribution to the construction of the SCDNT and, though the author expressed interest in several theories, she gave particular emphasis to Parson's structure of social action and von Bertalanffy's system theory (McEwen & Wills, 2009).

Self-care is the central concept of SCDNT. According to Orem (2001), self-care may be defined as the practice of activities that individuals initiate and develop within specific time frames, and whose objectives are to maintain life and personal well-being. Queirós (2010) adds that self-care is universal by covering all experiential aspects, not being restricted to basic and instrumental activities of daily living.

Orem considers that the SCDNT is a general theory composed of three inter-related theories: 1) the Theory of Self-care, which describes why and how people care for themselves; 2) the Theory of Self-Care Deficit, which describes and explains why people can be helped through nursing; and 3) the Theory of Nursing Systems, which describes and explains relationships that must be brought about and maintained for nursing to be produced (Tomey & Alligood, 2002).

The Theory of Self-Care includes the concepts of self-care, self-care activity and therapeutic self-care demand (Tomey & Alligood, 2002). Self-care is a regulatory human function that individuals deliberately perform for themselves or have performed for them to maintain life, health, development and well-being. When it is deliberate, controlled, intentional and effective, thus achieving a real empowerment, it is designated as self-care activity (Tomey & Alligood, 2002). According to Soderhamn (2000), the ability to self-care is not in itself a means to maintain, restore or improve health and well-being, but rather the potential for self-care activity as an integral part of human beings. The Theory of Self-care is the basis to understand the conditions and limitations of the actions of people who may benefit from nursing (Tomey & Alligood, 2002), although a balance between excess and lack of care is essential for individuals to be able to self-care.

The central idea of the Theory of Self-Care Deficit is that the need for nursing care is associated with the subjectivity of people's maturity in relation to health-related or health care-related action limitations (Tomey & Alligood, 2002). Thus, these limitations render them completely or partially unable to care for themselves or their dependents. This concept is the essence of the general theory of self-care deficit, considering that it determines the need for nursing interventions when individuals' demands for self-care

are greater than their ability to self-care. Although self-care deficit is an abstract concept, when expressed in terms of action limitations, it helps us to understand the role of the individual in self-care and provides guides for the selection of nursing interventions (Tomey & Alligood, 2002).

Queirós (2010) argues that an individual may present different self-care needs, autonomous skills to satisfy those needs and support needs in situations of transition, in which he/she cannot properly adapt himself/herself. According to Soderhamn (2010), the ability to acquire or restore self-care, either independently or with the help of third parties, occurs in three dependent phases. The first phase, known as estimative self-care, determines what should be done to restore self-care; the second phase, known as transitional self-care, recognises the different options to restore self-care and selects the most favourable one; the third and final phase, known as productive self-care, shows the individual's true capacity for self-care. According to the same author (2010), the self-care ability is only recognised when the individual is able to perform the self-care activity to maintain, restore or improve his/her health and well-being. This view brings us to the concept of transition proposed by Meleis, and cited by Abreu (2008), which is defined as a significant change in the individual when he/she is exposed to different stimuli and new knowledge. This may generate a new behaviour or result in a different definition of the self within the social context. According to Sholssberg, who was cited by Abreu (2008), the individuals' ability to determine and manage their needs and develop adaptive responses may be altered during a transition, thus an adaptation or adjustment period is necessary.

The Theory of Nursing Systems proposes that nursing is a human action, because these are action systems designed and produced by nurses through the exercise of their practice while working with individuals who have self-care limitations (Tomey & Alligood, 2002).

Orem identified three types of self-care requisites in the SCDNT: universal, developmental and health-deviation. These may be defined as the goals to be achieved through self-care actions carried out by the individual or a third party, i.e., they correspond to the groups of needs identified in theory (Tomey & Alligood, 2002).

Universal requisites originate from what is known, validated or in the process of being validated, about human structural and functional integrity at various stages of the life cycle, i.e. they are common to all people. Examples of such requisites are the maintenance of a sufficient intake of water, air and food and the maintenance of balance between activity and rest (Tomey & Alligood, 2002).

Developmental requisites are all those which promote processes of life and maturation and prevent harmful conditions that may hinder them (Tomey & Alligood, 2002), i.e., they are associated with a particular event such as a wedding or a new job.

Health-deviation requisites exist for people who are ill or injured, have specific forms of pathological situations or disorders, including defects or disabilities, and are undergoing medical diagnosis or treatment. The characteristics of health deviations, as situations extending through time, determine the care needs that individuals experience during the disease process (Tomey & Alligood, 2002).

The care needed to meet the self-care deviation requisites must be transformed into action components of the self-care systems. The complexity of these systems increases with the number of health-deviation requisites that must be met in specific time frames (Taylor & Alligood, 2002), using therapeutic self-care agents. According to Orem, a therapeutic self-care agent is defined as a maturing adult, or an adult who accepts and fulfils the responsibility of identifying and satisfying the therapeutic self-care demands of dependent others, or even an adult who accepts to regulate these individuals' self-care performance. According to Queirós (2010), these agents may be professionals or informal caregivers duly trained to provide care.

As regards professional care, Meleis, who was cited by Abreu (2008), believes that the most relevant role in nursing practice consists of assisting people in transition processes as it facilitates these process and helps people achieve their well-being. Kleinman, who was cited by Abreu (2008), reports that formal caregivers are endowed with professional skills and are socially recognised for the exercise of their role. Informal care is that in which the dependent person is cared for, usually free of charge, in a relationship of effective proximity which may be provided by a relative or a significant person (Abreu, 2008).

Orem identified the three types of practice of nursing science in nursing systems: 1) fully compensatory system, when nursing replaces individuals in self-care; 2) partially compensatory system, when individuals need nursing only to help them carry out what they are not able to do on their own; and 3) supportive-educative system, when individuals are able to perform self-care, although they need nurses to teach and supervise them while performing it (Tomey & Alligood, 2002). The supportive-educative system is also relevant to informal caregivers.

In this perspective, a sequential series of actions help overcome or compensate the limitations associated with people's health to undertake the regulatory actions of their own functioning and development or those of their dependants. In this sense, Orem identified five methods that nurses may use, in combination or isolated, when caring for patients: acting for and doing for others; guiding and directing them; providing physical and/or psychological support; providing and maintaining an environment that supports their personal development; and teaching them (Tomey & Alligood, 2002).

According to Orem, the nursing process is a system that allows diagnosing the need for care, planning the right procedure, and intervening. The method for conducting this process meets the following criteria: identification of self-care requisites; identification of self-care skills; identification of therapeutic demands; mobilisation of nurses' skills; and planning of assistance in nursing systems (Tomey & Alligood, 2002). According to Meleis and Trangenstein, who were cited by Abreu (2008), nurses care for patients, who are integrated in a sociocultural context (environment), undergoing a transition (or anticipating it), with the aim (nursing process) of promoting one's health and/or well-being through a set of actions (therapeutic interventions). The belief that human beings are constantly communicating and exchanging information with one another and their surrounding environment in order to survive is a belief underlying Orem's theory (McEwen & Wills, 2009). According to the author, an integrated human functioning includes physical, psychological, interpersonal and social aspects, as human beings are believed to distinguish themselves from others by their potential for learning and developing (Tomey & Alligood, 2002).

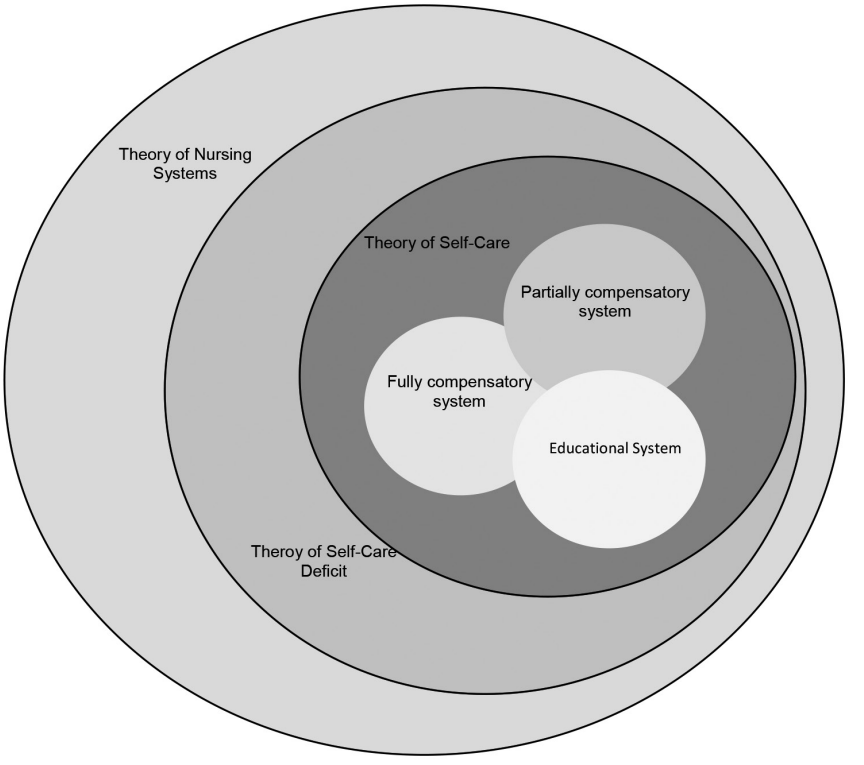

Figure 1. Self-Care Deficit Nursing Theory. Source: Orem, D. (2001). Nursing: Concepts of practice (6th ed). St. Louis: Mosby.

Critical Analysis

Orem's views about nursing science as a practical science are essential to understand how empirical evidence is gathered and interpreted. Orem identified two groups of nursing sciences: 1) nursing practice sciences, which included wholly compensatory nursing science, partially compensatory nursing science and supportive-educative nursing science; and 2) foundational nursing sciences, which included the science of self-care, self-care activity and human assistance (Tomey & Alligood, 2002). The concept of self-care may have different meanings in other disciplines; nevertheless, Orem defined and structured it in a unique way (Tomey & Alligood, 2002). The author's theory is expressed through a limited number of terms, which are clear and congruent among them. The SCDNT comprises three inter-related theories: self-care; self-care deficit; and nursing systems. This theory is a synthesis of the knowledge on self-care (and dependent-care), self-care activities (and dependent care), therapeutic self-care demands, self-care deficit and nursing action (Orem, 2001). According to Orem, this theory is not an explanation of a given situation/individuality specific to nursing practice, but rather a particular combination of conceptual properties or characteristics common to all nursing circumstances. As a general theory, it may be appropriate for nurses involved in nursing clinical practice, the development and validation of nursing knowledge, and the teaching and learning of nursing (Orem, 2001).

In research, the SCDNT has been at the basis of several studies (both qualitative and quantitative), which may be divided into two groups: 1) studies to develop instruments for measuring conceptual elements; and 2) studies to test the concepts in specific populations. Despite the fact that they are well-defined and capable of being assessed, all necessary tools have not yet been created to assess every theoretical entity. This is in addition to the fact that the various entities differ from population to population (Tomey & Alligood, 2002).

The relevance of Orem's theory is in its scope, complexity and clinical usefulness, as well as its ability to generate hypotheses and add knowledge to the nursing body of knowledge. It has proven to be equally useful in both the design of curricula to train nurses in several colleges and universities and the development of guidelines for nursing management/administration (Tomey & Alligood, 2002).

We believe that the contribution of Orem to theory, specific nursing knowledge and nursing science is explained by the creation of a theory that is comprehensive enough to frame and convey disciplinary meaning to the professional activity. This allows for the development of explanatory narratives of what is done by nurses, the patterns of knowing used by them and those which they, simultaneously, create and enrich when they need to find answers to problems related to the health, disease and well-being of the individuals and populations whom they must assist. On the other hand, through the SCDNT, Orem contributed to building a specific disciplinary language, by bringing concepts to nursing (migratory concepts) which are then recreated and acquire specific features, such as the major concept of self-care. This concept is central to the nursing discipline given its ability to clarify a purpose for it (to promote or restore the individuals' ability to self-care) and the explanatory power of an action (the acquisition of skills to achieve autonomy and self-determination). The germinating power of this concept should also be emphasised, as it allows for the development of other concepts, such as estimative self-care, transitional self-care and productive self-care. These acquire operational power and may be used to describe what we do and identify the stage where our action's beneficiaries find themselves.

Conclusion

The value of any nursing theory, particularly the grand theories, is explained by its ability to expand nursing as a practical human science. Understanding the nature of human beings, their interaction with the environment and the impact of such interaction on people's health helps to plan clinical practice and define the interventions that improve the individuals' health and well-being. The improvement of care should be the main focus of a grand theory in nursing.

The SCDNT has been very useful to guide clinical practice, education and management, as well as to promote structures from which other more accurate and testable concepts derived. Although this theory has only been used sparingly due to its complexity

and lack of validation, it has proven to be useful and valuable to expand nursing science. It results from a particular combination of conceptual properties common to all nursing circumstances, thus it should be used by everyone involved in the nursing discipline and profession.

References

Abreu, W. C. (2008). *Transições e contextos multiculturais*. Coimbra, Portugal: Formasau.

Barrett, E. A. M. (2002). What is nursing science? *Nursing Science Quarterly, 15*(1), 51-60. doi: 10.1177/089431840201500109

Carper, B. (2006). Fundamental patterns of knowing in nursing. In L. C. Andrist, P. K. Nicholas, & K. A. Wolf (Eds.), *A history of nursing ideas* (pp. 129-137). Sudbury, Canada: Jones and Bartlett Publishers.

Chinn, P. L., & Kramer, M. K. (2004). *Theory and nursing: Integrated knowledge development* (6th ed.). St. Louis, MO: Mosby.

Fawcett, J., Watson, J., Betty, N., Walker, P., & Fitzpatrick, J. (2001). On nursing theories and evidence. *Journal of Nursing Scholarship, 33*(2), 115-119. doi: 10.1111/j.1547-5069.2001.00115.x

Fourez, G. (2008). *A construção das ciências. As lógicas das invenções científicas*. Lisboa, Portugal: Instituto Piaget.

Kim, H. S. (2010). *The nature of theoretical thinking in nursing* (3rd ed.). New York, NY: Springer Publishing Company.

McEwen, M., & Wills, E. (2009). *Bases teóricas para enfermagem* (2ª ed.). São Paulo, Brasil: Artmed.

Meleis, A. I. (2011). *Theoretical nursing: Development & progress* (5th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

Moch, S. D. (1990). Personal knowing: Evolving research in nursing. *Scholarly Inquiry for Nursing Practice, 4*(2), 155-163.

Orem, D. E. (2001). *Nursing: Concepts of practice* (6th ed.). St. Louis, MO: Mosby.

Queirós, P. J. (2010). Autocuidado, transições e bem-estar. *Revista Investigação em Enfermagem, 21*, 5-7.

Queirós, P. J. (2013). O que os enfermeiros pensam da enfermagem? Dados de um grupo de informantes. *Revista Investigação em Enfermagem, 2*(5), 57-65.

Queirós, P. J. (2014). Conceitos disciplinares em uso por estudantes de licenciatura e de mestrado em enfermagem. *Revista de Enfermagem Referência, 4*(2), 29-40. doi: 10.12707/RIII13120

Schutz, P. R., & Meleis, A. (1988). Nursing epistemology: Traditions, insights, questions. *Journal of Nursing Scholarship*, *20*(4), 217-221. doi: 10.1111/j.1547-5069.1988.tb00080

Söderhamn, O. (2000). Self-care activity as a structure: A phenomenological approach. *Scandinavian Journal of Occupational Therapy,* 7(4), 183-189. doi: 10.1080/110381200300008724

Streubert-Speziale, H. J., & Carpenter, D. R. (2003). *Qualitative research in nursing: Advancing the humanistic imperative* (3rd ed). Philadelphia, PA: Lippincott Williams & Wilkins.

Tomey, A. M., & Alligood, M. R. (2002). *Teóricas de enfermagem e a sua obra* (5ª ed.). Loures, Portugal: Lusociência.

White, J. (2006). Patterns of knowing: Review, critique, and update. In L. C. Andrist, P. K. Nicholas & K. A. Wolf (Eds.), *A history of nursing ideas* (pp. 139-150). Sudbury, Canada: Jones and Bartlett Publishers.

Young, A., Taylor, S. G., & Renpenning, K. M. (2001). *Connection: Nursing research, theory and practice*. St. Louis, MO: Mosby.