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Conceptualizing Cognitive-Behavioral Therapy as a Supportive-Educative Nursing System for Patients with Insomnia

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Contents

From the Co-Editors

Welcome to the March 2016 issue of **Self-Care Dependent-Care Nursing**. The co-editors have been busy updating the Orem International Society for Nursing Science and Scholarship website. The logo has been changed and membership can now be renewed online. We would like to draw your attention to the article, "A Concept Analysis of Normalcy within Orem's Self-Care Deficit Nursing Theory" by Donna L. Hartweg, PhD, RN and Judith Pickens, PhD, RN. The concept analysis of normalcy is the first step toward further theory development. This article is a product of a theory development and refinement work-group established by the OIS Board two years ago. A second article that is of interest is "Conceptualizing Cognitive-Behavioral Therapy as a Supportive-Educative Nursing System for Patients with Insomnia" by Christine P. Kurtz, DNP, RN, PMHCNS-BC and Nola A. Schmidt, PhD, RN, CNE. This article suggests that cognitive-behavior therapy could be used as a nursing intervention for insomnia within the context of Orem's self-care deficit nursing theory. A new feature in the journal is a column that will include examples of how Orem is used in nursing practice and education. In the current issue, Catherine Vincent, PhD, RN; Katherine Pischke-Winn, MS, MBA, RN, Katherine Pakieser-Reed, PhD, RN, and Cynthia La Fond provide a real-life example of how Orem's SCDNT is being used at the University of Chicago Medicine in nursing practice. We invite nurses to send in examples of how Orem's SCDNT has been integrated into their curriculum and practice. ■

Virginia Keatley, Co-Editor
Mary White, Co-Editor
Violeta Berbiglia, Co-Editor Emeritus

President's Message

To clarify and strengthen the role of our organization in meeting the challenges of nursing theory application in the present nursing environment, members of the Orem Society's Board of Directors were busy in 2015. A core Strategic Planning Task Force comprised of Barbara Banfield, Gerd Berkel, Vickie Folse, Donna Hartweg, Mary L. White, and myself met regularly to explore methods to enhance the use of theory and to reinvigorate the International Orem Society. Although the Task Force's primary focus was the use of Self Care Deficit Nursing Theory (SCDNT) to determine contemporary trends, members explored current literature and reached out to nursing theorists, nursing theory experts, and practicing nurses for input. Our group concluded that the key endeavor of the Task Force should be driven by one central challenge:

Enhance the leadership role of the International Orem Society (IOS) as a positive force in promoting the international use of Orem's Self-care Deficit Nursing (SCDNT) in health care delivery, nursing research, and nursing education.

From this general purpose, the Task Force developed a Strategic Plan that includes objectives and tactics to establish creative relationships that increase the visibility of the organization and benefits our members. The entire Strategic Plan can be found on the website (http://oreminternationalsociety.org/). I want to underscore tactics already initiated that are intended to increase the value of the Society to professional nursing and our membership. An initial effort to build partnerships with practitioners resulted in the contribution by Vincent, Pischke-Winn, Pakieser-Reed, & La Fond that confirmed the utility of the SCDNT in a contemporary nursing service environment. The summary is published in this issue of the journal. Similarly, Dr. Nola Schmidt consulted with an educator's workgroup at the University of Hyogo, Japan to develop the concept of Dependent Care Agency for application to their nursing curriculum. With an eye toward capitalizing on technology services, the Orem Society web page has been redesigned to provide increased access to past conferences materials and enhance membership services.

In the midst of these Board of Directors activities during 2015, I want to direct your attention to another change. The official

name of the society has been changed from the International Orem Society (IOS) to the Orem International Society (OIS). The Board is hopeful this name change will facilitate web searches making our materials easier to locate.

On a last note, as I finished this column I was notified a new book on SCDNT will be available in the spring. *Foundations of Professional Nursing: Care of Self and Others,* authored by Katherine Renpenning, Susan Taylor, and Judith M. Pickens. This book targets undergraduate nursing students particularly those in RN to BSN programs. The need for such a book has been repeatedly identified by educators preparing practitioners and I believe will be essential to all consumers of nursing theory. I eagerly anticipate reading this new publication. ■

Sharie Metcalfe

A Concept Analysis of Normalcy within Orem's Self-Care Deficit Nursing Theory

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Abstract

The purpose of this concept analysis was to explore the meaning of the term normalcy within one theoretical perspective, that of Orem's Self-Care Deficit Nursing Theory (SCDNT). Six studies using Orem's SCDNT provided the context for a theoretical concept analysis of normalcy and promotion of normalcy. These studies provided evidence for identification of six defining attributes of normalcy, creation of model and contrary cases, and analysis of Orem's definition of normalcy. Further, Orem's four categories or set of actions for promotion of normalcy were analyzed for their adequacy and sufficiency. Defining attributes are having adequate resources for basic necessities of life, ability to perform activities of daily living and those consistent with personal interests, accepting a new normal, including realistic self-concept, maintaining one's health through self-care, and engaging in fulfilling interpersonal relationships. The analysis also provided support for the relationship of Orem's set of actions for promotion of normalcy to select universal, developmental, and health deviation self-care requisites. These relate to health as structural and functional integrity, life cycle development and development associated with adversity, and adjustment of self-concept to a new normal when health deviations are present. Follow-up concept analysis of normalcy using a colloquial method related to a specific target population and with non-Orem and non-nursing literature will enhance further understanding for application in nursing research and practice.

Keywords: *normalcy; Orem; Self-Care Deficit Nursing Theory; concept analysis*

United States healthcare practices have shifted in the last few years to emphasize both prevention of disease and management of chronic illness. In part this change has been fueled by the documented increase in chronic diseases such as type II diabetes and serious mental illnesses. Research across illness states, age groups, and cultural conditions suggests that "being normal" or normalcy is important to people within the context of chronic illness (e.g., Atkin & Ahmad, 2001; Mallinson, Relf, Dekker, Dolan, Darcy, & Ford, 2005; Zeigler & Nelms, 2009).

The promotion of normalcy is described within Orem's Self-Care Deficit Nursing Theory [SCDNT] (Orem, 2001) as a universal requirement of human beings for life, health and well-being. The purpose of this concept analysis is to explore the meaning of the term normalcy within one theoretical perspective, that of Orem's SCDNT. This focused analysis will provide a foundation for subsequent development of actions that promote normalcy in individuals and social groups as well as a broader exploration of normalcy and related terms.

Background

Orem (2001) defined normalcy as "that which is essentially human and that which is in accord with the genetic and constitutional characteristics and talents of individuals" (p. 225). In early writings, Orem (1971) also used the term "normality" as a synonym for normalcy, relating it to individuals having knowledge and beliefs of individual human and social norms. The promotion of normalcy is action directed toward "human functioning and development within social groups in accord with human potential, known human limitations, and the human desire to be normal" (Orem, 2001 p. 225). Orem further identified general categories or sets of actions to meet each universal requisite, or basic requirements for health and well-being. The general set of actions for promotion of normalcy includes the following: a) Developing and maintaining a realistic self-concept; b) Taking action to foster specific human developments; c) Taking action to maintain and promote the integrity of one's human structure and functioning; and d) Identifying and attending to deviations from one's structural and functional norms.

Promotion of Normalcy: A Self-Care Requisite

SCDNT is a general theory of nursing that helps nurses to understand human structures and relationships common in all nursing situations. The Theory of Self-Care, one of three theories within SCDNT, is a foundational science that explains self-care as a human regulatory function that individuals must perform for themselves or have performed for them through dependent-care or by nursing care. Self-care is a process of action sequences, deliberately produced with therapeutic quality to regulate human functioning and development within norms compatible with life, health, and well-being (Denyes, Orem, & Bekel, 2001). Reasons for engagement in self-care emanate from types of self-care requisites. Orem identified three types of requisites: universal self-care requisites (USCR), developmental self-care requisites (DSCR), and health deviation self-care requisites (HDSCR). Interrelationships exist between and among the self-care requisites, such as a relationship within two universal self-care requisites, the prevention of hazards and promotion of normalcy. These two also relate to the six other universal requisites (See Orem, 2001, Figure 10-2, p. 228). Through the general set of actions for promotion of normalcy, Orem also implied relationships between promotion of normalcy and select developmental and health deviation self-care requisites.

This concept analysis will examine evidence from theoretical literature within Orem's Self-Care Deficit Nursing Theory to further explore Orem's conceptualization of normalcy, including the general set of actions for promotion of normalcy. We will also describe any interrelationships among and within various types of self-care requisites suggested by this analysis.

Method: Concept Analysis of Normalcy

Background on Concept Analysis

Concept analysis within the nursing discipline has been common since the 1980s. Purposes of these analyses range from examining the concept's structure and function (Walker & Avant, 2011) to explicating its meaning within testable and practical nursing theories (Fawcett, 2012; Risjord, 2009).

The practice of concept analysis has come under recent criticism for its overuse in nursing

Table 1: Types of Self-Care Requisites

A. Universal Self-Care Requisites (Essential requisites*)
1. Maintenance of a sufficient intake of air
2. Maintenance of a sufficient intake of water
3. Maintenance of a sufficient intake of food
4. Provision of care associated with elimination processes and excrements
5. Maintenance of a balance between activity and rest
6. Maintenance of a balance between solitude and social interaction
7. Prevention of hazards to human life, human functioning, and human well-being
8. Promotion of human functioning and development within social groups in accord with human potential, known human limitations, and the desire to be normal. (Desire for normalcy)

B. Developmental Self-Care Requisites
1. Developmental 1: (Essential requisites*):
   Regulating human functioning and development during all stages of the life cycle.
2. Developmental 2: (Situation-specific requisites*):
   Mitigating or overcoming the effects of human conditions and life situations that adversely affect human development.

C. Health Deviation Self-Care Requisites (Situation-specific requisites*)
1. Seeking and securing appropriate medical assistance in relationship to pathological events
2. Being aware of and attending to effects and results of pathology
3. Carrying out medically prescribed diagnostic, therapeutic and rehabilitative measures related to pathology
4. Being aware of, attending to, or regulating discomforting or deleterious effects of medical care
5. Modifying self-concept and self-image in accepting oneself as being in a particular state of health and in need of health care
6. Learning to live with the effects of pathologic conditions and states, the diagnostic and treatment measures in a life-style that promotes personal development

From *Denyes, Orem, & Bekel (2001), pp. 49-50; Orem (2001), pp. 224-236.

as well as limitations of its various methodologies (Draper, 2014). Criticisms of the method espoused by Walker and Avant (2011) include the generation of defining attributes or characteristics without exploration of sufficient evidence and creation of cases prior to explication of defining attributes. Other methodological criticism suggests that analyses are often conducted without consideration of context (Fawcett, 2012; Risjord, 2009). To address this issue, Risjord proposed three types of concept analysis: theoretical (using theoretical and related empirical literature to provide context), colloquial (using specific populations as the primary data source), and mixed (a combination of both theoretical and colloquial). In Risjord's approach, evidence for the defining attributes flows from empirical findings that can lead to enhanced understanding. Our methodology is informed by review of these critiques.

As the initial purpose is to understand normalcy as presented by Orem and by those who use her theory as a framework for research, the context for the analysis becomes Orem's Self-Care Deficit Theory of Nursing. After exploration of the concept, normalcy, the universal requisite of promotion of normalcy will be explored.

Search Methodology

Prior to any analysis, a literature search was conducted to identify relevant articles. CINAHL and PsychINFO were searched with the following key words, "normalcy" and "Orem" or "normalcy" and "self-care". The PubMed database was also searched using "normalcy" AND "self care" AND "nursing". These available MeSH search terms in PubMed were most aligned with those used in CINAHL and PsychINFO. Consistent with Orem's first publication (Orem, 1971), the search was limited to the time period of 1971 to the present and to English language publications. Twenty-four articles were identified through CINAHL; forty through PsychINFO with eight through PubMed. There was significant overlap in titles.

Criteria for inclusion. Based on selection of theoretical concept analysis for our method, the criteria for selection of publications was literature framed within Orem's Self-Care Deficit Nursing Theory. This included research articles and dissertations.

All publications were first reviewed for those including an Orem citation in the reference list. Articles whose reference list included one or more Orem citations were then read to determine the extent of theory utilization. This inclusion criterion was defined as application of Orem's theories and concepts, such as self-care requisites, self-care agency, or self-care. Each selected article specifically included some emphasis on the concept, normalcy, or the universal self-care requisite, promotion of normalcy. This review resulted in a total of six publications, with five initially identified through CINAHL and one additional through PsychINFO. PubMed search added no new studies for review.

Quality appraisal. For the purpose of this concept analysis, no quality appraisal was conducted on the selected publications beyond meeting the inclusion criteria. However, the authors noted that all selected studies of normalcy within the context of Orem's Self-Care Deficit Nursing Theory are qualitative studies including use of grounded theory (Raithel, 2000) and hermeneutic phenomenology (Marcuccilli, Casida, & Peters, 2013). These methods traditionally do not incorporate a theoretical perspective to frame the study. An in-depth literature review on the role of theory in qualitative research by Tavallaei and Abu Talib (2010) confirmed the role of theory in various types of qualitative research is not clear and remains subject to debate. After reviewing the hierarchy of evidence for practice generated from qualitative studies (Daly, et al., 2007), we concluded this issue was beyond the scope of this paper.

Concept Analysis Steps

The steps of this theoretical concept analysis attempt to improve on methodological concerns identified above. These iterative steps are as follows:

Step 1: Extrapolate evidence from research studies to identify the defining attributes or characteristics of normalcy
Step 2: Synthesize these findings into one set of defining attributes
Step 3: Create a model case and a contrary case
Step 4. Review Orem's definition of normalcy in relationship to defining attributes of normalcy identified in this concept analysis, and to model and contrary cases.
Step 5. Analyze Orem's general set of actions related to promotion of normalcy to evaluate sufficiency and adequacy in relationship to data from the studies reviewed here.

Step One: Identification of Defining Attributes of Normalcy. In this section, data from the six studies are reviewed for identification of defining attributes of normalcy. This step precedes development of model and contrary cases and is used to provide "theoretical and

empirical justification for selection of the attributes, properties, or dimensions" of the concept (Fawcett, 2012, p. 286). The use of evidence from these studies to identify defining attributes, and then develop model and contrary cases, addresses a major critique of concept analysis (Risjord, 2009).

Ailinger & Dear (1997). In this qualitative study, twelve men and forty-seven women ages 27-79 with mild-moderate severity of rheumatoid arthritis (RA) identified impaired functioning related to normalcy resulting from their condition. Expressions of altered functioning in this study included: "I used to sew all my own clothes but I can't do it anymore; I've changed my ambitions; I buy different clothes and use short haircuts; I used to go hiking and skiing" (p. 137).

From these data, certain themes or defining attributes of normalcy include: *Being able to perform activities consistent with personal interests, including basic functions such as personal care (hair, dressing, etc.), and having realistic expectation of accomplishing goals and ambitions.*

Harris & Williams (1991). The purpose of this qualitative study was to identify USCRs in ten elderly men ages 65-70 living in a homeless shelter. In the analysis of interviews, the two primary USCRs identified were prevention of hazards and promotion of normalcy. Three indicators of normalcy were getting money, keeping clean, and having clean clothes. Data supporting these conclusions are as follows: "There is just not a whole lot of places to wash up everyday, but I do not want to be smelly 'cause folks shun me,'" and "I want and need clothes that are clean and neat. It helps me keep some good feelings 'cause having to ask for everything brings me down'" (p. 41).

Defining attributes of normalcy extrapolated from this study include: *Having enough money to provide for basic needs and being able to achieve positive self-concept through personal hygiene*.

Marcuccilli, Casida, Peters, & Wright (2011). These authors used hermeneutic (interpretive) phenomenology to explore sex and intimacy as essential aspects of normalcy among nine individuals ages 31-70 with implantable left-ventricular assist devices (LVAD).

The authors identified three themes related to [changes in] sexual functioning and intimacy as a result of having received an LVAD: (a) Improved sexual relations with LVAD ("It's just like I didn't have the machine at all"…"sex is better with the LVAD" [p. 507]); (b) Sexual adjustment (self-care behaviors such as use of "protective barriers, like abdominal binders to protect the external components of the LVAD" [p. 507]); and (c) Nonsexual intimacy (represented by married participants no longer engaged in sexual intercourse due to age and/or functional limitations imposed by the LVAD but who have increased connections with their partners through other intimate activities such as holding hands). Marcuccilli and colleagues concluded that these three themes were consistent with the concept of normalcy from Orem's theory of SCDNT.

Defining attributes of normalcy derived from this study include: *Accepting "new normal" due to functional limitations imposed by treatment; engaging in fulfilling sexual and/or nonsexual intimate relationships.*

Marcuccilli, Casida, & Peters (2013). These authors, who reported additional findings from the study conducted by Marcuccilli et al. (2011), explored how 7 men and 2 women age 31 to 70 living at home with implantable left-ventricular assist devices (LVAD) "meet the health-deviation requisite of modifying self-concept to accept this form of treatment and restore normalcy" (p. 2456). They identified two themes consistent with modifying self-concept within Orem's SCDNT: (a) Having LVAD means living (that is, using technology to treat heart failure means being able to continue being alive), for example, "I just looked [at the LVAD] and I think, 'I've got to do this thing the rest of my life.' I realize I have the rest of my life to live now, and I didn't before….I realize it saved my life" (p. 2461); and (b) A desire to be 'normal' in public, for example, "I sometimes wear a different type of jacket so I don't upset people so much, 'cause…(people) get shocked when they see someone with wires stickin' out all over (them)." (p. 2462).

Based on data from this study, the authors reformulated LVAD-specific HDSCR related to self-concept: "1) Modify self-concept by accepting oneself as being in need of technology-assisted living to attain self-acceptance sufficient for continuous engagement in therapeutic LVAD self-care; and 2) Modify self-image to preserve ego integrity and psychosocial-sexual relationships while living with an LVAD" (p. 2458), the latter as suggested by Casida, Peters, and Magnan, (2009).

Defining attributes of normalcy include: *Accepting a "new" normal. Accepting not always being able to do what one used to do. Modifying self-concept to adjust to a new normal.*

Pickens (1999). This secondary analysis of interview data obtained from 6 men and 13 women with serious mental illness was conducted to identify themes related to normalcy. Perception of their mental illness, or how these individuals perceived their deviation from normal, was the first major theme. A second theme identified was the "desire for normalcy," described by wanting

to have normal things and experiences (food, place to live, relationships, transportation, money, education, "better life"; p. 236), doing meaningful activities (work, keeping busy, making "right decisions," participating in "normal" community activities (p. 236) and being well ("get straightened out," "maintain," "be more functional," be "more like self" (p. 236), safe ("hope nobody would hurt me," "do not want to be abused," (p. 236), free (be/stay out of hospital, "not be chased by cops," or go to jail, have freedom to come and go), and independent ("make own decisions," "have own place," be own boss, have/handle own money); also not doing harm to self or others ("not messing up," not using drugs [p. 236]). Self-care actions for promotion and maintenance of normalcy also were identified.

Defining attributes of normalcy extrapolated from this study include: *Having adequate resources and basic necessities of life; having fulfilling relationships. Doing activities that are meaningful. And being well, free to come and go as one wants, and independently able to make decisions. Not harming or being harmed by self or others.*

Raithel (2000). In the only dissertation reviewed for this concept analysis, Raithel used grounded theory to study the "social process of normalcy" (p. 99) described by 18 participants ages 21-50 with moderate to severe asthma. Maintaining health was identified as the central phenomenon of normalcy.

The following statements reflect the importance of maintaining health when living with moderate to severe asthma: "It's like anybody else; you want to be as normal or healthy as you can be" (p.104). "The main key is that I should stay healthy" (p. 105). Part of achieving health maintenance is adjusting to a new normal, for example, "You just have to say, 'Okay, I can't do that anymore. But I can still do things'" (p. 106). "Not that you have to do that [restrictions] all the time. But when it's time that is going to be bothersome in terms of the pollen or whatever it is, you may have to make some adjustment" (p. 106).

Based on data from this study, Raithel reformulated normalcy as "a social process by which individuals strive to maintain health using actions of struggling, experiencing, listening, affirming, changing, and failing, with the consequences of this social process being taking control and caring for oneself" (p. 102).

Defining attributes of normalcy derived from this study are: *Maintaining one's health, which results in taking control and caring for oneself. Adjusting to a "new" normal.*

Step Two: Synthesis of Defining Attributes of Normalcy. Synthesis of the defining attributes of normalcy derived from research findings resulted in six defining attributes as evidence of normalcy:

1. Having adequate resources to provide for the basic necessities of life.
2. Being able to perform activities of daily living and activities consistent with personal interests.

Table 2: Summary of Defining Attributes of Normalcy Derived from Orem-based Research Studies

Author(s)	Defining Attributes of Normalcy
Ailinger & Dear (1997)	Being able to perform activities consistent with personal interests, including basic functions such as personal care (hair, dressing, etc.), and having realistic expectation of accomplishing goals and ambitions.
Harris & Williams (1991)	Having enough money to provide for basic needs and being able to achieve positive self-concept through personal hygiene.
Marcuccilli, Casida, Peters, & Wright (2011)	Accepting "new normal" due to functional limitations imposed by treatment; engaging in fulfilling sexual and/or nonsexual intimate relationships.
Marcuccilli, Casida, & Peters (2013)	Accepting a "new" normal. Accepting not always being able to do what one used to do. Modifying self-concept to adjust to a new normal. Taking action to address stigma.
Pickens (1999)	Having adequate resources and basic necessities of life; having fulfilling relationships. Doing activities that are meaningful. And being well, free to come and go as one wants, and independently able to make decisions. Not harming or being harmed by self or others
Raithel (2000)	Maintaining one's health, which results in taking control and caring for oneself. Adjusting to a "new" normal.

3. Accepting and adjusting to a new normal, including realistic self-concept, due to structural and functional limitations imposed by illness and/or change in conditions of living.
4. Maintaining one's health through making decisions about and implementing care for oneself.
5. Engaging in fulfilling interpersonal relationships.
6. Being safe; not harming or being harmed by self or others.

Step Three: Create a Model and a Contrary Case. A model case is "an example of the use of the concept that demonstrates all the defining attributes of the concept" (Walker & Avant, 2011, p. 163). A model case is a pure exemplar or one that absolutely shows what the concept is (Fawcett, 2012; Walker & Avant). Model cases can be real-life examples, derived from the literature, or constructed by the analyst.

*Model Case of Normalcy**

Jack is a 58 year old male who is married with two grown sons. He was diagnosed with Parkinson's Disease (PD) in 1995. Jack was initially devastated by his diagnosis. He wondered what the effect would be on his functional ability over time, on his role as a husband and father, and on his teaching career as a successful high school math and science teacher. When Jack disclosed his diagnosis to his wife and sons, he was relieved they were supportive and assured him that they would deal with this challenge as a family. Jack was always athletic, being an avid golfer and hiker. He still golfs occasionally although he rides in a cart now and is attentive to his balance throughout the game. He continues to hike everyday while choosing less strenuous routes. He has had to modify some of his self-care routines, such as the way in which he showers, shaves, and dresses but for the most part manages well on his own. He tries to focus each day not on what he has lost, but on what he still has, such as the love and support of his family and friends, his intelligence, his passion for life, and his sense of humor. As he became more symptomatic, Jack retired from classroom teaching and began teaching online courses at a local community college. Despite this work modification, he still receives adequate health insurance through his job and sufficient income to maintain their previous lifestyle. Jack has become an advocate, speaking at local churches and community events to raise money to support research. Jack attends a support group for people living with PD, and experiences a strong sense of connection, solidarity, and shared optimism with others who participate. He expresses a real sense of community now, whereas before the group participation, he felt very alone with his experience of having PD.

Contrary Case of Normalcy

A contrary case is a clear example of what the concept is not. Contrary cases should contain none of the defining attributes (Walker & Avant, 2011).

Georgia is a single, 20 year old female nursing major at a small private liberal arts college in the Southeast. She was diagnosed with anorexia nervosa at age 14 and received inpatient and outpatient treatment during high school. When entering college at age 18, her weight was within normal limits, and she joined the women's track team and also the campus's Global Health Brigade, the latter because of interest in future international healthcare service. Georgia has a 4.0 GPA after three semesters, a rarity at this highly selective school. Since arrival at college, Georgia had difficulty "fitting-in" to the campus environment and changed roommates on several occasions. She now lives in a single dorm room, where she eats many of her meals alone. Georgia also broke off all relationships with her family since arrival at college resulting in loss of their financial support. She also lost her relationship with her twin sister with whom she previously had a close relationship.

In the spring, Georgia began to lose weight, large clumps of her hair fell out, and her track performance declined. A medical evaluation required for team participation revealed a weight <85% of her recommended weight, blood glucose of < 70 mg/Dl, as well as hypochloremia, hypokalemia, and metabolic alkalosis. The coach requested she leave the team for health reasons, which resulted in loss of her college scholarship.

Despite return of symptoms of anorexia nervosa, Georgia views herself as "overweight" and continues to work out daily at the fitness center, running on a treadmill for at least an hour. A nursing faculty member recently referred her back to the health center for evaluation after she fainted during a clinical experience. Despite these overt indicators of illness, she states her weight has not changed and she has no health problems. Georgia recently informed the Global Health Brigade she could not afford participation in the short-term mission to Honduras because of loss of her track scholarship. This inability to participate in the international trip has created

* This model case was adapted from an interview conducted by Marlo Thomas, entitled "The Givers: What Inspires Michael J. Fox? A very Personal Interview," published in the Huffington Post, posted on April 5, 2012, and retrieved at *http://www.huffingtonpost.com/marlo-thomas/michael-j-fox-interview_b_1402876.html).*

significant anxiety about her future goals. This question of safety with clinical performance and inability to participate in the international trip has also created significant anxiety and questions about her future goal of becoming a nurse.

Step Four: Review Orem's definition of normalcy in relationship to defining attributes of normalcy identified in this concept analysis, and to model and contrary cases. Orem (2001) defined normalcy as "that which is essentially human and that which is in accord with the genetic and constitutional characteristics and talents of individuals" (p. 225). In early writings, Orem (1971) also used the term "normality" as a synonym for normalcy, relating it to individuals having knowledge and beliefs of individual human and social norms.

Orem's definition of normalcy is quite broad. This concept analysis has resulted in identification of concrete attributes or characteristics that help to define what it means to be "essentially human". For example, having adequate resources to provide for the basic necessities of life is essential to living a life that would be considered "human" as opposed to "inhumane," or animal. Performing activities required for daily living and activities consistent with personal interests, as well as engaging in fulfilling interpersonal relationships, are uniquely human endeavors. Having a sense of safety, that is, not living in fear of harming or being harmed by self or others is essential to a human being who is in a "normal" state rather than pure survival mode. Orem (2001) described *health* as a holistic concept that comprises biopsychosocial aspects of a person, or "that which makes a person human" (p. 182). She stated that deviation from structural or functional norms is correctly described as absence of health. Therefore, adjusting to altered health state or change in living conditions, and maintaining health within genetic and constitutional characteristics and/or limitations are activities that human beings might be expected to do within the context of individual human and social norms. The defining attributes identified in this concept analysis belong to the "normal" experience of being human. These defining attributes were incorporated into a model case that clearly demonstrated the concept of normalcy in the situation of a life-altering chronic illness. And, a contrary case was developed that clearly demonstrates what normalcy, as defined by Orem, is not. Although these defining attributes are not exhaustive, they provide a beginning description of concrete characteristics of normalcy based on research within Orem's theory.

Step Five: **Analyze Orem's general set of actions related to promotion of normalcy to evaluate sufficiency and adequacy in relationship to data from the reviewed evidence.** The preceding analysis has focused on the concept of normalcy. Orem (2001) also identified a general set or four categories of actions for meeting the universal self-care requisite, promotion of normalcy (p. 227). Data from the six reviewed studies support the general set of actions, as follows:

1. Developing and maintaining a realistic self-concept: Two studies provided evidence for including this general action as essential to the promotion of normalcy. The two actions identified by Harris and Williams (1991) "keeping clean" and "having clean clothes", appear related to self-concept. Without these resources, homeless individuals in this study felt shunned and "brought down". Marcuccilli and colleagues (2013) identified methods used by people with LVAD to modify their self-concepts to meet one category of HDSCR: "modifying the self-concept (and self-image) in accepting oneself as being in a particular state of health and in need of specific forms of health care" (Orem, 2001, p. 235). The action to "accept this form of treatment and restore normalcy" (p. 2456), while having a LVAD clearly seems related both to developing and maintaining a realistic self-concept.

2. Taking action to foster specific human developments: The general sets of actions were identified early in development of SCDNT when Orem named two types of requisites, universal and health deviation. Orem later identified the need for another classification, the developmental self-care requisites. These include two types (Orem, 2001, p. 232): (a) needs that are commonly recognized in the life cycle, such as those in childhood and adulthood and developed by theorists such as Erikson (1950, 1959); (b) needs that occur with specific conditions or adversity, such as poor health or disability, loss of possessions, or oppressive living conditions.

Review of the six studies supports the relationship of promotion of normalcy to both types of developmental requisites: fostering specific human development related to the life cycle as well as when adversity occurs. Data regarding the need for relationships, sexual/intimate (Marcuccilli et al., 2011) or others (Pickens, 1999) reflect select developmental stages identified in Erikson's Developmental Theory. An example is the sixth stage of psychosocial development, intimacy versus social isolation. Wanting to do "meaningful activity," (Pickens 1999) may be related to Erikson's seventh stage, generativity versus stagnation.

Harris and Williams (1991) identified actions necessary to mitigate the effects of homelessness and lack of personal possessions. When

interviewing persons with severe mental illness, Pickens (1999) found the promotion of normalcy related to conditions such as having food, shelter, and relationships, which are all necessary for continued development. Both relate to situations of adversity and support Orem's second type of developmental self-care requisites.

3. Taking action to maintain and promote the integrity of one's human structure and functioning: Orem (2001) distinguished between two concepts, health and well-being. Health is related to "soundness or wholeness of developed human structures and of bodily and mental functioning" (p. 186). This could include absence of disease or ability to function in the presence of disease conditions. The objective notion of health contrasts with the perceived condition of well-being, such as contentment, pleasure, happiness and movement towards one's ideal.

When studying patients with severe asthma, Raithel (2000) identified the theme of "maintaining one's health, which results in taking control and caring for oneself". Patients avoided pollen and other triggers in an effort to maintain both structural health and also function with the disability. Raithel also suggested proposed an alteration to Orem's definition, defining normalcy as "living in such a way as to maintain human functioning and continued development in order to promote a sense of well-being" (p. 12). This suggests support for not only functioning but promoting well- being.

4. Identifying and attending to deviations from one's structural and functional norms: Evidence from the studies fully supports this general action as it relates to physical and mental deviations from structural and functional norms and to developmental situations related to adversity. For example, participants in the study by Marcuccilli et al. (2011) identified and attended to deviations from structural and functions norms by developing self-care actions "to adjust and enhance sexual activity and intimacy and to promote normalcy and sustain overall health and well-being while living with an LVAD" (p. 509).

Participants' perceptions of their mental illness, or how they perceived their "deviation from normal", was a major theme in the study by Pickens (1999). This theme was represented by some participants' description of their mental illness in diagnostic terms, such as: "I'm bipolar manic depressive". Symptoms were also used to describe mental illness: ""I'm hearing voices," "I think I get a little bit paranoid". Some used vernacular terms: "I got sick"; "I had a nervous breakdown" (p.235). Self-care actions taken to promote normalcy included taking action to gain knowledge about the illness, seeking treatment, and taking medications.

When studying patients with chronic asthma, Raithel (2000) identified "struggling to attain (the social process of) normalcy (as) an endeavor which involved the informants' recognizing their symptoms and accompanying disruption of their activities, followed by initiating self-care which generally resolved the attack" (p. 109). For example, one participant identified "knowing your limitations" and learning to say no (p. 105).

Discussion

This section highlights four discussion areas: (a) the strengths and limitations of this concept analysis; (b) additional approaches that may further explicate the concepts of normalcy and promotion of normalcy; (c) the need for identification and development of instruments to measure various aspects of normalcy; and, (d) the interrelationships of the defining attributes of normalcy to the elements of universal, developmental, and health deviation self-care requisites and their concomitant sets of actions.

The methodology used for this concept analysis addressed critiques of concept analysis processes. First, context was added by framing the analysis within one theory, Orem's Self-Care Deficit Nursing Theory and selecting evidence from studies using SCDNT for this context. This evidence from the cases within the studies led to identification of the defining attributes and creation of a model and a contrary case.

This concept analysis of normalcy and beginning identification of actions related to promotion of normalcy has a number of limitations. One of the major constraints is the limited amount of empirical work that has been done on the concept of normalcy within Orem's general theory of nursing. As a result, only six articles were available to inform our theoretical concept analysis. This clearly identifies the need for more research related to normalcy and promotion of normalcy within the framework of Orem's SCDNT.

One useful endeavor would be exploration of non-Orem literature, both nursing and non-nursing, that refers to related concepts, such as normal, normality, normalization, and "normalcy". This approach would expand the literature from which to explore the concept of normalcy and contribute to further development of Orem's conceptualization of normalcy and actions that promote normalcy.

A second type of concept analysis, colloquial concept analysis, could be used by delimiting the target population (Risjord, 2009). For example, one could explore all nursing and non-nursing literature on normalcy and related terms for one population such as persons with severe mental

illness. Further, exploring how concepts related to normalcy are operationalized and how they are measured could provide important insight for additional studies.

It is evident that the concepts, normalcy and promotion and maintenance of normalcy, are difficult to measure. Related to this, Orem (2001) asked about positive indicators of psychological, cognitive, or biological aspects of promotion of normalcy. What might these be? Greater specificity in identification of the attributes of normalcy and promotion of normalcy may provide "indicators" of these concepts and lead to valid measurement. For example, accepting and adjusting to a new normal, including realistic self-concept, due to structural and functional limitations imposed by illness and/or change in conditions of living, is one of the defining attributes of normalcy identified in this concept analysis. Since there are many tools available to measure self-concept, it would be reasonable to utilize one of these tools to assess the effect of nursing actions to promote normalcy related to self-concept.

Evidence from the literature supported the set of four general actions proposed by Orem for promotion of normalcy. What was apparent from the studies was the relationship of the defining attributes to the elements of universal, developmental, and health deviation self-care requisites, including their sets of actions. For example, Harris and Williams (1991) identified getting and taking prescription medications as prevention of hazards, while Pickens (1999) identified this same action as promotion of normalcy. Other researchers provided strong support for actions to promote normalcy that meet Orem's two types of developmental self-care requisites, that is, those related to the life cycle and those that occur during periods of adversity.

Another defining attribute, "realistic self-concept," suggests a relationship to health deviation self-care requisite 5, "modifying the self-concept (and self-image) in accepting oneself as being in a particular state of health and in need of specific forms of health care" (Orem, 2001, p. 235). For example, the way in which Marcuccilli and others (2013) addressed self-concept seemed to relate either to the first action identified in Orem's general set of actions for promotion of normalcy, "developing and maintaining a realistic self-concept," or to "modifying the self-concept (and self-image) in accepting oneself as being in a particular state of health and in need of specific forms of health care," a HDSCR. Additionally, the authors identify "desire to be normal in public" as a means to address self-concept/image for people with LVAD. This suggests the close relationship, or interrelationship between USCR promotion of normalcy and HDSCR. These observations are consistent with Orem's statements that "evidence of health deviation leads to demands for determining what should be done to restore normalcy," and "health deviations may bring about feeling of illness or of not being able to function normally" (2001, p. 233).

Conclusion

This theoretical concept analysis examining "normalcy" within the context of Orem's Self-Care Deficit Nursing Theory led to identification of six major defining attributes of normalcy and development of model and contrary cases. Orem's four categories or set of actions for promotion of normalcy were supported through the analysis of extant literature. The analysis also supported the interrelationships among and within various types of self-care requisites. Recommendations for the future study include additional research framed within Orem's SCDNT, exploration of normalcy beyond Orem's theoretical perspective including beyond the nursing literature, and development or utilization of new or existing research tools. Future study should also include colloquial analysis of distinct populations with the ultimate objective to promote normalcy of individuals and social groups with similar health conditions. ■

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Conceptualizing Cognitive-Behavioral Therapy as a Supportive-Educative Nursing System for Patients with Insomnia

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Abstract

Difficulty initiating and maintaining sleep is one of the most common health complaints of the general population. Approximately 35-50% of people experience occasional insomnia symptoms (Walsh et al., 2011) while 12-20% have insomnia disorder (Morin, et al., 2011; Roth et al., 2011). An effective treatment is cognitive behavioral therapy for insomnia (CBT-I; Schutte-Rodin, Broch, Buysse, Dorsey, & Sateia, 2008), a non-pharmacological, evidence-based intervention aimed at changing sleep behaviors. The purpose of this paper is to frame CBT-I as a nursing intervention for insomnia within the context of Orem's self-care deficit nursing theory (Orem, 2001). Orem's theory provides a framework from which to view the process of improving patients' sleep using CBT-I as a supportive-educative nursing system. Through the therapies of CBT-I, patients develop the power components of self-care agency resulting in behavior change, which is consistent with Orem's notion of deliberate action and self-care. Because holistic patient care, support, and patient teaching are fundamental aspects of nursing care to which nurses are acculturated, nurses are ideally suited to provide CBT-I.

Keywords: Orem, self -care deficit nursing theory, insomnia, cognitive-behavioral therapy for insomnia

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Applying Orem's (2001) theory to practice builds the science of nursing by making linkages between theory and practice. The purpose of this paper is to link a nursing intervention for insomnia within the context of Orem's theory, thus showing that nurses have developed capabilities to implement this nursing intervention. This nursing intervention, cognitive behavioral therapy for insomnia (CBT-I), is one area that has not been addressed using Orem's theory. CBT-I is a non-pharmacological, evidence-based treatment for insomnia. Although nurses are well-positioned to implement CBT-I, their involvement has been limited.

After providing an overview of insomnia and CBT-I, a supportive-educative nursing system for patients who have insomnia is described based on the theoretical concepts of basic conditioning factors, self-care requisites, self-care agency, self-care, health, and well-being. CBT-I helps patients who have insomnia develop their self-care agency to meet the self-care requisite of balance of sleep/rest and activity and other self-care requisites that are inherent in having insomnia.

Overview of Insomnia

Difficulty initiating and maintaining sleep is one of the most common health complaints of the general population. Approximately 35-50% of people experience occasional insomnia symptoms (Walsh et al., 2011) while 12-20% have insomnia disorder (Morin et al., 2011; Roth et al., 2011). Risk factors for insomnia include female gender, older age, and shift work (Schutte-Rodin, Broch, Buysse, Dorsey, & Sateia, 2008). Insomnia is associated with psychiatric illness such as mood disorders as well as medical problems of the cardiovascular, pulmonary, and gastrointestinal systems (National Institutes of Health (NIH), 2005). People who have insomnia seek medical care more often and use more over-the-counter medications than those without sleep problems. Quality of life is often impaired due to the consequences of insomnia as well as its treatment (NIH). Societal effects of insomnia include reduced productivity, increased absenteeism, and increased healthcare costs (Kessler et al., 2011; Sarsour, Kalsekar, Swindle, Foley, & Walsh, 2011).

The most common treatments used by insomnia sufferers are over-the-counter antihistamines, alcohol, and prescription medications (NIH, 2005). Studies have demonstrated that hypnotic medications, most often benzodiazepine receptor agonists (BZRAs), are efficacious for the short-term treatment of insomnia but their effects are not long lasting (Riemann & Perlis, 2009; Siversten et al., 2006; Soeffing et al., 2008). Hypnotic medications are intended to alleviate insomnia symptoms only while medications are being taken, they do not "cure" insomnia (NIH, 2005). Moreover, results from a meta-analysis showed that approximately half of the effect of hypnotic medication can be attributed to the placebo effect (Huedo-Medina, Kirsch, Middlemass, Klonizakis, & Siriwardena, 2012).

Huedo-Medina et al. (2012) suggest that because side effects of hypnotic medications, such as residual sedation, cognitive and motor impairment, dependence, and rebound insomnia are common, attention should be given to psychological interventions for insomnia. Non-pharmacological treatment of insomnia, particularly CBT-I, has been a focus of recent insomnia research. Evidence consistently supports the efficacy of CBT-I for improving quantity and quality of sleep with positive long-term effects (McCurry, Logsdon, Teri, & Vitiello, 2007; Reimann & Perlis, 2009; Schutte-Rodin et al., 2008; Siversten et al.; Soeffing et al.). For patients who experience pharmacological treatment-resistant chronic insomnia, CBT-I combined with hypnotic medication has shown superior results compared to medication alone (Okajima et al., 2013). Additionally, these patients have been able to decrease hypnotic medication usage when CBT-I is added to treatment. In clinical guidelines for insomnia, CBT-I is recommended as first-line treatment for older adults who have primary insomnia (Baker et al., 2014) as well as for adults who have chronic primary and comorbid insomnia, including those who have used hypnotic medications on a long-term basis (Schutte-Rodin et al., 2008).

Cognitive-Behavioral Therapy for Insomnia

CBT-I is a psychological and behavioral treatment that addresses the underlying causes of insomnia, which is most commonly due to learned thoughts and behaviors that disrupt sleep (Edinger & Carney, 2008). Examples of underlying causes include distorted thoughts or inaccurate beliefs about insomnia, feelings of powerlessness and anxiety related to sleep, spending too much time awake in bed, and lying in bed frustrated and tense. CBT-I works by replacing maladaptive thoughts and behaviors with more effective ones. The term CBT-I refers to the use of cognitive therapy plus at least one behavioral intervention. Various behavioral interventions are used including sleep hygiene education, stimulus control therapy, sleep restriction therapy, and relaxation therapy. Most often, a combination of several therapies is provided over a period of several weeks (Schutte-Rodin et al., 2008). CBT-I can be conducted individually, in group sessions, and in self-help formats. A course of CBT-I may last anywhere from 1 to10 weeks, with each session lasting 30 minutes to 2 hours.

Cognitive Therapy

A major feature of chronic insomnia is anxiety related to distorted thoughts about lack of sleep and the effects insomnia has on one's ability to function during the day. Anxiety leads to increased emotional and physiological arousal, which perpetuates insomnia. Typical thoughts about insomnia, such as "I can't function tomorrow if I don't get 8 hours of sleep tonight" become habitual and automatic so patients are usually not consciously aware of them. Cognitive therapy (CT) involves educating patients about sleep and teaching them how to consciously replace distorted, negative sleep-related thoughts with more accurate, positive thoughts. This involves didactic instruction and homework, such as the use of a thought record (Edinger & Carney, 2008).

Behavioral Therapies

A variety of behavioral therapies are known to effectively treat insomnia. Sleep hygiene education (SHE) is the most basic behavioral therapy for insomnia and consists of recommendations such as: (a) limiting caffeine and alcohol use, (b) regular exercise that is not close to bedtime, (c) consuming a light carbohydrate snack before bed, and (d) keeping the sleeping environment quiet, dark, and cool. These are the most common behavioral interventions provided by primary care providers to people with insomnia (Edinger & Carney, 2008); however, SHE alone has not been found to be effective in improving insomnia (Schutte-Rodin et al., 2008).

One behavioral therapy that is often combined with SHE is stimulus control (SC) therapy, which is a behavioral approach that increases the association between bedtime/the bed and restful sleep. Instructions for SC include going to bed only when sleepy, using the bed only for sleep or intercourse, and leaving the bed if awake for more than 30 minutes and returning to bed when sleepiness returns. This therapy attempts

to "undo" the conditioning that occurs when excessive time is spent in bed tossing, turning, and worrying. With repeated use of these behaviors, a new association is created wherein the bed and bedtime is positively associated with sleep (Perlis, Jungquist, Smith, & Posner, 2005).

Another behavioral therapy, known as sleep restriction (SR) therapy, requires that patients limit their time in bed to the average amount of time they typically spend asleep (Perlis et al., 2005). For this behavior therapy, patients keep sleep diaries for 2 weeks to determine the average amount of time spent asleep and awake in bed. Patients choose a fixed wake time and then go to bed at a time that allows for them to be in bed no greater than 1 hour more than their average total sleep time. This therapy results in a sleep phase delay as patients must stay awake according to the time in bed prescription while awakening at the same time each morning. SR is believed to be effective for two main reasons. First, it eliminates the tendency for patients to spend extended time lying awake in bed resulting in the conditioned response of wakefulness at bedtime. Second, the lack of sleep that initially occurs with this therapy results in an increased homeostatic pressure, or drive, for sleep. This increased sleep drive allows patients to initiate sleep more easily (Perlis et al., 2005).

Relaxation therapy (RT) is a behavioral treatment used to help reduce hyperarousal that often accompanies insomnia. Many approaches, behavioral or cognitive, are used to achieve the general goal of helping patients relax (Summers, Crisostomo, & Stepanski, 2006). Progressive muscle relaxation and breathing exercises utilize specific behaviors to reduce somatic symptoms such as muscle tension. Relaxation can also be achieved with the use of guided imagery, a cognitive approach, during which patients imagine a relaxing, multisensory experience to induce a relaxed state (Perlis et al., 2005).

Conceptualization of Orem's Self-Care Deficit Theory for Care of Insomnia

According to Orem (2001), nursing care is needed when persons are unable to provide adequate self-care to maintain health, recover from illness or injury, or effectively manage the consequences of disease or injury. Three theories contribute to Orem's self-care deficit nursing theory: (a) the theory of self-care, (b) the theory of self-care deficit, and (c) the theory of nursing systems.

Theory of Self-Care

Basic conditioning factors. The central idea of the theory of self-care (Orem, 2001) is that self-care is learned and deliberately performed in accordance with individuals' self-care requisites and abilities. The ability to perform health-sustaining activities is affected by human and environmental factors called basic conditioning factors (BCFs), which include age, patterns of living, environmental issues, and availability of resources. Consideration of BCFs is essential to obtaining a holistic assessment of patients' capabilities for self-care. For patients with insomnia, age, gender, lifestyle behaviors, sleeping environment, and health problems are BCFs that may contribute to sleep problems.

Self-care requisites. Self-care is performed for the purpose of meeting self-care requisites. Self-care requisites are divided into three categories: (a) universal, (b) developmental, and (c) health-deviation (Orem, 2001). All three types of self-care requisites are affected for individuals diagnosed with insomnia (See Table 1).

Universal self-care requisites. Universal self-care requisites are those necessary for all individuals to sustain health and well-being throughout the life cycle. Balance between activity and rest is a universal self-care requisite that predominates when a person has chronic insomnia. Orem (2001) stated, "a balance between activity and rest controls voluntary energy expenditure, regulates environmental stimuli, and provides variety, outlets for interest and talents, and the sense of well-being that comes from both" (p. 226). Persons with chronic insomnia often have fatigue which leads to inactivity. Over time, reduced activity decreases sleep drive and ability to maintain deep sleep (Schutte-Rodin et al., 2008). This process perpetuates poor sleep further disturbing the balance between activity and rest. Poor sleep decreases quality of life and productivity (NIH, 2005), thereby impacting the universal self-care requisite of preventing hazards to human life, human functioning, and human well-being (Orem, 2001). Chronic fatigue can impair abilities of individuals to function safely and impart feelings of anxiety and ineffectiveness. The universal self-care requisite of normalcy may also be unmet due to fatigue because individuals may not have the energy to meet their full potential. Engagement of self-development can be limited by insomnia because positive mental health is not promoted.

Developmental self-care requisites. Developmental self-care requisites involve changes throughout the lifecycle and the need to cope with stresses that accompany life changes (Orem, 2001). Throughout life, health behaviors may need to be adjusted due to developmental issues, health changes, or external factors. Insomnia can interfere with conditions that promote

Table 1: *Self-Care Requisites for Persons with Insomnia*

Universal
Balance between activity and rest
Prevention of hazards to human life, human functioning, and human well-being
Normalcy
Developmental stages of adulthood
Sleep disruptions related to parenthood
Sleep pattern changes related to shift work
Sleep changes related to aging
Health deviation
Seeking and securing appropriate medical assistance
Awareness and attention to effects of insomnia
Awareness and attention to the relationship between anxiety and insomnia
Effectively carrying out therapies of CBT-I
Awareness and attention to side effects of hypnotic medications
Accepting a self-concept that one has the ability to change sleep-related behaviors

development. For example, insomnia may be precipitated by the birth of a child when parents must adjust to sleep interruptions related to infant care. Another developmental self-care requisite for adults may involve sleep pattern changes that result for working individuals who work night and/or rotating shifts. As individuals age, they awaken frequently due to elimination needs and discomfort. These frequent interruptions can make it difficult for individuals to go back to sleep and diminishes the amount of solid sleep obtained (*Teodorescu*, 2014).

Health deviation self-care requisites. Health deviation self-care requisites exist when nursing care is needed due to illness or injury (Orem, 2001). Orem has identified categories of health-deviation self-care requisites that are relevant to patients experiencing chronic insomnia. Insomnia patients spend time and energy seeking and securing health care treatment. They are acutely aware of the effects insomnia has on their health and well-being. Lack of sleep contributes to states of anxiety and depression, which forms a vicious cycle with insomnia. Persons with insomnia become anxious causing states of arousal that make it difficult to obtain good sleep. In turn, the effects of poor sleep increase their anxiety. When patients engage in CBT-I, they must learn to effectively carry out the therapies to manage their sleep. Additionally, they must attend to the side effects caused by hypnotic medications.

Orem (2001) identified the need to modify "self-concept (and self-image) in accepting oneself as being in a particular state of health and in need of specific forms of health care" (p. 235). One goal of CBT-I is to help patients perceive that they have the power to modify their behaviors to promote healthy sleep. Patients often perceive that the cause of insomnia is external to them and that getting a prescription will cure them; however, hypnotic medications are a short-term solution. Insomnia patients are often preoccupied with sleep loss and impaired daytime functioning, but are unaware of how their own behaviors are contributing to the problem. Through CBT-I, nurses can assist patients to identify health-deviation self-care requisites and perform self-care by increasing self-care agency.

Self-care agency. Self-care agency, a foundational concept of self-care deficit nursing theory, is essential to working effectively within the supportive-educative system (Orem, 2001). Self-care agency, defined as a complex, learned capability to engage in self-care, can be conceptualized as a repertoire of actions individuals have learned through daily life experiences and the instruction of others (Orem, 2001). Capability, which depends on having the power to take action to achieve specific goals, is affected by BCFs such as age, gender, lifestyle, and health problems. To determine patients' self-care agency, it is important that nurses know which human capabilities empower patients to perform self-care. Orem has identified 10 "power components" necessary for patients to engage in self-care operations. Several of the power components are relevant to patients' ability to use CBT-I effectively.

The first power component, maintaining attention and vigilance to self-care (Orem, 2001), is integral to making necessary behavior changes for CBT-I to be effective. Most of the

work of CBT-I is done independently by patients in their home environments and requires consistency and diligence to be successful. It is important for nurses to convey to patients that they are ultimately in charge of their own self-care and responsible for making changes in their sleep habits. Patients who do not have the internal resources to maintain vigilance, such as those with severe depression, are not likely to be successful with CBT-I. Likewise, patients may need to alter external conditions, such as sleeping with a snoring spouse, to operationalize effective self-care behaviors. Simply conceptualizing oneself as a self-care agent and paying attention to self-care behaviors may be an important cognitive change for many patients.

Orem's (2001) fifth power component, motivation, involves setting self-care goals that align with the meaning self-care holds for individuals in terms of life, health, and well-being. Patients must be able to identify their own goals for insomnia treatment and be willing to do the work necessary to achieve them. Again, it is imperative that patients understand that the decision to change sleep-related behavior is theirs and success of treatment is largely dependent on their adherence to the therapies.

The sixth power component involves "the ability to make decisions about care of self and to operationalize these decisions" (Orem, 2001, p. 265). Deliberate action requires that individuals make decisions about their health and the activities they will do to achieve it. For example, people who have insomnia must make a decision to seek treatment to improve their sleep. Once having made a decision, they must have the capacity to find a healthcare professional, attend an appointment, follow-up on a referral to a behavioral sleep specialist, and begin CBT-I.

Once individuals are connected with a behavioral sleep specialist, they are obtaining technical knowledge from an authoritative source which is one aspect of Orem's (2001) seventh power component. "The ultimate success of CBT-I depends on patients' willingness, ability, and motivation to learn and implement behavioral changes at home" (Edinger & Means, 2005, p. 551). A well-planned program of CBT-I wherein content is introduced sequentially allows for integration of skills before teaching new material. Nurses can assess patients' progress and support their learning. Discussion of the effectiveness of new skills and ways to overcome obstacles helps patients solidify new knowledge and skills.

Support throughout the duration of CBT-I facilitates the last power component, the ability to consistently perform new self-care behaviors and integrate them into everyday life (Orem, 2001). New behaviors take practice to become habits. Providing a program over an adequate time period assists in ensuring patients "stay on track" and practice new behaviors to achieve the ultimate goal of integrating effective self-care behaviors into their lives. Adherence to treatment instructions is positively associated with patients' perceptions of self-efficacy (Edinger & Means, 2005). Thus, fostering development of self-care agency with an emphasis on patient choice and autonomy may be an effective approach to achieving treatment adherence.

Learning and using knowledge are essential for self-care (Orem, 2001). People acquire power components, which are necessary for the development of self-care agency, throughout life. Therefore, by assisting patients to develop power components pertinent to good sleep behaviors, nurses can enhance patients' self-care agency (see Table 2). The ultimate exercise of self-care agency is deliberate action, described as goal-seeking activity. Deliberate action, taken with an end-result in mind, is based on "investigation, reflection, and judgment" (Orem, 2001, p. 272) of the current situation.

Understanding the evolution of insomnia and the rationale for CBT-I provides a foundation for self-care related to insomnia treatment. The success of interventions such as CBT-I depend on the development of self-care agency for the ultimate goal of deliberate action for effective self-care to occur.

Self-care. According to Orem (2001), self-care is the practice of activities individuals do for themselves to maintain life, health, personal development, and well-being. Effective self-care for good sleep includes behaviors consistent with the therapies of CBT-I. Individuals who are able to balance rest and activity practice self-care. Self-care is ineffective or absent for individuals who have developed negative sleep habits.

Health and well-being. Health describes living things "when they are structurally and functionally whole or sound" (Orem, 2001, p. 181). Good sleep is an important aspect of health. Studies have shown an association between insomnia and frequent use of health care services as well as increased work absences and decreased productivity (NIH, 2005). Well-being is defined as a perception about one's "contentment, pleasure, and kinds of happiness, as well as spiritual experiences, movement to fulfill one's self-ideal, and continuing development" (Orem, 2001, p. 524). As previously described, there is ample evidence showing that insomnia negatively impacts well-being.

Table 2: *Power Components Necessary for Effective Sleep Behaviors*

Power component 1: Maintaining attention and vigilance
Keeping a sleep diary Altering environmental factors
Power component 5: Motivation
Setting sleep goals: establishing regular sleep pattern, discontinuing hypnotic medication, increased sleep time, improved well-being Manage sleep behaviors
Power component 6: Make and operationalize decisions
Seek treatment Follow-up with referrals Implement recommended therapies
Power component 7: Acquire and operationalize technical knowledge
Attend CBT-I sessions Practice new behaviors at home
Power component 10: Consistently perform self-care operations
Integrate new behaviors at home Avoid relapse to former sleep habits

Theory of Self-Care Deficit

Orem (2001) proposed a theory of self-care deficit to explain what happens when individuals are unable to perform self-care to meet their therapeutic self-care demand. This theory helps explain why individuals require nursing care. Individuals have a self-care deficit when they have developed negative sleep habits and are unable to maintain a balance between rest and activity. They may lack knowledge about proper sleep habits or lack the ability to change their sleep behaviors. Their therapeutic self-care demand may be increased due to developmental and health-deviation self-care requisites resulting from insomnia. They may become frustrated and anxious, thereby perpetuating the sleep problem. These individuals can be helped by providing CBT-I to meet the therapeutic self-care demand resulting from insomnia.

Theory of Nursing Systems

Nursing care varies from providing complete care for totally dependent patients in hospital settings to providing support and education for patients living independently in the community. Orem (2001) describes three nursing systems: (a) wholly compensatory, when a patient is unable to perform any self-care and is dependent on others; (b) partially compensatory, when a patient is able to complete some aspects of care but requires assistance from others; and (c) supportive-educative, when a patient is able to perform self-care but requires guidance and assistance in decision making, behavior management, and teaching. Psychological and behavioral interventions, such as CBT-I, fall within the supportive-educative system of Orem's theory (2001). When a person with chronic insomnia lacks the ability to perform self-care, nurses can implement CBT-I as a supportive-educative system. Guiding, directing, and providing psychological support using CT, SHE, SC, SR, and RT are ways nurses care for patients. Figure 1 provides a visual illustration of Orem's self-care deficit nursing theory with respect to CBT-I.

Conclusion

Nurses can use Orem's (2001) self-care deficit nursing theory to conceptualize CBT-I as a supportive-educative nursing intervention that fosters self-care agency, and ultimately, effective self-care behaviors related to sleep. Because holistic patient care, support, and patient teaching are fundamental aspects of nursing care to which nurses are acculturated, nurses are ideally suited to provide CBT-I. Orem's theory provides

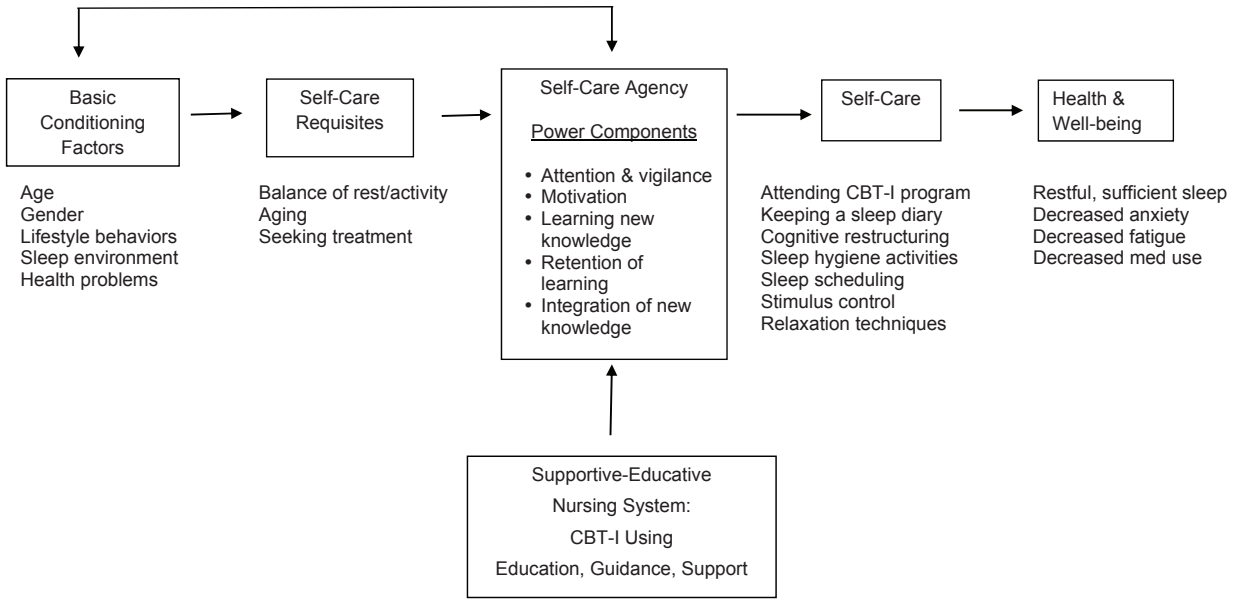

Figure 1. CBT-I Described Using Orem's Self-Care Deficit Nursing Theory

a framework from which to view the process of improving patients' sleep using CBT-I as a supportive-educative nursing system. ■

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Use of Orem's Self-Care Deficit Nursing Theory at University of Chicago Medicine

In committing to the American Nurses Credential Centers' (ANCC) Magnet recognition program, nurses at the University of Chicago Medicine (UCM) started their Magnet journey by collaborating to identify a nursing theorist who would fit the collective personality and sense of professionalism of the nursing staff. During quarterly workshops, the nursing shared governance staff leaders reviewed the literature on nurse theorists and led open forum discussions. Eight theorists/theories were originally presented and discussed and after careful consideration, the staff determined that Dorothea Orem's Self-Care Deficit Nursing Theory (SCDNT) was the theory that the nurses identified as reflecting the collective practice of UCM nurses, both in the inpatient and outpatient/ambulatory arenas. Orem's theory supports the work of UCM nurses to:

- promote primary healthcare and education to maintain one's health within one's community,
- deliver acute nursing care while in the hospital when patients are acutely ill and need to be supported until they are restored to a level of self-care to be able to return home, and
- provide dignified, supportive care, and caring through the end of life.

Orem's SCDNT paved the journey for open forum discussions on the UCM Nursing Professional Practice Model (PPM):

The professional practice model (PPM) schematic reflects the individual nurse and her/his dedication to delivering high quality patient care as a member of the interprofessional team and a commitment to professional life-long learning. The PPM is the driving force of UCM nurses and nursing care. The model depicts how UCM nurses practice, collaborate, communicate, and develop professionally to provide the highest quality care for patients. The model describes the professional nurse and how she/he practices autonomously based on the unique needs and attributes of the patient and family. We like to refer to the oval shape in the center as "O for Orem!"

We wanted to apply SCDNT in a way that was compatible with available resources and provided concrete ways that the theory could guide nursing practice. After presentations and discussions with nurses in the Center for Nursing Processional Practice and Research (CNPPR) and in Unit Based Council meetings, we developed a two-page document providing nurses with information about the three essential theories (self-care, self-care deficit, nursing systems), key concepts with definitions and examples, key points of the theory, and nursing systems with an exemplar. This information will be posted on the intranet shared governance website and on nursing unit/clinic bulletin boards. All presentations provided by the CNPPR, in-person and computer-based training, includes information about how the SCDNT frames the content of the presentation. During this implementation process, nurses commented about the importance of using a nursing theory, and in particular the SCDNT, to highlight the professionalism of nursing in providing holistic care for the patient and family, and how the theory guides practice in a variety of clinical settings—in particular for patient education.

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CALL FOR PAPERS

Self-care, Dependent-Care, & Nursing (SCDCN) 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.

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-care and dependent-care.

Author Guidelines

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 (6th 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.

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 co-editor, **Dr. Mary L.White** at **whiteml@udmercy.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. ■

Call for New Scholar Papers

The purpose of the *New Scholar Papers* feature is to foster the advancement of nursing science and scholarship in the area of Orem's Self-Care Deficit Nursing Theory through the recognition of developing scholars.

New Scholar Qualifications

- Member of the Orem International Society (Apply for membership at: http://oreminternationalsociety.org/
- Enrollment in or completion of nursing graduate studies
- Scholarly productivity related to the advancement of nursing science and scholarship in the area of Orem's Self-Care Deficit Nursing
- Submission of letters of support

Recognition of New Scholars

- Each *New Scholar* will be featured in an issue of *Self-Care, Dependent-Care & Nursing*, the official online journal the Orem International Society for Nursing Science and Scholarship. The OIS will award the scholar a complimentary membership.

Submission of Papers

Papers will be submitted using the *Author Guidelines*. ■

Orem Collection in the Alan Mason Chesney Medical Archives at Johns Hopkins University Medical Institutions

Below are the links for The Dorothea Orem Collection, which is now live on the Alan Mason Chesney Medical Archives at Johns Hopkins University Medical Institutions website: http://www.medicalarchives.jhmi.edu/papers/orem.html

Complete Finding Aid: http://www.medicalarchives.jhmi.edu/finding_aids/dorothea_orem/dorothea_oremd.html

The related Joan Backscheider Collection description is also available. http://www.medicalarchives.jhmi.edu/papers/backscheider.html

Complete Finding Aid: http://www.medicalarchives.jhmi.edu/finding_aids/joan_backscheider/joan_backscheiderd.html ■

New Publications

FOUNDATIONS OF PROFESSIONAL NURSING: Health and Self-Care

Authors: Katherine Renpenning, Susan Taylor, Judith Pickens.

Available on May 28, 2016

Students transitioning to BSN will be provided with content that helps them see nursing as a profession with a disciplinary knowledge base. This book provides direction for thinking from a nursing perspective in all situations of nursing practice and clinical settings. The early chapters present information on change and the development of nursing. The basic view is that of a complex systems approach. Although it will be particularly useful for programs for students transitioning from RN to BSN, it will also be of interest to nurses and other healthcare professionals who are interested in the science of self-care.

This text addresses what the authors view as fundamental requirements for nursing education today:

1. Educational models and resources that enable the practitioner to apply fundamental concepts across all settings, in a variety of clinical situations, and care settings.

2. Thinking from a nursing perspective and from a systems perspective are foundational to nursing practice.

3. Importance of interaction among science of self-care, foundational nursing sciences and nursing practice sciences in the development of nursing knowledge and evidence based practice.

4. Demonstrating for the student The use of knowledge from other disciplines is an essential aspect of teaching in baccalaureate education. ■

Review Panel