Self-Care and the Developmental & Family Life Cycle Theory: A Working Framework

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Abstract

The purpose of this paper is to explore and understand how the Developmental and Family Life Cycle Theory and Orem's Self-Care Deficit Theory can be used by advance practice nurses (APNs) as a framework for family health assessment, family nursing interventions, and outcome evaluation. This paper will explore the differences and similarities between the two theories, their usefulness in family education, and family functioning. Lastly, the strengths identified in both theories will be extracted to form a working model for APNs in the context of community health nursing using a specific example from the perspective of an APN.

Keywords: self-care, self-care deficit, nursing systems, nurse, family development, family life cycle, family-centered care

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Nurses have an ethical obligation to ensure recipients of healthcare services – whether an individual, family, group, community, or population – are their primary commitment (American Nurses Association, 2015). Nurses strive to promote the health of individuals, families, and the respective communities in which they live. Particularly, family health nurses who work in the community, are uniquely positioned to help improve the health of families as well as facilitate family adaptation during chronic illness. Kaakinen et al. (2018) explain that individuals within a family and the family unit as a whole, develop and change overtime – the family life cycle. Therefore, it is incumbent on nurses working with families to understand the normal changes and experiences that occur in families and individuals over a lifetime. The Developmental and Family Life Cycle Theory provides a framework to accomplish that goal. Dorothea Orem's Theory of Self-Care – which includes three interrelated theories – is a conceptual model where the family is seen as a conditioning unit that influences an individual's self-care system. Orem believed that an individual or families' ability to provide self-care, whether it be performing personal care needs or performing tasks necessary to manage chronic disease processes, is imperative to maintain life, health and overall wellbeing. In the context of community nursing – where the main approach to family nursing is family-centered care (FCC) – the Developmental and Family Life Cycle Theory and Orem's Theory of Self-Care, gives nurses the guidance they need for family assessment, nursing interventions and evaluation.

Dorothea Orem was a nursing scholar who dedicated her life to creating and developing a theoretical structure to improve nursing practice. Very early in her work, Orem became aware of the nurses' ability to "do nursing", but their inability to describe nursing to administrators, physicians, and colleagues (Hartweg & Fleck, 2010). Orem believed that without this

understanding, nurses could not improve nursing practice (Hartweg & Fleck, 2010). In an attempt to answer the question – "What condition exists in a person when judgements are made that a nurse(s) should be brought into the situation (i.e., that a person should be under nursing care)?" (Orem, 2001, p. 20) – Orem expressed the formal object of nursing described as:

> The condition is the inability of persons to provide continuously for themselves the amount and quality of required self-care because of situations of personal health. With children it is the inability of parents or guardians to provide the amount and quality of care required by their child because of their child's health situation. (Orem, 2001, p. 20)

Orem sought to understand the phenomena she observed, creating conceptualizations of nursing education, disciplinary knowledge, and ultimately formulating a general grand theory of nursing known as the Self-Care Deficit Nursing Theory (SCDNT) (Parker & Smith, 2010).

Orem's general theory of nursing – SCDNT – comprises of three interdependent theories: The Theory of Self-Care, Theory of Self-Care Deficit, and the Theory of Nursing Systems. Orem believed that general theories are not invariable, but rather guide the work of scholars, practitioners, and researchers leading to improvements and better understanding (Taylor & Renpenning, 2011). For a practical science such as nursing, the development of the SCDNT encompasses not only the "what" and "why", but also the "who" and "how" (Orem, 2006). As a result, Orem described the SCDNT as an action-based theory with clear implications and specifications for the roles of the patient and nurse (Hartweg & Fleck, 2010).

Orem defined agent as "the person who engages in a course of action or has the power to do so" (Orem, 2001, p. 514). Furthermore, the self-care agent, dependent-care agent, and the nurse agent are persons who receives care, family member or friend who provides care, and the nurse who provides care – respectively. Self-care for one's self or dependent-care (care provided

by a family member, for example) must be learned and performed for life, human-functioning, and well-being (Hartweg & Fleck, 2010). Agency is described as the capability, ability, and power to perform actions deliberately (Hartweg & Fleck, 2010). Orem (2001) defined self-care agency (SCA) as a "complex acquired ability to meet one's continuing requirements for care of self that regulates life processes, maintains or promotes integrity of human structure and functioning and human development, and promotes well-being" (p. 254). The same concept is applied to dependent-care agency – the capability, ability or power to meet a socially dependent person's self-care demands or limitations in their self-care agency (Taylor, 2001). If these capabilities do not exist within the self-care agent or the dependent-care agent, then the abilities of others are needed, such as the abilities of nurse or other medical professionals (Hartweg & Fleck, 2010).

When one's self-care agency or dependent-care agency is not adequate to meet all therapeutic self-care demands (TSCD) – which are the actions that should be performed overtime for life, health, and well-being – a self-care deficit exists (Hartweg & Fleck, 2010). Assessment of the nature and extent of the self-care deficit is needed before appropriate assistance is provided. The role of the nurse to identify and quantify the self-care deficit and the dependent-care deficit, is an essential aspect in the development of the nursing system (Taylor & Renpenning, 2011). The theory of nursing systems encompasses the two previous theories discussed; essentially, proposing that nursing systems are determined by the self-care agent and/or the dependent-care agent, based upon their self-care and/or dependent-care limitations. The nursing systems theory sets the foundation for the structure and content of nursing practice, centered upon the limitations assessed (Taylor and Renpenning, 2011). The nursing systems theory also includes the concept of nursing agency – the capabilities and power of the nurse to

carry-out action that is purposeful, goal-oriented, thought-out, carried-out, or produced (Taylor & Renpenning, 2011, p. 21).

Orem's conceptual self-care model has a significant contribution to nursing education and the nursing profession as a whole. The rationale for choosing this conceptual framework derived from its applicability to various nursing settings, such as acute care, ambulatory care centers, community health centers, home health care, hospice, palliative care, and rehabilitation. However, there are limitations and weaknesses that exist. Kumar (2007) explains that activities adults engage in to maintain health, life and well-being, are usually initiated voluntarily. Orem's theory of self-care assumes the self-care agent and/or the dependent-care agent are innately motivated, and have the self-efficacy to assume self-care responsibilities. For example, prior to assessing a patient or family members' deficit in providing self-care or dependent-care, the healthcare provider must first assess one's belief in their capabilities and determine whether the patient or family member is motivated to provide the care needed. Additionally, although the four concepts that define nursing practice – person, nursing, health, and environment – are addressed in the model, there is a limited emphasis placed on how the environment affects the person and subsequently, their health. As a result, the lack of holistic care of as it relates to person – the patient – is often a critique of Orem's SCDT. Given these limitations, the SCDT is one of the most common nursing theories used in clinical practice (Shah, 2015).

The Developmental and Family Life Cycle Theory or the Family Development Theory (FDT) – also informs the practice of nurses working with families. The FDT provides a systematic framework for nurses to assess a families' developmental stage, and through specific and intentional interventions, nurses help families adjust and adapt through family transitions. Reuben Hill and Evelyn Duvall were both family scholars who have contributed greatly to the

FDT. Martin (2018) describes the very beginning of their collaborative work which began with a report on the "First National Conference on the Family" – a conference that occurred as a result of then-president Harry Turman's perception that families were in disarray following World War II (Martin, 2018, p. 50). Martin (2018) gives a summary of their report:

> Duval and Hill's report summarized developmental tasks and challenges across the life cycle for children and families and provided the basis for a stage model of modern family development that informed and inspired family research and practice for half a century (p. 50)

Many other family developmental theorists expanded on the original FDT. They all share the principal idea that families are stressed during the time of predictable change and transition, and require assistance to adjust and adapt to regain family stability (Kaakinen et al., 2018).

The FDT is specifically targeted to understanding families and not individuals (Kaakinen et al., 2018). Zilbach (2003) describes a family as" consisting of a unity of interacting personalities, is a living, changing, growing organism" (p. 304). The FDT contains specific family life cycle stages that begins with a married couple, which then progresses into the married couple bearing children and identifying roles while caring for an infant. The next three stages characterize the family structure during the different stages of childhood development: family with preschool-aged children, family with school-aged children, and family with adolescent children. The launching family structure is the family with young-adult or adult children who may or may not leave the home. The final two stages describe the structure of the middle-aged parents preparing for retirement, then the aging family structure which includes the death of one spouse and continues up to the death of the remaining spouse (Kaakinen et al., 2018, p. 42). Zilbach (2003) noted that "the sibling structure exists until the death of the last sibling. At that

point, a family has come to an end, family history, myths, traditions continue on in the new family units that have been spawned and created in the course of the family life" (p.309).

Each stage of the family life cycle contains developmental tasks each member of the family must achieve, in order to successfully transition to the next stage (Carter & McGoldrick, 1989). Carter and McGoldrick (1989) explain that developmental tasks emerge due to changing needs and demands, which must be addressed in order for the family – and individual members – to continue to function and grow (Carter & McGoldrick, 1989). Kaakinen et al. (2018) noted that "although family developmental needs and tasks must be performed at each stage of the family life cycle, developmental tasks are general goals, rather than specific jobs that must be completed at that time" (p. 43). Using the FDT allows family health nurses to determine the family structure of the families they work with as well as determine the families' developmental stage. More importantly, the developmental tasks within this framework, serves as a guide for nurses to anticipate the stressors families – and individuals within families – may experience. For instance, a young- adult child in the launching phase of the family life cycle, preparing to become a dependent-care agent to a parent with a chronic illness with dependent-care needs. In this particular example, the nurse understands and anticipates the individual stress and collective stress the family will face during this transition. Therefore, tailored nursing interventions are employed to ensure the dependent-care agent and other members of the family adapt and adjust appropriately to the roles they will assume.

Another strength of the FDT is that the developmental approach allows family nurses to assess the extent to which the family has achieved the tasks that correspond with each stage of family development (Kaakinen et al., 2018). When the nurse and family formulate a plan of action to improve health and adapt to illness, the nurse understands that assessment of family

response to interventions, and assessment of the families' progress towards their goal(s) is imperative. As an example, when a self-care agent or dependent-care agent is provided with educational material and resources on maintaining a diabetic diet, the nurse must assess their understanding of the information they were given, as well as assess how much of what they understand translates into practice. Based upon the nurses continued assessment, changes in interventions will pursue appropriately.

The main criticism of the FDT is that the original work on the model was based on the nuclear, heterosexual family without consideration for divorce, remarriage, couples without children, or lesbian/gay couples and parents (Kaakinen, et al., 2018). Fortunately, McGoldrick et al. (2015) expanded on the original FDT to include varying family structures: stepfamilies, LBGTQ families, divorced families, single-parent families, and families who adopt children. McGoldrick et al. (2015) understood the difficulty in determining normal predictable patterns in families, given the ever-changing prospects of family structure, function, and process. It is also worth noting that the FDT does not take into account the importance cultural diversity and health disparities, have on family development. Kaakinen et al. (2015) noted that "future theory development and research [is] need to expand understanding of family development across time, while considering changes and diversity within family development" (p.47). Although the aforementioned limitations of the FDT continue to be expanded on, the rationale for choosing the FDT is because, similar to the SCDT, the FDT gives family nurses a framework to assess critical deficits in basic family functions (i.e., developmental tasks) that threaten overall family functioning.

The SCDT and the FDT both drive family nursing interventions and outcome evaluation. The role of the family nurse must go beyond the product of nursing (i.e., nursing intervention), as

evaluating outcomes is an essential aspect of the nurse's role in determining whether intended family outcomes are achieved. Nurses can ensure families achieve outcomes by providing care that is family-centered – an approach to health-care delivery with emphasis on collaboration between individual patients, their families, nurses and other members of the healthcare team (Kaakinen et al., 2018). In their study on adaptation and caregiver burden in parents caring for children with cancer, Crespo et al. (2016) found that parents who perceived the care they received to be family-centered, reported lower levels of caregiver burden and increased quality of life, thus allowing parents to adjust and adapt more efficiently to their role as caregiver. Consequently, the significance of family-centered care (FCC) is critical to families adapting and adjusting to changes and life experiences, thus leading to better health outcomes.

The sociogram seen in the Appendix integrates both Orem's SCDT and the FDT into a working model that can be used by APNs in their practice when caring for families. Particularly, families who provide caregiving services to a family member with a chronic illness. This sociogram depicts the relationship between the four nursing metaparadigm concepts – person, health, environment and nursing. At the center is the person who contributes to the family structure and function, and helps advance the development of the family through the family life cycle. The person can be a self-care agent, a dependent-care agent, or both. The person is surrounded by their environment, which influences the person and their family. The double-headed arrows depict the interactions the self-care agent or the dependent-care agent have with the environment. The environment includes the APN who provides support to the family if and when needed; the support by the nursing agent is depicted as double-headed arrows in the form of continuous assessment and interventions. Health is also included as part of the environment that surrounds the family, as there are factors within the environment that determine the varying

degrees of health the person or family experiences. To illustrate how this sociogram is applicable to family assessment, nursing interventions, and outcome evaluation, a family assuming the care of a family after hospitalization and subsequent rehabilitation stay will be used.

The Harris family began their stage of the family life cycle as a nuclear family when Mr. Harris and Mrs. Harries got married. They moved through the next several stages of the family life cycle as they raise three children. The Harris family is currently in the launching phase of the family life cycle with two of their adult children living out-of-town, and their young-adult daughter who still lives at home. The Harris family experienced a major transition in their lives as Mr. Harris was hospitalized after suffering a stroke; he was also newly diagnosed with Type 2 Diabetes Mellitus (DM) as he was found to have a HbA1c level of 11%. Mr. Harris has a known history of hypertension (HTN) and hyperlipidemia (HLD) for which he is prescribed medications. The interaction with the Harris family and the community health APN begins after Mr. Harris' discharge to home from rehabilitation.

Mr. Harris, Mrs. Harris and their daughter meet with the APN as part of his post-hospitalization follow-up. With Mr. Harris' health history in mind, the APN conducts a family assessment to determine the family structure and which developmental cycle the family is currently in. Using the FDT, the APN understands that the Harris family is feeling a significant amount of stress and anxiety as Mr. Harris learns to navigate life with neurological deficits; Mrs. Harris and their daughter are learning to manage life with a family member who has functional limitations. After the APN determines motivation, self-care agency, dependent-care agency, and self-efficacy of each member, Mr. Harris' needs, self-care deficits and dependent-care deficits are determined. Using Orem's SCDT, the APN ascertains that nursing support is needed for: nutrition education, medication management education, diabetes education, meal preparation

assistance, education on caring for someone with functional limitations, education on self-care requisites – such as personal care – and information on community resources on how to manage the stress of caregiving. The fundamental principle of Orem's SCDT is that individuals and families can take responsibility for their own health (Hartweg & Fleck, 2010). With that in mind, the APN progresses to nursing systems – systematic actions by the APN to address the gap that exists between Mr. Harris' care demands and dependent-care capabilities.

Education is critical when working with the Harris family. The APN educates the Harris family on Mr. Harris' disease processes – HTN, HLD, Type 2 DM and risk of subsequent strokes. The education provided to the family explains each disease process individually and how, when not properly managed, they can lead to further decline in health status. Mr. Harris admits that he was not managing his blood pressure well, and now understands how poor management lead to him having stroke. To assist Mr. Harris and his family manage his chronic disease processes, the APN sends a referral to a home health agency for home-visiting nurse to assistance. The role of the home-visiting nurse is to reinforce education provided by the APN and further assess for any additional needs the Harris family may have. The home-visiting nurse will educate the caregivers on how to use a glucometer, how to administer insulin properly, and educate the family on normal and abnormal blood glucose levels, and when it is appropriate to contact the APN. The visiting- nurse will also reinforce nutritional education provided by the APN to help promote better eating habits. When asked about goals, Mr. Harris would like to regain strength in his right arm and right leg. To help Mr. Harris achieve that goal, the APN sends a referral to the same home-health agency for in-home therapy to address right sided weakness and functional limitations. Mr. Harris's caregivers will also receive education on how to care for a family member with functional limitations.

Through shared-decision making, the APN and the Harris family agree on these measurable goals in order to prevent subsequent strokes and other acute medical events: decrease in HbA1c to less than 8%, blood pressure goal of less than 130/80, decrease in body mass index (BMI) to less than 35 kg/m2, decrease in triglycerides, increase in high-density lipoprotein (HDL), and decrease in low-density lipoprotein (LDL). These measurable outcomes will be assessed at varying times during the next three to six months. The APN will also assess whether Mr. Harris meets his functional goals as that is important to his mental and physical health.

The APN understands that adherence to prescribed medications is imperative to prevent subsequent strokes and other acute medical events. As a result, the APN performs a thorough medication reconciliation to explain to Mr. Harris and his caregivers dosing of all medications, time of dosing, adverse effects and medication indications. The APN educates Mr. Harris's caregivers on the importance of medication adherence; they commit to ensuring Mr. Harris takes all medications as prescribed. Adherence to medications will be assessed by obtaining laboratory data and through blood pressure log kept by caregivers. To ensure that Mr. Harris adheres to the dietary changes needed to manage diabetes and high blood pressure, the APN initiates the process for Mr. Harris to receive home-delivered nutritious meals through MANNA.

The APN will remain in continuous dialogue with the Harris family, home-visiting nurse and home-visiting therapist to obtain necessary information that will help guide the plan of care. As a result of the anticipated stress and anxiety Mr. Harris's caregivers may experience, the APN provides Mrs. Harris and her daughter information on how to manage stress and anxiety. The APN also encourages the caregivers to engage in self-care and to use resources such as respite of day-care services if and when needed. Although Orem's SCDT and the FDT have limitations, the strengths of each theory, together make an effective model for nurses to use in family health.

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Appendix

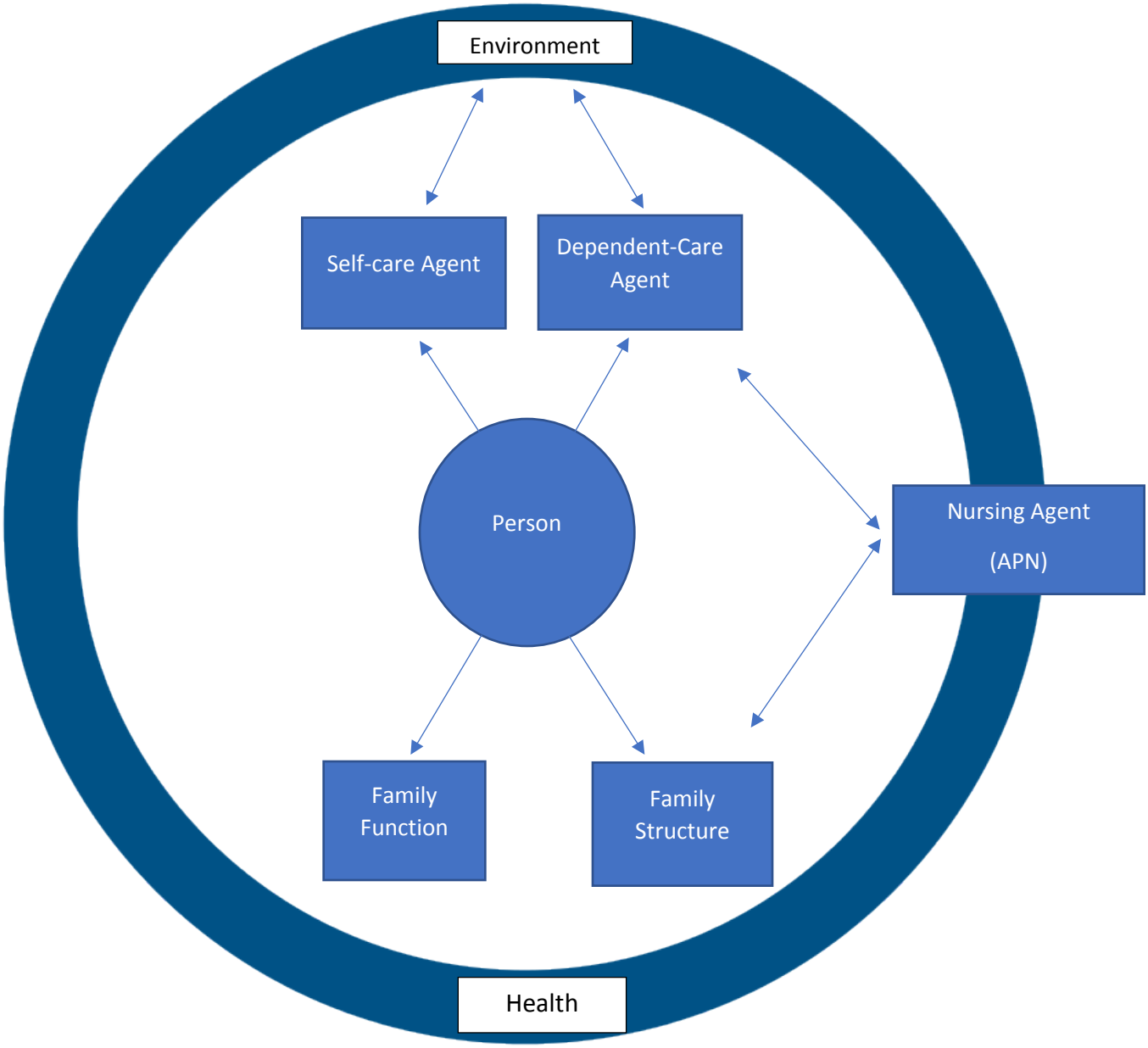

Figure 1