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Chapter 1

Orlando's Theory

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EDITOR'S INTRODUCTION

Ida Orlando was one of the first nurses to attempt to build a theory for nursing practice. Her experiences in mental health research helped her form the essential question in her theory: What is the meaning of behavior in the immediate situation? To Orlando, the role of the nurse is to understand the meaning of the specific behavior of the patient with whom she or he is interacting. This function is the same regardless of the setting or the age or diagnosis of the client. The vignettes presented in the case studies section dramatically illustrate how the nurse's use of this basic principle enhanced the patient's well-being. One of the strengths of this theory is its universality across practice domains.

THE THEORIST

The thinking of a person developing knowledge is influenced by many factors. Experiences with family, culture, colleagues, and education affect the person's thinking whether the person is aware of it or not. Thus the work of a nurse theorist may have implicit or explicit connections to previous knowledge.

Ida Jean Orlando, a first-generation American of Italian descent, was born in Jersey City, New Jersey, in 1926. She received her primary and secondary education in the public school system in Brooklyn, New York, and her diploma in 1947 from New York Medical College, Flower and Fifth Avenue Hospitals School of Nursing. Helen Daum was dean of the school and director of nursing. Orlando's basic education included clinical placements in hospitals for psychiatric and communicable diseases and a six-month affiliation at the U.S. Public Health Service Department of Indian Affairs Hospital in Talihina, Oklahoma.

Orlando continued her education at St. John's University, a Jesuit institution, in Brooklyn, New York, searching for what a professional nurse was to produce. She received a BS degree in 1951 with a major in public health nursing. Mary C. Mulvaney was dean of the division of nursing education at St. John's. During this time Orlando's clinical experience was with the Brooklyn Visiting Nurse Association.

Orlando's continued quest for a distinct function for professional nursing motivated her to enroll in the mental health consultation program at Teachers College, Columbia University, from which she received her MA in 1954. Ruth Gilbert was program director and Louise McManus was dean. Orlando's clinical experiences were with the James Jackson Putnam Child Guidance Center in Roxbury, Massachusetts, the Maryland Department of Health, and Brooklyn State Hospital.

Nationally, it was a period when nursing was trying to define its work, and nurses from Teachers College were actively involved in this endeavor. McManus (1948) discussed the nature of professional nursing, stressing that each situation was unique and the automatic reactions of fixed habits of response were insufficient or inadequate as the basis of nursing practice. Gilbert (1940, 1951), author of *The Public Health Nursing and Her Patient*, believed that for nurses, mental hygiene offered "a deliberate, observant, objective way of working, a habit of stopping to question and to think through what the behavior of the patient may mean in relation to a situation, and how the nurse herself relates to that situation" (1940, p. 1). Gilbert viewed (contd. on p. 3)

nursing as a process leading to understanding in each instance. She focused attention on the dynamics of behavior and on establishing nurse and patient relationships.

Orlando identified L. Thomas Hopkins (Orlando, personal communication, October 25, 1985; Hopkins, 1937, 1941, 1954), in whose course she enrolled for two semesters, as an instructor who attracted her attention with his conception of the learning process. His work focused on needs, on the influence of past experiences on meanings in a present situation, and on the importance of perceptions in determining behavior. He stressed that behavior emanates from and is validated in experience. Hopkins identified W. H. Kilpatrick (1926, 1941) as his great teacher, whereas Kilpatrick cited John Dewey as his own formative influence.

In the 1950s there was also a national move to upgrade the care of psychiatric patients. Professional schools of nursing were revising their curricula to incorporate new knowledge and to move away from the use of a medical model as the basis of the program. These movements were reflected in the literature of the period and in the grants awarded to schools of nursing.

At this time, Yale University was awarded a five-year project grant from the National Institute of Mental Health (NIMH). Marion Russell was project director. Upon the recommendation of Ruth Gilbert, Orlando was hired by Dean Elizabeth Bixler as a research associate at Yale University. She became the project investigator of the grant, which was entitled "Integration of Mental Health Concepts in a Basic Nursing Curriculum."

For three years Orlando carried out the investigation using a field methodology approach in which she was a participant observer. She recorded her observations of contacts between patients and nurses. Through analyses of these observations, Orlando formulated her theory of nursing (1961). Her formulations are an ingenious conception of the elements and relationships of a nurse's process of action and of the method required to understand the meaning of behavior in an immediate experience.

In 1958, after the completion of the grant, Orlando continued at Yale and was appointed by Dean Florence S. Wald as the director of the graduate program in mental health and psychiatric nursing. According to Wald (personal communication, November 27, 1985), Henderson (1966), Wiedenbach (1958), Russell, and Robert C. Leonard were particularly supportive of Orlando's nursing formulations. Orlando continued at Yale in this position until 1961, when she resigned to move with her husband, Robert, J. Pelletier, to Boston.

Orlando's next contribution to nursing theory occurred at McLean Hospital, Belmont, Massachusetts. She was hired by the hospital director, Francis deMarneffe, MD, as a clinical nursing consultant. Orlando received an NIMH grant to test her theory. The results of this research and refinement of her theory were published in 1972.

Orlando has consistently emphasized the need to articulate a distinct function for professional nursing, which she views as prerequisite to charting a path for an independent rather than a dependent profession. She has clarified the distinction between lay and professional nursing and has stressed the need to classify nursing phenomena according to nurses' observations of patients' behavior (1967, 1976, 1980, 1983, 1985).

Orlando has served as a consultant to schools, hospitals, health departments, and individuals. She was hired by the New England Board of Higher Education as the nursing consultant to a project on mental health continuing education for faculty from associate degree programs (1977). She has lectured and conducted seminars and workshops across the United States and in Canada and is a member of the board of the Harvard Community Health Plan. Her 1961 book has been published in five foreign languages.

Orlando has held various positions in education and service and is currently director of nursing, Tri-City Unit, Metropolitan State Hospital, in Waltham, Massachusetts.

MAJOR DIMENSIONS OF THE THEORY

Orlando's nursing theory was developed by induction from the analysis of nursing situations. For three years Orlando recorded what she heard and saw in some 2,000 nurse-patient contacts. Despite different attempts to categorize these records, Orlando could establish only two mutually exclusive categories: one judged good nursing and the other bad nursing. A presentation of a random selection of records to nurses with dissimilar views, experience, education, and personality revealed that these nurses agreed with Orlando's categorization. This finding led Orlando to realize that what made good and bad nursing happen was contained in these anecdotal records. Orlando formulated her theory from these qualitative data.

The framework used to present the major concepts of Orlando's theory is based on my previous analyses of Orlando's theory using the works of Dewey and Kuhn (Schmieding, 1983a, 1983b). There are five major interrelated concepts in Orlando's theory. These are: (1) function of professional nursing—organizing principle; (contd. on. p. 5)

(2) presenting behavior—problematic situation; (3) immediate reaction—internal response; (4) nursing process discipline—investigation; and (5) improvement—resolution. Although her concepts are interrelated, each will be discussed separately. Other components of the theory will be incorporated in the presentation.

Function of Professional Nursing—Organizing Principle

An organizing principle is the fundamental concept of a theory. It is an abstract concept that operates a priori to investigation. It guides inquiry by directing one's focus to certain classes of stimuli, restricts the phenomenological field, and provides a framework with which to analyze data. Its relationships to other concepts in the theory are tacit or clearly formulated.

The function of professional nursing is the organizing principle of Orlando's theory. Orlando conceptualizes it as "finding out and meeting the patient's immediate needs for help" (1972, p. 20). This concept relates to Orlando's view of nursing, which focuses on the patient's needs for help in an immediate experience. She states that

nursing . . . is responsive to individuals who suffer or anticipate a sense of helplessness; it is focused on the process of care in an immediate experience; it is concerned with providing direct assistance to individuals in whatever setting they are found for the purpose of avoiding, relieving, diminishing or curing the individual's sense of helplessness. (1972, p. 12)

When patients cannot meet their own needs they become distressed. Orlando identifies helplessness, need, or distress as originating from the patient's physical limitations, adverse reactions to the setting, and experiences that prevent the patient from communicating his or her needs (1961, p. 11): "*The purpose of nursing is to supply the help a patient requires for his needs to be met*" (p. 8; emphasis in original). When the requirements for help are supplied, the patient's distress is diminished and the patient's sense of adequacy and well-being are improved (p. 5).

It is the responsibility of the nurse to meet the immediate need for help either by supplying help directly or by calling in the services of others. The core of the nurse's practice, therefore, is understanding what is happening between the patient and the nurse (Orlando, 1961, p. 4). To accomplish this, both the patient and the nurse must participate in a communication process to identify the nature of the problem as well as its solution: "First, *the nurse must take the initiative in helping the patient express the specific meaning of his (contd. on p. 6)*

behavior in order to ascertain the distress. Second, she must help the patient explore his distress in order to ascertain the help he requires for his need to be met" (1961, p. 26). If this is achieved, the function of professional nursing has been fulfilled.

Orlando emphasizes that the distinct function of nursing characterizes and justifies the work of the nursing profession and should be identifiable in every nurse-patient contact (Pelletier, 1976). She believes that the function remains the same regardless of the patient's age, diagnosis, or treatment, or whether the patient is at home or in an institution. The focus of inquiry is the patient's immediate experience (Orlando, 1972, p. 20).

Whereas Orlando characterizes lay nursing as routine, repetitive, or custodial, she writes that professional nursing is required when the cause of the patient's distress is not known or clearly understood by either the nurse or the patient before the nurse's investigation is conducted (1980). As the individual causes and requirements are determined, the nurse designs activities to promote the person's ability to nurse the self.

The abstract concept of finding out and meeting the patient's immediate needs for help directs the nurse's attention to the nurse-patient situation. It becomes an acquired way of thinking. Consequently, in each contact the nurse's subliminal thought is, "Does the patient have an immediate need for help or not?" If the patient has an immediate need for help and the nurse finds out and meets that need, the function of professional nursing is achieved. There is a subtle but critical conceptual difference between meeting the patient's needs and *finding out* what help the patient needs and then meeting this immediate need. Whereas Orlando's concept of function clearly specifies the characteristic action of the nurse, "meeting needs" is less restrictive. In fact, this broad concept has led nurses to take responsibilities for non-nursing activities, including medical tasks, all because these activities meet patients' needs. To find out and meet the patient's immediate need for help restricts the focus of inquiry to the patient's immediate experience.

Orlando's concept of the function of nursing operates in every immediate nursing experience in a subdued, subordinate form, and determines what data the nurse looks for in each situation.

Presenting Behavior--Problematic Situation

A problematic situation disrupts the equilibrium: its meaning, however, is obscure or uncertain. To find out the immediate need for help the nurse must first recognize the situation as problematic.

Patients manifest their immediate needs for help through their behavior. Orlando notes: "*The presenting behavior of the patient, regardless of the form in which it appears, may represent a plea for help*" (1961, p. 40). The patient's behavior can be revealed by one or more of the following forms: verbal, such as asking a question, making a request or demand, or simply making a comment to the nurse; nonverbal vocal, such as crying, wheezing, coughing, or moaning; nonverbal behavior, such as reddened face, tears in the eyes, clenched fist, skin color, or pacing (pp. 36-37). The presenting behavior represents a change in the patient's condition: it causes the nurse to take notice and is a signal to the nurse that the patient may have an unmet need.

To fulfill the function of nursing, the nurse must first find out the patient's meaning of her or his behavior. This is not as straightforward as it appears, because patients, when in distress, cannot initially express their distress without the nurse's help (Orlando, 1961, p. 23). The initial observation of the patient, however, is inadequate to understand what the patient is trying to communicate. It is an unclear presentation of what the problem really is and is unreliable for determining the extent of the distress or the immediate need for help (Orlando, 1961, pp. 39-40). Whatever the behavior, the nurse must find out its meaning and then determine the immediate need for help. This cannot be done without deliberation with the patient.

The nurse-patient situation is viewed as a dynamic whole. The patient's behavior affects the nurse and the nurse's behavior affects the patient. The interaction is unique for each situation (Orlando, 1961, p. 36). The presenting behavior of the patient, the stimulus, causes an automatic internal response in the nurse, and the nurse's behavior causes a response in the patient. An understanding of this complex subjective phenomenon is necessary to understand a person's action.

Immediate Reaction—Internal Response

An interruption in equilibrium creates a problematic situation. At that moment the person experiences an organic response that is both cognitive and affective. This internal response comprises the subjective data in the immediate experience. It is unique for each person and represents the starting point of investigation.

Orlando labels the internal response an "immediate reaction." It includes a person's perception, thought, and feeling about another person's behavior. The reaction is automatic, and its components cannot be controlled. The immediate reaction cannot be observed: (contd. on p. 8)

only the action can. Orlando identified the items in any person's process of action and specified how each is related to or affects other aspects of the immediate reaction. She notes that these items

occur in the following automatic, sometime instantaneous, sequence: (1) The person perceives with any one of his five sense organs an object or objects; (2) The perceptions stimulate automatic thought; (3) Each thought stimulates an automatic feeling; and, (4) Then the person acts. The first three items (perceptions, thought and feeling) taken together are defined as the person's immediate reaction. (Orlando, 1972, p. 25).

Orlando notes that the content of the immediate reaction reflects the nurse's individuality and explains that what a nurse perceives or thinks about a patient reflects the nurse's meaning or interpretation of her or his perception. These may or may not be correct from the patient's point of view (1961, p. 40). If a nurse is preoccupied with application of principles, this would condition the nurse's first thoughts (p. 3). In other words, the immediate reaction reflects how the nurse experiences her or his participation in the nurse-patient situation (p. 67).

The items in the immediate reaction may not always be readily available to a person. Often there is nondescript awareness in a nursing situation, referred to as an intuition, that something isn't right. This awareness is brought about by the thoughts that occur from direct observations (Orlando, 1961, p. 29). The first step in analyzing the situation is to make these thoughts explicit.

The presenting behavior of the patient provides the stimuli for the nurse's immediate reaction; the immediate reaction forms the basis for the nurse's action. Although the content of the immediate reaction cannot be controlled, the action can. The next phase of the process is the nurse's action.

Nursing Process Discipline—Investigation

Investigation is a deliberate attempt to understand the meaning so as to get the facts. It is a complex process in which observations and thoughts are used in a serial, responsive way in the conduct of inquiry.

A nursing situation is comprised of the behavior of the patient, the immediate reaction of the nurse, and the nurse's action. Orlando calls the interaction of these elements the nursing process (1961, p. 36).

A major concept of Orlando's theory is the deliberative nursing process, renamed the "nursing process discipline" in 1972. At that (contd. on p. 9)

time she also expanded the use of her theory to the entire system of nursing. The use of the process discipline requires that a shared process occur between the nurse and the other person in order to find out the meaning of the behavior, to determine what help is needed, and to find out if the person was helped. Understanding Orlando's conception of a person's action process is critical to grasping the use of the process discipline.

A person acts after experiencing an immediate reaction to the behavior of another person. Orlando notes that in any person-to-person contact neither individual has access to the items of the immediate reaction of the other person. Only the action, the primary datum in an experience, can be directly observed. What a person perceived, thought, and felt about a perception, therefore, remains a secret from the other person unless an individual openly discloses his or her reaction (1972, p. 25).

The use of the nursing process discipline requires that a nurse verbally state to the other person any or all aspects of the items contained in her or his immediate reaction. The items stated must be expressed as self-designated, and the other person in the contact must be asked to verify or correct the item verbally expressed (Orlando, 1972, pp. 29-30). An example would be, "When I see you pacing (a perception), I think you are worried about something (a thought about a perception); am I correct or not?" ("I" indicates self-designation, and the question seeks correction or verification of the thought). It should be noted that some requirements of the process discipline may be met nonverbally. This process continues until the nurse observes improvement in the other person's verbal and nonverbal behavior. This approach characterizes the relational aspect of Orlando's work; namely, the relationship of the presenting behavior to the patient's immediate need for help, and the relationship of the action of the nurse to the improvement in the patient's behavior.

The nurse who uses this approach is more likely to fulfill the function of nursing, because when one person expresses his or her immediate reaction, the other person in the contact is more likely to do so also. This minimizes the opportunity to make assumptions and increases the opportunity to correct or validate the individual's private interpretation of the other person's action. As a result, each person in a contact has a better understanding of his or her own and of the other person's immediate experience (Orlando, 1972, pp. 31-32).

In her earlier work Orlando formulated specific guides for the nurse's action. She describes how aspects of the immediate reaction, namely (contd. on p. 10)

the perceptions, thoughts, and feelings, could be used in a deliberative way to find out the immediate need for help.

Perceptions can be useful in establishing the meaning of the presenting behavior: *"Any observation (perception) shared and explored with the patient is immediately useful in ascertaining and meeting his need or finding out that he is not in need at that time"* (Orlando, 1961, pp. 35-36). She believes that it is more efficient to use perceptions than other aspects of the immediate reaction. Thoughts can be used, but she cautions that these may not be valid: *"The nurse does not assume that any aspect of her reaction to the patient is correct, helpful or appropriate until she checks the validity of it in exploration with the patient"* (Orlando, 1961, p. 56). Although Orlando referred to any aspect of the nurse's reaction, it seems evident here that she was referring to thought, as one does not need validation of one's thought about the perception. The nurse, however, can verify whether or not the patient has the same perception as the nurse. The nurse can have a change in feeling if the thought leading to it is also changed.

Feelings can also be used to find out the patient's immediate need for help. Feelings come from thoughts stimulated by perceptions. Orlando (1961) notes that the nurse's expression of a feeling could be helpful if it was explored in such a way that the patient could react to it. She emphasized that the thought provoking the feeling should be expressed so that the patient would know the origin of the feeling (p. 49). The nurse's obligation to the patient does not stop with the expression of her or his perceptions, thoughts, or feelings. The effect of the action on the patient must be determined; therefore, *"the nurse initiates a process of exploration to ascertain how the patient is affected by what she says or does. Only in this way can she be clearly aware of how and whether her actions are helping the patient"* (Orlando, 1961, p. 67).

Orlando's methodological procedures are an integral part of her theory, which makes it a practical theory to use. The simplicity of the description of Orlando's nursing process discipline disguises the complexity of its use. The various principles and features associated with its use are clearly described. Using them skillfully, however, requires repetitious examination of one's own process of action. Specific consultation is often required to determine why a person was unable to initiate an exploratory action (Orlando, 1972, pp. 32-34).

When the meaning of the patient's behavior is not understood, the function of professional nursing has not been achieved. Orlando identified "automatic personal responses" as contributing to ineffec- (contd. on p. 11)

tive nursing. When a nurse uses an automatic response, she or he acts on any perception, thought, or feeling without exploring it further with the patient (Orlando, 1961, p. 61). Actions the nurse arrives at independently are not helpful, as they do not consider the patient's perception of the problem (p. 34).

Automatic personal responses are actions that do not meet the requirements of the nursing process discipline; they are nondeliberative. When a nurse withholds her or his immediate reaction, the other person in the contact cannot verify or correct it. This allows the person to make assumptions about the nurse's verbal and nonverbal behavior. If the nurse does not state the response as self-designated, the other person is allowed to make assumptions about the origin of what is heard. When the nurse does not phrase the response as a question, the other person may not feel the freedom to correct or verify what was heard. Neither person in the contact knows the immediate reaction of the other; therefore, each is left with an unverified understanding of the other's action (Orlando, 1972, pp. 30-31). This forms an unreliable basis for action and decision making, because the problem and its solution are decided upon a priori to the investigation.

Automatic actions are not effective because the nurse's action is decided upon for reasons other than the meaning of the patient's behavior or the patient's immediate need for help. Because the patient is not involved in the process, the nurse is unaware of how her or his activity affects the patient (Orlando, 1961, p. 65). Automatic actions may occur because the nurse cannot express and explore her or his immediate reaction with the patient. Regardless of the cause, "when the nurse does not explore with the patient her reaction (*expressed or unexpressed*) it seems reasonably certain that clear communication between them stops" (Orlando, 1961, p. 55).

Improvement—Resolution

As the situation becomes clear, it loses its problematic character and a new equilibrium is established. Orlando calls the product of finding out and meeting the patient's immediate need for help "improvement." The improvement is observable in the verbal and nonverbal behavior of the patient. This change allows the nurse to observe whether the patient's sense of helplessness has been relieved, prevented, or diminished (Orlando, 1972, p. 21). Orlando notes that it is not the nurse's activity that is evaluated but rather its result: whether the activity serves to help the patient communicate her or his need for help and how it is met (1961, p. 70). If there is no (contd. on p. 12)

improvement, the nurse knows that the patient's immediate need for help has not been found out. The nurse therefore begins the process all over again with whatever behavior is observed.

Improvement is relative to the patient's condition at the outset of the nurse-patient contact:

In each contact the nurse repeats a process of learning how to help the individual patient. Her own individuality and that of the patient requires that she go through this each time she is called upon to render service to those who need her. (Orlando, 1961, p. 91)

Orlando believes that the cumulative effects of repeatedly meeting a patient's needs for help will contribute to the individual's adequacy in caring for the self (p. 9).

Orlando's (1961) closing remarks in her original work reflect the focus of a theory based on the immediate experience. She explains that she had "not dealt with long-range nursing goals because the process of helping the patient takes place in immediate situations and the outcomes for the person being helped depend on those very experiences" (p. 90). Thus finding out and meeting the patient's immediate need for help begins and ends in each immediate experience.

Summary

Orlando's theory is descriptive, prescriptive, and predictive. She describes a deliberative nursing process that implies the nurse's conduct. It is predictive in that if the nurse finds out and meets the patient's immediate needs for help the patient's behavior improves; if not, it remains the same or worsens.

Orlando's theory of nursing, which includes the concept of the deliberative nursing process, must not be thought of as a technique. This is a common misinterpretation of her theory. The use of the deliberative nursing process is a part of the theory whereby the function of professional nursing is accomplished. Without using a concept of the function of nursing to direct the nurse's focus of attention to the immediate experience of the patient, the nurse's process of care can lead anywhere without accomplishing the professional function of nursing. Orlando's theory systematizes the practice of nursing by permitting nurses to control their process of action.

Nursing takes place in complex situations: its essence evolves through a serial process between the patient and the nurse: (contd. on p. 13)

A deliberative nursing process has elements of continuous reflection as the nurse tries to understand the meaning to the patient of the behavior she observes and what he needs from her in order to be helped. Responses comprising this process are stimulated by the nurse's unfolding awareness of the particulars of the individual situation. (Orlando, 1961, p. 67)

RESEARCH

A survey of the literature reveals that while many studies that incorporate aspects of Orlando's theory acknowledge her work, a number do not: for example Allen, Frasure-Smith, and Gottlieb (1982), Chapman (1969), Dumas and Johnson (1972), and Mahaffy (1965) use all of the steps in Orlando's deliberative process as "the experimental nursing" with no acknowledgement. This presentation of the research on Orlando's theory will include those studies done at Yale while she was there and those specifically identifying the use of Orlando's theory. The reader is alerted to the fact that during the period prior to and immediately after Orlando published her theory, researchers were more precise in how they operationalized the theory than were the researchers in the later studies.

The research studies are categorized here by type of study. Studies are on: (1) patient behavior and patient need; (2) nurse's action; (3) effects of nursing on patient response; (4) Orlando's quantitative research in care of patients and the training of nurses; and (5) application of the theory to administration of nursing and nursing education.

Patient Behavior and Patient Needs

Several researchers investigated specific aspects of the patient's presenting behavior. Elder (1963) studied nurse-patient contacts to determine how clearly and adequately patients' behaviors expressed their discomfort or their need for nursing assistance. She found that (1) patients did not adequately communicate their need for nursing assistance at the initial contact, and (2) the form of the initial behavior was not reliable for assessing the degree of discomfort. Elder's findings corroborated Orlando's formulations that the presenting behavior of the patient, regardless of its form, may be a plea for help, but is unreliable for determining the distress or the type of help needed.

Patient behaviors related to pain provided the basis for several investigations by Bochnak and her colleagues. Bochnak hypothe- (contd. on p. 14)

sized that a deliberative nursing approach was more effective in relieving the patient's pain than was a nursing action based on an automatic process (1963; also reported in Bochnak, Phymes, & Leonard, 1962). All patients in the control group and less than half in the experimental group received medication for pain. Patients in the control group did not experience marked relief of pain, whereas most of those who received deliberative nursing had a marked relief of pain.

In another study of patients' request for pain medication, Tarasuk [Bochnak], Rhymes, and Leonard (1965) found that both the speed and degree of relief were greater in the patients receiving deliberative nursing than in those who did not. Whereas only 31 percent of the patients in the experimental group received pain medication, all in the control group did.

Barron (1966) compared the effects of deliberative, automatic, and friendly nursing approaches to surgical patients with complaints of pain. Patients who received deliberative nursing received less pain medication and experienced more initial relief and greater long-range relief than did patients in the other two groups. Thus three studies on pain support the effectiveness of Orlando's deliberative nursing process and validate her formulations regarding patient's initial inability to clearly express their need for help. The presenting behavior, in the form of a request for pain medication, was often not the patient's immediate need for help.

Gillis (1976) studied the presenting behavior of sleeplessness in patients who called for help during the night. Ten patients received care by staff nurses and nine received deliberative nursing from the investigator. Gillis found that when the patients' specific needs were found out and met, few patients required sleep medication and most were able to sleep. All patients in the control group received medication; however, only three were relieved and slept. These findings strengthen Orlando's assertion that the presenting behavior may be a plea for help but that it is unreliable for determining the nature of the distress or of the need for help.

Four research studies on patients' perceptions of needs were reported. Faulkner (1963) studied different aspects of the needs of postpartum patients. Among the findings were that one need may have several associated needs and that patients rarely summoned the nurse for emotional needs.

The concept of patient needs was investigated by Gowan and Morris (1964) through interviews with postoperative patients who had expressed a request. A major finding was that 81 percent of the patients had unstated requests that were unexpressed because of the (contd. on p. 15)

way the nurse was perceived: “too busy,” “nurse would disapprove,” and “hated to bother nurse.” The findings of these two studies on needs support Orlando's assertion that patients have an initial inability to communicate their distress and need for help clearly and explicitly and that it is therefore the responsibility of the nurse to take the initiative to find out whether the patient has an immediate need for help.

The needs of grieving spouses (Hampe, 1975) and spouses of acutely ill patients (Dracup & Breu, 1978) were the focus of two research studies. Hampe used Orlando's definition of need but used predetermined categories of needs. Dracup and Breu based their research on the needs identified by Hampe. Neither of these studies explicitly tested Orlando's formulations.

Nurse's Action

Cameron (1962, 1963) examined the verbal response of a nurse to determine similarities and differences in the nurse's response when the patient was helped or not helped to overcome obstacles that interfered with the comfort and or capability of the patient. When the outcome was effective the nurse focused on the patient and on the meaning of the behavior to the patient and asked questions designed to seek clarification and interpretation rather than to obtain factual information.

Through participant observation Fishelis (1963) conducted an exploratory study to determine if nurses who attached labels to patients' behavior explored with the patient the meaning of the behavior, and whether the labels led to activities that benefited the patient. Interviews with nurses and patients indicated that nurses had not explored the behavior with the patient, that none of the nurses' explanations of the patients' behavior were correct, and that the nurses' activity had not benefited the patients. These results lend support to Orlando's formulation that activities carried out without deliberation with the patient are most often ineffective.

Dye (1963a, 1963b) studied the effects of nurses' activity on patient-initiated interactions. The results revealed that most activities were performed nondeliberatively, patients' distress more often arose from adverse reactions to the setting rather than from their illnesses. This study validates Orlando's finding that patients have adverse reactions to the setting and that a deliberative approach is more likely to identify and resolve this type of distress.

Effects of Nursing on Patient Response

The studies previously described used spontaneous behaviors from the patient, needs of patients, and nursing actions as starting points of the research. The next studies were designed to examine the effects of nursing on newly admitted patients, patients receiving prescribed procedures, or patients who had contact with the nurse for other health-related reasons.

In two pilot studies, Anderson, Mertz, and Leonard (1965; also reported in Mertz, 1963) investigated the effects of a deliberative nursing process on the vital signs of patients assumed to have a high degree of stress. Their subjects were patients admitted to an emergency room and to a large state psychiatric hospital. Statistically significant differences between the two types of nursing were found, as measured by patients' behavior and blood pressure for all patients and by pulse rates for patients admitted to the emergency room. These findings lend support to the effectiveness of deliberative nursing in relieving stress associated with admission. It also confirms the use of Orlando's theory with different types of patients and in different settings.

Stress related to hospitalization was the focus of Elms's research. In an exploratory study of patients admitted for elective gynecological surgery, Elms (1964) hypothesized that deliberative nursing would be more successful in alleviating stress than routine nursing. Measurements of vital signs showed only a decrease in pulse rate to be statistically significant; however, 71 percent of the patients in the experimental group noted that their stress was relieved by the nursing approach, whereas less than 40 percent in the two control groups had their stress relieved by nursing.

In a larger study using the same type of design and patient population, the findings of Elms and Leonard (1966) contradicted to some extent the earlier findings by Elms. There were few differences among the groups as measured by vital signs. There was, however, a significant difference when patients were asked to identify factors responsible for relief of distress. In the experimental group, 48 percent of the patients cited nursing care as the reason for their relief, whereas in the two control groups only 8 percent or less of the patients attributed relief of distress to nursing care.

Dumas and her colleagues conducted a number of studies on the effects of Orlando's deliberative nursing process with gynecological patients. In a pilot experiment and two other separate experiments, (contd. on p. 17)

Dumas and Leonard (1963; also reported in Dumas, 1963) hypothesized that deliberative nursing would reduce the incidence of postoperative vomiting. They found that the incidence of postoperative vomiting was significantly less in the patients receiving deliberative nursing. Patients whose distress was not relieved tended to vomit more postoperatively. This finding lends support to the aspect of Orlando's theory that predicts that the patient's condition remains the same or worsens the longer the immediate need for help is not identified and met. In a fourth experiment in the same unit as the previous studies, but with a different nurse providing care, the results contradicted the earlier findings (Dumas, Anderson, & Leonard, 1965).

A fifth clinical study reported by Dumas and Johnson [Anderson] (1972) measured the effects of experimental nursing on seven variables associated with postoperative recovery in gynecological patients. They found that patients who were relatively free of emotional distress preoperatively had a lower incidence of postoperative vomiting and used fewer antiemetic drugs. Patients receiving experimental nursing on the evening of admission had a statistically significant difference in the distress level from the control group. There was little difference between the control and experimental groups on the other indicators of postoperative recovery. The authors concluded that type of surgery was the most influential confounding variable.

In a study by Rhymes (1964) on the influence of the nurse's action on the incidence of vomiting and urine retention in general postoperative patients, the investigator found a clear difference in the type of nursing care given to patients who did not vomit or need catheterization following surgery. These research studies lend support to the use of Orlando's deliberative nursing process in the preoperative care of patients.

Tyron conducted two investigations (1963, 1964) to determine the effects of patient participation in the outcome of an enema prescribed for patients in labor. She found that patients who were permitted to participate in the planning of the procedure had a more effective outcome than those who did not participate. These findings strengthen Orlando's assertions that automatic actions are usually not effective because they do not consider the patient's perception of the situation.

In a subsequent study, Tyron (1966) hypothesized that patients' participation, as gained through a deliberative nursing approach, would also apply to routine "support" measures for patients in labor.

The results on the dependent variables of the study were inclusive. The analysis was hampered by the low use of comfort measures. There were, however, fewer undesirable behavioral responses by patients in the experimental group.

Several researchers have tested the effectiveness of Orlando's deliberative nursing as measured by physiological responses other than vital signs. Pride (1968) used electively hospitalized medical patients to determine if there was a causal connection between deliberative nursing and a physiochemical established index of patient welfare. The nursing treatment groups were experimental nursing; friendly, unfocused nursing; and "no approach." The dependent variable of stress was measured by the urine potassium output and by the IPAT anxiety scale. Pride found that patients who received experimental nursing excreted less urine potassium than patients who received other forms of nursing. The relationship between the anxiety measure and the nursing approach was not verified. The conclusion was that hospitalization stress could be reduced by a deliberative nursing approach.

Clausen [Cameron] (1983) hypothesized that mothers receiving deliberative care would exhibit a higher level of milk ejection reflex and would breastfeed their babies longer than those receiving routine care. She found that mothers who received the experimental nursing approach exhibited higher level functioning of the milk ejection reflex. Differences in length of time the mothers breastfed were not reported.

Studies focusing on the use of a deliberative nursing approach related to the care of children were reported by Wolfer and Visintainer (1975) and Thibaudeau and Reidy (1977). Wolfer and Visintainer hypothesized that children and parents who received specific psychologic preparation and supportive care (deliberative nursing) prior to minor surgery would show less upset behavior and better coping and adjustment than those who did not. Their results indicated that children who received deliberative care, as opposed to the control group, showed less upset behavior, more cooperation, and fewer postoperative adjustment problems. Parents of these children had significantly lower anxiety ratings, higher ratings on information received, and were more satisfied with the care than parents of the other groups.

Thibaudeau and Reidy compared parents' knowledge of illness, care prescribed, and compliance with treatment after experimental nursing intervention. Their findings show that the mothers who received experimental nursing had significantly more knowledge of the illness and complications than mothers who did not; a greater (contd. on p. 19)

proportion of these mothers complied with the prescribed treatment as well.

The findings from the last four studies indicate the effectiveness of Orlando's deliberative nursing process with different types of patients and in different settings as measured by various criteria. Clinical applications of Orlando's theory have been reported by Harrison (1966) with a patient with chronic lung disease and by Nelson (1978) with patients with a renal transplant.

Orlando's Quantitative Research

Orlando conducted a complex research study on her theory (1972). She received federal funding for this research, which took place over more than three years. The central aim was to establish a measure for the nursing process discipline (called the "deliberative nursing process" in 1961). Secondary aims were to (1) test the effectiveness of the process discipline and (2) test the effectiveness of training nurses to use the process discipline. Effective or helpful outcome was defined as a behavioral change that indicated relief from distress or a solution to a work or living problem. Subjects were clinical supervisors and staff nurses; one-half of each group was trained prior to and the other half after the initial data collection. Systematic observations of the subjects were obtained by tape recordings made on six psychiatric units before and after training. Recordings were made of contacts between the subject and object. Objects included patients, nurses, and other professional staff members. Predetermined time intervals for the recordings prohibited natural beginnings and endings of contacts between subjects and objects.

Two sets of data were analyzed: (1) written training records of 28 nurses previously trained in the use of the nursing process discipline, and (2) 144 ten-minute tape recordings. In the analysis of the training records five different forms of verbal expressions were isolated. The training records were analyzed to determine if the nurse's expression of the nursing process discipline was an objective indicator that the person's expression was consistent with her or his immediate reaction and whether there was consistency between use of the nursing process discipline and helpful or effective outcomes. The tape recordings were analyzed to determine the verbal use of the process discipline and its relationship to effective outcome. Orlando was able to establish a valid measure for the process discipline. The use of the process discipline had a significant positive relationship to the outcome in both the tape recorded and the written process re-
(contd. on p. 20)

cords. The findings indicated statistically significant increases in the use of the nursing process discipline by subjects and an improvement in the behaviors of people with whom the subjects were in contact.

Research in Administration and Education

Orlando's theory was used by Schmieding (1983a) to study the immediate reactions and actions of nursing service administrators to realistic hypothetical situations posed by their staff. The findings indicated that the administrators' thoughts were seldom about the nurses who posed the problems, the administrators' feelings were overwhelmingly negative, and the majority of their actions indicated that there would be no investigation of the problem situation. In a subsequent study (Schmieding, 1984), staff nurses, head nurses, and supervisors were asked to select an administrative action most helpful to them and to record what their superior might use. A majority selected actions that explore their immediate reactions. The majority thought that their superior would use a nonexploratory action more often than the subjects would select it as most helpful.

Haggerty (1985) recently conducted a study applying Orlando's theory to the analysis of baccalaureate and associate degrees student nurses' responses to videotapes of patients whose behavior manifested physical or emotional distress. She found that the responses were not associated with the type of educational program. Subjects were more likely to explore the nature of the physical than the emotional distress.

Summary

A significant amount of research has been based on Orlando's theory. In general, the results indicate that the deliberative nursing process is an effective approach to use with different types of patients and in different settings. The research on patient behaviors validates the initial inability of patients to state their needs for help clearly.

Theory without research of the theory serves little purpose. Theory guides research, and the findings of the research serve to enhance and extend the theory. Orlando urges the study of the cumulative effects of the nursing process discipline. She stresses the need to classify observable facts from nurse-patient situations into such categories as behaviors that nurses respond to; distress caused by the inability to nurse the self; and activities that meet the immediate need for help (Orlando, 1985). The implementation of a nursing (contd. on p. 21)

practice theory depends on nurses who are committed to research it as well as on nurses who are willing to test its application to practice.

CASE STUDIES

Orlando's theory has general application.* It can be used with any patient, hospitalized or not. It is also useful in situations involving nurses and other people who affect the nurse's professional practice.

An interesting phenomenon emerged when nurses were asked to describe cases that clearly reflected the use of Orlando's theory. Initially, most of them had difficulty recalling specific cases. Why was that? One nurse's comments sums up the remarks of the others: "I don't consciously decide to use Orlando's theory. Rather it is a way of thinking, a way of responding that is integrated into my total practice. Dramatic cases seldom occur because I constantly explore my perceptions or validate or correct my thoughts in my contact with people. Crises rarely develop." Thus examples, while frequent, might be considered "small": there are no spectacular results. Some results included the following: a patient was able to sleep because the nurse found out that the patient was upset about something in the environment; a patient's strength was conserved because the nurse was able to explore with the patient's doctor her immediate reactions to the doctor's order for the patient; a patient was able to resume psychotherapy because with the nurse's help she was able to express her anger to her therapist; a patient was not declared legally incompetent because a nurse found out that his immediate need for help was hearing aid batteries.

The components of the nursing process, in its current usage, are inherent in Orlando's theory. Assessment is done by exploring with the patient the meaning of her or his behavior to determine whether the patient has an immediate need for help. Plans to meet the need for help are made in deliberation with the patient. The intervention is based on the plans and carried out by the persons identified in the plan. The outcome of the intervention is evaluated in deliberation with the patient. The patient is involved in every step of the nursing process. If the patient is unconscious or unable to speak, the nurse enlists family members or significant others to participate on behalf (contd. on p. 22)

*The author acknowledges the help of Martha Brown, Susan Berry Cann, LaVonne Davidson, Lois Haggerty, and Marilyn Rossier in the development of this section.

of the patient or relies on observations of nonverbal physiological and nonverbal vocal manifestations in carrying out the steps of the nursing process. These observable data might include vital signs, skin color, eye movements, moaning, or wheezing.

Orlando's theory is a process rather than a content theory and is used in the ongoing contacts with the patient. When a patient disregards or does not know or understand the information or the plans that are made to promote his or her state of well-being, the use of Orlando's theory helps to identify the cause of the patient's ineffective behavior.

In this section the use of Orlando's theory is demonstrated in situations in which the nurse does not focus on the patient's presenting behavior or in which the nurse has unverified reactions to the patient. The following sections apply the theory to cases involving nurses' contacts with other nurses and with physicians.

Patient Situations: Focus Not on Patient's Behavior

The use of Orlando's theory directs the nurse's focus on the patient's presenting behavior. Because situations are complex, the nurse may direct her or his focus to other elements. A nurse might focus on the patient's medical diagnosis or condition or on labels attached to the patient. When nurses do not explore the meaning of the patient's presenting behavior, their actions are based on assumptions and are usually ineffective in helping patients. In the following case, one nurse's focus is the patient's medical condition.

A Patient's Concern for His Wife. John Lang,* a 73-year-old retired farmer, was admitted to a tertiary care hospital for a transurethral resection. The surgery was scheduled for 11:00 a.m. the day after admission, but because of an emergency case it was rescheduled for 1:00 p.m. Mr. Lang tolerated both the surgery and the spinal block anesthesia well and was taken to the postanesthesia recovery room (RR) at 2:45 p.m. Mr. Lang immediately tried to raise himself up from the waist, directing his eyes to the tube leading from the catheter and toward the clock above the nurse's station.

Mary Reily, the nurse who was taking his vital signs, told him that the surgery had gone well and that everything was all right. She also told him that it was normal for the tube to have blood-tinged drainage. Since his vital signs were stable and his color was good, Ms. Reily (contd. on p. 23)

*The names and circumstances used in the cases have been changed to protect the identity of the people.

assumed that Mr. Lang was worried about regaining the use of his legs. She expressed her thought but did not formulate it so as to have the patient verify or correct it. She said, "Don't worry, you will get your feeling back into your legs soon." Repeated statements that "all was well" and admonitions to "lie quietly" had no effect. Mr. Lang's activity increased and he began to cry. This illustrates Orlando's concept that if the distress is not identified it cannot be relieved; the patient's behavior remains the same or becomes worse.

The head nurse (HN) who observed Mr. Lang's behavior also thought that many patients who have spinal blocks worry about regaining the use of their legs. She expressed her perception and sought confirmation or correction of her thought by saying, "I wonder, are you crying because you think you won't get back the use of your legs?" "No," sobbed Mr. Lang "it's my wife, she won't go home until she sees me." His persistent attempts to sit up ceased immediately. Further exploration revealed that Mr. Lang was worried that his wife, who was elderly and had cataracts, would not get home until after dark because he was not able to leave the RR. The HN made arrangements for Ms. Lang to see her husband in the RR. Mr. Lang said to his wife, "I'm so relieved that now you can drive home while it's light."

The patient's presenting behavior may represent a plea for help (persistent attempts to sit up). This illustrates the patient's initial inability to express the distress (worry about wife), and need for help (to see his wife so she could get home in daylight) without help from the head nurse. Although the staff nurse's intention was to help the patient, her focus was on the patient's medical condition and not on his behavior.

Concerns about a patient's medical condition can cause nurses to focus on interventions rather than on the patient's behavior. The following case is an example of the possible cumulative effects of nursing when a nurse focused on the patient's behavior and identified the patient's distress.

The Wound That Didn't Heal. Nora Seek, a 51-year-old diabetic, had an above-the-knee amputation of her left leg. The stump was not healing, which prevented her from beginning physiotherapy. The nurses on the unit thought she was depressed. She did not make eye contact when she talked with people and her facial expression never changed (the presenting behavior). The nursing diagnosis established for her was ineffective coping related to loss of leg. The nurses made repeated attempts to give Ms. Seek support and to help her accept the loss of her leg, but her behavior remained the same. A new primary nurse, James Levey, assigned to Ms. Seek explored her (contd. on p. 24)

behavior. He stated, "Your eyes are downcast and your mouth curves down, which makes me think you're terribly sad. Am I correct?" Ms. Seek immediately started to cry and said, "Oh, I feel utterly useless. My family doesn't want the burden of having a one-legged person around" (the distress).

The nurse continued to explore Ms. Seek's distress and found that she had not shared her thoughts with her family. Mr. Levey suggested that Ms. Seek talk with her family about her concerns. She agreed and asked him to be there when she talked with them (need for help). A conference was held, during which Ms. Seek shared her thoughts. She had misinterpreted questions from her family about what special assistance she would need at home as indications that she would be too much of a burden on them. After the conference her verbal and nonverbal behavior improved and her stump began to heal. Three days later she started physiotherapy and was discharged in ten days.

Would the wound have healed, or healed as rapidly, without the nurse's intervention? In addition to improving the patient's condition, the cumulative effects of nursing may also contribute to a reduction in the cost of care.

Nurses encounter situations in which they focus their concern on the patient's condition and feel frustrated because they know they are not determining the reasons for a patient's distress. Orlando's theory provides the basis for expressing this frustration in a way that can be helpful to the patient. The following case demonstrates this approach.

A Nurse's Concern about a Patient's Diet. George Tome, 78 years of age, had frequent hospitalization due to compromised circulation caused by Raynaud's disease. He recently had skin grafts to his foot, which were healing more slowly than expected. The primary nurse, Susan Wong, planning to change Mr. Tome's foot dressing after lunch, noted that he had eaten only bits of the food (presenting behavior). Ms. Wong's first two nursing actions were automatic responses: she asked questions but withheld the thought leading to the questions. She said, "Didn't you like the food?" "It was OK," replied Mr. Tome. The nurse then said, "Then why didn't you eat it?" Mr. Tome replied, "I didn't feel hungry." Ms. Wong began to experience feelings of frustration. She hesitated to clarify her thoughts and feelings and then said, "I really feel frustrated. The reason I asked about why you didn't eat was because I'm concerned your skin graft won't heal properly if you don't eat enough protein. Do you understand my frustration?" Mr. Tome looked up abruptly at the nurse and said "I didn't think anyone here cared about an old man like me (the distress). So bring back the tray and I'll try to eat a little more." Within (contd. on p. 25)

ten minutes he had eaten all the food on his tray. Thereafter he continued to eat and his skin graft began to heal more quickly. Within one week Mr. Tome was discharged.

It is not possible to say that Ms. Wong's action healed the wound and thereby reduced the length of Mr. Tome's hospitalization, but without Ms. Wong's action the continued lack of proper nutrition would have retarded healing. As a result an infection might have developed, which might have resulted in additional skin grafts and possibly an amputation.

Labels are frequently attached to patients. They may influence both clinical and administrative actions of nurses. The following example demonstrates that actions based on assumptions about people who are labeled are inappropriate for designing care.

A Patient Labeled "Schizophrenic." Helen Hunt, a 62-year-old woman diagnosed as having schizophrenia, was admitted to a gynecology unit for uterine bleeding. Laura Kelly, the head nurse, expressed concerns to her supervisor about caring for "schizophrenics" because she didn't know how to talk with them. The supervisor told her to talk as she did with any other patient; namely, explore perceptions for their meaning and explore thoughts for their validity. The next day Ms. Kelly heard Ms. Hunt yelling, "Don't take my blood, don't take my blood" (the presenting behavior). In the patient's room she found a resident, a nurse, and a lab technician trying to explain to Ms. Hunt that they needed to do a blood test to find out what was causing her illness. They repeatedly stated that they were there to help her, not to hurt her. Ms. Kelly came to the patient's side and explored her perception. She said, "I'd like to know why it is that you are saying, 'Don't take my blood?'" Ms. Hunt looked up, said nothing for a moment, and then, pointing to each of the other people in the room she said, "You, you, and you get out," and then pointing to Ms. Kelly, she said, "and you sit down and stay." Ms. Kelly found out that Ms. Hunt was afraid the test would require too much blood and would make her weaker than she already was (the distress). When Ms. Kelly explained that only a little blood was required, Ms. Hunt agreed to have it down (the need for help).

Actions based on the label of "schizophrenic" attached to Ms. Hunt came to the supervisor's attention as a result of an administrative decision. Ms. Kelly informed the supervisor that for staffing purposes two units would be combined by transferring patients from another unit to the unit where Ms. Hunt was a patient. When the supervisor questioned why the unit with fewer patients was not being closed, she was told that the nurses felt it would upset Ms. Hunt to move.

When the supervisor asked if Ms. Hunt had said this, Ms. Kelly was not sure. The supervisor said that if indeed the patient was involved in the decision it was all right, but she would not want the move made on the nurses' assumption that Ms. Hunt would be upset. Ms. Kelly found that the staff had not asked Ms. Hunt about the move because they were convinced that it would upset this "schizophrenic" to move. Ms. Kelly checked out this assumption with Ms. Hunt. She said, "I have a problem I'd like to talk with you about. Because there is not enough staff I need to close a unit and move those patients to another unit. I'd like to close this one because it has the fewest patients. The nurses, however, think it would be too upsetting for you to move. Would it be?" Ms. Hunt smiled and replied, "Is that your problem? Get the wheelchair, honey—I'm ready to move." If a nurse explores the administrative decision with the patient before implementing it, she or he will have factual information about how the patient will be affected by the decision. Actions based on assumptions are neither effective or efficient.

Patient Situations: Nurses' Reactions against Patients

Despite the value placed on care and concern for patients, nurses, as humans, have negative personal reactions to patients that interfere with their ability to help. These reactions are usually based on incorrect assumptions about aspects of a patient's behavior. When this occurs, the focus of the nurse is directed to the self; generally the nurse's thoughts are about threats to her or his self-esteem or self-image. If these judgmental thoughts are withheld, patients are left to make their own interpretations of the nurse's verbal and nonverbal behavior. In the case that follows, several nurses had reactions against a patient; one nurse expressed her feelings to the patient.

The Woman Doesn't Want Her Baby. Ms. Barry, a 39-year-old diabetic who was four months pregnant, was admitted for vomiting. She spoke only when she was asked a direct question and stayed in bed even though she could be up (the presenting behavior). She said that she had vomited since her admission, but no one had confirmed it. At report, nurses began to speculate about Ms. Barry's condition. One nurse said, "I don't think she wants this baby." At the next report, another nurse said, "I don't think she's vomiting." These remarks were passed along from shift to shift, and what were at first speculations were now stated as facts. No one had discussed her thoughts with Ms. Barry.

Terry Brown, a staff nurse, was shocked to hear that Ms. Barry (contd. on p. 27)

didn't want her baby—how could any woman feel that way? Although Ms. Brown felt apprehensive, she decided to express her feeling to Ms. Barry while caring for her. She said, "I'm shocked because I hear you don't want to have this baby. Is that true?" Mrs. Barry's eyes began to well over with tears. She sobbed, "Of course it's not true. It's just that I'm so afraid I'll die in labor. When my other child was born 15 years ago I wasn't a diabetic" (the distress). The nurse was stunned and remarked, "Does your doctor or anyone else now this?" "No, I haven't told anyone for fear they'd think I was a hysterical woman." Ms. Brown explored the distress with Ms. Barry, and the patient agreed to share her fears with her husband and her doctor (the need for help). Upon hearing about Ms. Barry's fear, the other nurses on the unit became sympathetic toward her. It should be emphasized, however, that if the nurse who first thought Ms. Barry did not want her baby had explored the thought with the patient, the other nurses' rush to judgment might have been prevented.

The presenting behavior of a patient that is sexually oriented or has sexual overtones may cause a nurse to have thoughts that lead to embarrassment and anger. These thoughts are often more difficult for a nurse to express than are those arising from other forms of behaviors.

The Flirtatious MI Patient. Mr. Mark Shea, 37 years of age, was admitted to the coronary care unit (CCU) with a myocardial infarction. He was kept heavily sedated for the first several days. As he began to converse more with people, however, he often made remarks to the nurses that were flirtatious, or carried a sexual innuendo (the presenting behavior). For example, he repeatedly commented that he didn't want to miss the classes on sex education. His nursing diagnosis was potential disturbance in self-concept related to threat to sexuality. Nursing goals were established and selected recommended interventions were initiated.

Despite interventions that encouraged the patient to "express views about himself" and to "ask questions about his health problem," his behavior did not change. Although most of the nurses thought these remarks were caused by the threat to his self-image, they were, nonetheless, embarrassed and annoyed by them. In consultation with the psychiatric clinical specialist, Mr. Shea's primary nurse, Gwen Miller, agreed to share her negative reaction with Mr. Shea the next time he made a sexual comment to her. She expressed the feeling and its origin by saying, "I really get embarrassed and annoyed when you make sexual remarks like that, because I don't think you have any respect for nurses. Is that the way you feel about nurses?" Mr. Shea (contd. on p. 28)

looked at Ms. Miller with eyes wide open and said, "I'm sorry. I didn't realize my remarks annoyed you. The reason I make them is that it's the only way I can keep my mind off worrying about my heart and how it might affect my life." Ms. Miller explored Mr. Shea's distress and found that he was concerned about dying during sexual relations. She found out that he thought the CCU nurses' job was only to watch over his physical condition and that talking with patients about their fears was not the nurses' role. Learning that he could call for a nurse just to talk about his fears and concerns resulted in cessation of the sexual remarks.

When a patient's behavior remains the same or gets worse, it is a clear indication to the nurse that the patient's real distress has not been identified. This is empirical evidence that the professional function of finding out and meeting the patient's immediate need for help has not been achieved. When nurses have personal reactions against a patient they should seek consultation to clarify the thoughts that lead to the negative feelings. These reactions can then be expressed to patients in a form that helps nurses maintain their professional focus on the patient's immediate need for help.

Relationships with Other Nurses

An unencumbered working relationship between nurses is vital for the provision of professional nursing. Resentment, distrust, and personal anger between and among nurses shifts the focus of attention to the nurses themselves rather than to finding out and meeting patients' immediate needs for help. Problems can easily arise when patients are transferred from one nursing unit to another or when a new nurse manager is appointed. Orlando's theory is helpful in clarifying these misunderstandings.

A Case of Misunderstanding. Lucy Johnson, staff nurse on the evening shift in the postoperative recovery room (RR), noticed that the past several weeks she had escorted patients to 2-South, nurses had seemed slow in coming to assist her with the transfer (the presenting behavior). When Ms. Johnson related this to her head nurse, she was encouraged to explore her thoughts with the nurse on 2-South. The RR head nurse believed that a problem could be solved more readily if the nurse who had the reaction also initiated the expression and exploration of it with the person against whom the nurse was reacting.

The next evening, the nurse on 2-South requested that a patient be kept in RR another half hour; Ms. Johnson, however, had already left (contd. on p. 29)

with the patient. When Ms. Johnson came on to the unit she had to use the call light to summon help with the transfer. As she waited she became angry: she thought the nurses on 2-South were purposely slow in coming to her assistance because they thought RR nurses had it easy. After the patient was comfortably situated, Ms. Johnson went to the nurse's station to give report. She decided to first express her anger and its origin, because she believed if she didn't it would interfere with her report on the patient. Ms. Johnson said, "I'm angry because recently when I transferred a patient to this unit I had to wait for assistance. I think it's because you think we have it easy in RR. Am I right?" The charge nurse responded, "We don't think you have it easy; it's that we have less staff these days and it seems you plan your transfers at our busiest times" (the work-associated problem). Ms. Johnson said, "I'm glad you don't think we have it easy. I transfer patients from the RR when they are ready to leave; if I keep a patient longer than is needed I can't justify the charges for our services. I don't plan it purposely at this time. Do you understand?" The other nurse said, "I feel better on hearing that." Both nurses agreed, however, that there was a staffing problem at this time of day and requested a meeting with nurse administrators to discuss this problem (anticipated improvement of work problem).

Although the problem may appear small, it is not. As negative reactions build one on another, patient care is compromised; nurses focus on each other and therefore are less available to focus on patients. The next example shows how a new head nurse kept the focus on a staff nurse.

A New Head Nurse. Jane Geis was recently promoted to head nurse of a 30-bed medical unit. She had heard about the unit's cardiac rehabilitation classes. Before starting her new assignment, she inquired about the classes in an informal discussion with some staff members and found they were seldom held. Ms. Geis expressed her regret.

Ms. Geis was to be oriented to the unit's routines for three days by Peggy Gowan, a senior staff nurse. These nurses exchanged information easily on the first two days. On the third day, Ms. Gowan said, "By the way, you really annoyed me with your negative comment about the cardiac rehab classes" (the presenting behavior). Ms. Geis was surprised at the remark. She thought the classes were important and wondered what she had said to cause Ms. Gowan to think otherwise. Rather than making statements to demonstrate her support of the classes, she directed her focus to the nurse. She said, "I think the classes are important; what did I say that you thought was a negative (contd. on p. 30)

comment about the classes?" Ms. Gowan said she really didn't recall precisely.

Ms. Geis still did not understand the meaning of Ms. Gowan's remarks so she explored her next thought: "I wonder, my thought is that you might have heard the end of my conversation with some of the nurses last week and concluded I wasn't supportive of the classes. Could that have been it?" "I think that could be. I heard you say 'I'm not sure what I can do about it' and assumed you didn't think they were important" (the work-related problem). Ms. Geis then asked if she thought it would be helpful to have a meeting to discuss this issue. "Yes—it might help us figure out what to do" (improvement of work-related problem).

Expressing negative feelings to one's supervisor can be difficult. During orientation Ms. Geis expressed her thoughts about various aspects of the unit and had asked Ms. Gowan for her thoughts about them. She invited negative as well as positive feedback. The staff nurse's expression of her negative feeling might have been related to Ms. Geis's previous deliberative actions with Ms. Gowan.

Nurse-Physician Contact

Orlando's theory has application to problematic situations with physicians. The stress and strain in the health care system deeply affects nurses because they are in a pivotal position between the patient and the physician. Because of the power physicians have, and often exercise, nurses frequently have immediate personal reactions that they are unable to express to physicians. An example illustrates this predicament.

The Noncompliant Nurse. The surgery schedule was nearly completed when the operating room (OR) was notified that Henry Schmidt, a trauma victim, was being rushed to surgery for abdominal bleeding. The surgeon and chief of surgery, Richard Meir, had already performed two previous operations that day. The OR nurses described him as "not in a good mood."

After Mr. Schmidt's surgery, Dr. Meir came into the RR to write postoperative orders. He said to Leah Jones, the RR nurse, "I'm going to leave you and everyone else all the orders you'll need between now and tomorrow morning. I don't want to be bothered again tonight!" (the presenting behavior). Ms. Jones thought it was a strange remark for him to make, but did not check out why he had said that. She remembered that she had often heard him raise his voice at nurses.

On her first neurological check, Ms. Jones found Mr. Schmidt's (contd. on p. 31)

pupils unequal. A review of his record revealed that it had not been previously noted. Ms. Jones thought, "Dr. Meir gave strict orders not to call him; he'll probably yell at me if I call." She felt frightened. Nonetheless, she called Dr. Meir, describing her immediate reaction in a disciplined way: "I know you left strict instructions not to bother you, but Mr. Schmidt's pupils are unequal and I want to know, are you aware of this or not?" The doctor said "No" and then added, "I was exhausted when I said that. I'm glad you called." The patient had a subdural hematoma and was returned to surgery for a craniotomy.

Ms. Jones did not automatically comply with the physician's request. She determined that the patient's immediate need for help was medical intervention and called to express her immediate reaction to the physician. The case is a dramatic example of a situation in which a nurse was confronted with the decision to comply or not comply with a physician's demand. The reader might think, "any nurse would have called the physician in this situation"; one would hope so. It must be emphasized, however, that some nurses do refrain from calling for medical help for the patient because of they are afraid of the physician. Using Orlando's theory helps to keep the focus on the patient's immediate need for help. By expressing her or his immediate reaction to the physician in a disciplined way, the nurse develops the courage needed to be the patient's representative to the physician.

Orlando's theory has application to the control of nursing practice. Problem situations between physicians and nurses often relate to physicians' attempts to make nursing decisions. If this is allowed, the nurse administrator loses the ability to keep the nursing department professionally focused on meeting patient's immediate needs for help. The next case exemplifies this situation.

Maintaining Nursing Authority. A cardiac surgeon, Henry Lucas, called Verna Roberts, the director of nursing, and requested that a staff nurse be transferred from his service because she had been discourteous to a patient. Ms. Roberts asked him if he had witnessed the incident, and, if not, on what was he basing his request. Dr. Lucas had not witnessed the incident but was told of it by his surgical resident. Ms. Roberts told Dr. Lucas that she would investigate the complaint, and that if it was valid the nurse would be reprimanded or discharged; she would not transfer a nurse for disciplinary purposes.

Dr. Lucas then said, "Let me know what action you intend to take." Ms. Roberts explored her thought with the doctor. "When you ask me to let you know the action I intend, it makes me believe you think you are responsible for making nursing decisions. Am I correct or not?"

“It’s not that at all. I just want to know how it comes out,” said Dr. Lucas. “Well, I’m relieved to hear that. If you thought you were responsible for nursing decisions there would be a problem, because that is what I was hired for. Can you understand my relief?”

Discussion with the staff nurse and patient revealed that there was a misunderstanding about the room to which the patient should have been admitted; therefore, the patient thought that the nurse didn’t think he was good enough for a private room, whereas a critically ill patient needed that room. No action was taken against the nurse. There were no further incidents such as this with this physician.

CONCLUSION

For a theory of nursing to have an impact on practice, nurses must understand and be able to use it. The theory must have a sufficient number of interrelated concepts to help the nurse focus on relevant phenomena in a nursing situation, but not so many that the nurse becomes confused. The nurse must be able to validate the theory’s effectiveness through empirical observations. A practice theory should be efficient. Waiting for the nurse to determine an immediate need for help increases the time during which a patient experiences distress and helplessness.

Orlando’s theory contains easily understood terms; however, the concepts are easily misinterpreted. The organizing principle, to find out and meet the patient’s immediate needs for help, is a concept that describes what most nurses would define as effective practice.

Patients and nurses come in contact with each other because the patient needs some form of help. The help may be learning self-care, learning how to prevent illnesses, or reinterpreting experiences. The use of Orlando’s theory ensures that the help provided will be individualistic, because the patient is involved in validating every aspect of the nursing process.

The use of Orlando’s theory does not prevent the use of other theories in the care of patients, as long as plans based on these theories are made in deliberation with the patient. Long-range goals can be established for a patient, but if a patient is experiencing an immediate need for help this must be attended to; if it is not, the long-range plan is useless.

I have attempted to show that Orlando’s theory has direct application to the professional care of patients. Through its use, nurses can both control and evaluate the effectiveness of their practice. Its appli- (contd. on p. 33)

cation to practice has implications for the education of professional nurses and for the development of research to test and develop the theory. Patients who receive care from nurses using Orlando's theory will participate both in specifying their distress and in deciding on the action that will increase their sense of adequacy and well-being

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