A Process-Oriented Approach

SELECTING A

NURSING MODEL

FOR PSYCHIATRIC

NURSING

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The nursing literature is replete with articles and books that describe nursing conceptual frameworks and models and encourage their use in clinical, education, and research activities. Although much information exists on the content of nursing models, less has been written about how a model is to be chosen and the process that may facilitate the choice of a model. This article reviews potential benefits and limitations of nursing models and conceptual frameworks and describes a three-phase process for selecting a model for psychiatric nursing practice.

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Nursing Model

Nurses who are considering the adoption of a nursing model or conceptual framework for clinical practice often find themselves overwhelmed by the diversity of choice and volume of information. Without a plan of how to establish a “goodness of fit” between models that are by nature abstract and the concrete requirements of clinical practice, they often feel anxious and uncertain about how to begin the selection process. Two commonly expressed concerns of nurses who are contemplating adopting a model are, “How will we decide which model to choose when there are so many to choose from?” and “How will we select a conceptual framework model that fits our particular practice needs?”

Benefits and Limitations of Adopting a Model

Conceptual nursing models are particular frames of reference within which patients, their environments and health states, and nursing activities are assessed. Their use has been characterized as one of four recent developments in nursing that have resulted in considerable change in the content of nursing education programs, in the organization and administration of nursing services, and in the quality of patient care. Nursing authors have suggested that a move towards model-based practice is the most important target for change in nursing today, and that it should precede all other innovations (Fawcett, 1989; Pearson, 1986a). The argument is put forth that the accountability of individual nurses is difficult to measure until there is a shared understanding of what nursing is. Furthermore, as the role of nursing expands, it becomes important that nurses possess a clear understanding of the nature and domain of nursing.

Models offer guidance in these areas by providing a structure whereby the nature of nursing is described and for thinking, observing, and interpreting what is seen. The nature of clinical problems, the purposes of nursing practice, the settings in which nursing practice occurs, and characteristics of the recipients of nursing care are all identified by nursing conceptual models (Fawcett, 1989). The models assist with the identification of the range of human responses to actual or potential health problems that may respond to nursing actions. They provide a foundation from which assessment proceeds, providing a common data base from which nursing diagnoses are made. Models explain in general terms why individuals respond to health problems in the way that they do, and they help provide an understanding of the desired outcomes of nursing interventions. In furnishing direction in these areas, models play an integral role in providing a frame of reference for practice.

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Critics of nursing models have suggested, however, that they are incomplete and lack adequate testing and refining (Hoon, 1986). In response to these criticisms, Field (1987) states that “no one will deny that models are currently incomplete and that they lack adequate testing and refining, but to negate the role they can play in providing a useful framework for assessment and nursing intervention is an unfortunate, if not uninformed, attitude.”

A common criticism expressed by psychiatric nurses is that nursing conceptual models lack the degree of specificity needed for intervening in discrete, highly individualized, clinical situations. For this reason, psychiatric nurses have often relied primarily on a wide range of non-nursing models; for example, medical, behavioral, and sociotherapeutic models (McKeena, 1989). Johnston and Fitzpatrick (1982) suggest that theoretical formulations, such as the psychoanalytic perspective of nursing, have been developed from broad perspectives of man, health, or environment. These formulations have specifically described mental health and illness.

The breadth of these theories has encouraged nurses to identify with disciplines other than nursing and has limited the unification and advancement of theoretical orientations in psychiatric mental health nursing. The identification with non-nursing models has resulted in nurses assuming the role of doctor’s assistant, individual psychotherapist, behavior therapist, and sociotherapist, thereby losing their nursing identity. Reed (1987) states, “while non-nursing theories may provide valuable knowledge for practitioners, they may obscure or be incongruent with or limit nursing’s perspective for the principle concerns of nursing.”

A clear understanding is required of what is and is not nursing; this understanding can be provided by nursing conceptual models. As we argue for a clear delineation of what falls within the domain of nursing, nursing should engage in lively discourse with other disciplines and branches of knowledge. Knowledge can and should be borrowed from other disciplines, as well as the arts and sciences; in fact, this is how all existing nursing conceptual models have been developed. What is of paramount importance, however, is that this knowledge be refined, transformed, and tested for its relevance to the unique central goals and concerns of nursing. When these criteria are met, borrowed knowledge, through the process of transmutation, has become nursing knowledge.

Meleis (1984) has suggested that nursing models offer a common language and a beginning articulation on what nursing is and what roles nurses play. Models offer a view of the philosophical underpinnings of nursing and speak in different ways on how to help patients be comfortable, how to deliver treatment with the least damage, and how to enhance high-level wellness. Nursing conceptual models provide a broad orientation to the domain of nursing.

Nursing conceptual models by themselves do not, however, provide a suffi-
cient base of knowledge for nurses to make judgments (Field, 1986). Although they are extremely useful in indicating nursing as distinct from other health-related professions, such as psychiatry, psychology, social work, and occupational therapy, knowledge from other disciplines is also needed. We emphasize that conceptual models provide a framework for the development of more situational and clinically specific nursing theories and for reinterpreting and transforming the knowledge borrowed from other disciplines so that it becomes relevant to the goals and needs of the nursing profession.

Meleis (1985) also suggests that the articulation of the actions, goals, and consequences of actions enhances the accountability and visibility of the nursing profession. Defining the focus and the means to achieve that focus, and being able to predict consequences, increases control of nursing practice and therefore increases professional autonomy.

Although subjectively derived frameworks can be valuable to the individual, they have limited usefulness because they are intuitively derived, highly personalized, and do not allow for comparisons. Because they have not been articulated, they can be neither easily communicated nor evaluated. Without effective and efficient communication, further theory development will be delayed because concepts cannot be refined, sharpened, extended, and validated (Meleis, 1985).

The Choices

Experienced nurses who practice using a personal, nonarticulated framework or model have a number of options. They may continue in this manner, recognizing that valuable opportunities to refine theory, strengthen clinical practice, and enhance the accountability, autonomy, and visibility of the nursing profession may be lost. They may select from currently existing nursing models and conceptual frameworks one that resonates with their beliefs and style of practice, modifying and adapting the model to meet the needs of a particular clinical specialty. A third option exists for nurses who are dissatisfied with the possibilities presented by current models: they should be encouraged to develop and articulate their own model.

The Process

The following process enables nurses to proceed confidently in assessing the goodness of fit between existing nursing conceptual frameworks and models and the needs of a particular clinical practice (Figure).

**Setting the Stage.** In the first phase, a climate conducive to change is built, beginning with the clear acknowledgment of the participants as expert resources. This approach not only adheres to the principles of adult education, whereby learners engage in learning that has an immediate application, but it also helps nurses to feel in control of the process, a crucial element in building participant cooperation. Also important is the recognition that nurses who have been practicing for a number of years already possess intuitive, although nonarticulated, frameworks of their own. The process described here demonstrates valuing this intuitive framework and enabling participants to retrieve and describe part of this framework to assess the usefulness of existing nursing models for the participant’s own practice situation.

Various conditions must be met before the actual inquiry process is begun. There should be realistic expectations about what nursing conceptual frameworks and models can and cannot do. If the benefits are thought to be worthwhile, the timing of the actual inquiry process can be considered.

Support must be available from nursing management, including senior nurse administrators. If support for initiating model selection activities is not strong because of lowered resources, competing interests or other pressing priorities, it may be wise to postpone further investigation until a more conducive climate can be created. Shea, Rogers, Ross, et al (1989) have indicated that although it is essential to have the demonstrated support of senior nursing management, it is also important that the process of selecting and implementing a model be “owned” by staff rather than “imposed” on them.

Ouellet, Rodgers, and Gibson (1989) have suggested that representatives from all levels of management and appropriate programs and units within the agency should be consulted and involved. They suggest that an ad hoc nursing practice committee could be formed with the mandate to select an appropriate model in collaboration with the staff nurses. This approach, while it offers valuable advice in terms of securing the involve-
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To highlight the most meaningful, fundamental, and imperative aspects of personal and professional life.

Once these elements have been described, nurses can use these thoughts to discriminate for themselves how currently existing models and conceptual frameworks meet their own philosophic and practice needs. Moreover, asking nurses to be reflective and introspective ultimately facilitates the gradual unfolding of a professional self-awareness that is the precursor of a stronger professional identity.

Reflecting on the central themes that emerge, the nurse considers what it means to be a person; to be a client; to be related as a nurse to the client through the process of caring; to be related as a client to the nurse through the process of receiving care; and to influence and be influenced by the surrounding environment. These themes in turn illuminate the attitudes, beliefs, values, assumptions, and motivations that produce the pattern from which a characteristic practice style emerges. The more clearly these themes are articulated and the way in which they influence practice elaborated, the easier it will be for nurses to identify nursing models that reflect a similar or compatible orientation.

The second step of this phase involves the categorization of the attributes of the clients being served. Describing the particular sets of client problems and the priorities for care related to these clients will enable nurses to focus more specifically on the recipients of nursing actions. What types of problems do these clients characteristically encounter? What are their goals? What level of insight into their problems do they possess? To what extent do the client and caregiver agree as to the nature and cause of the problem? What support systems are available to the client? Are the client’s coping methods effective or ineffective? With the nurses’ own philosophic position in mind, their clinical knowledge and skill assumed, and the concrete problems of the client articulated, attention can be directed to specific dimensions of the client’s functioning. How well current nursing practice models address relevant factors and thus how useful they are for serving particular client populations can now be addressed.

Step 3 of this phase involves the identification of the attributes of successful interventions, or those that have a high likelihood of being effective for the types of client problems characteristically encountered. Reflecting on nursing interventions and those from other disciplines allows the nurse to synthesize her perspective about the person, health, environment, and nursing. If interventions are judged to be effective, irrespective of the discipline using them, it may be reasonable to assume that some truth about the person’s physical, psychological, spiritual, social, or cultural essence has been understood, appreciated, and acted on.

Trying to define effective and ineffective interventions often opens up other avenues for further exploration; for example, what are the legitimate goals of interventions. The assumptions that will inevitably surface about the person, health, nursing, and environment during the examination of effective interventions can then be compared with the nurse’s intuitive, spontaneous ideas described in the first step. When there is a sense of coherence, congruence, and flow in the thinking at Steps 1, 2, and 3, these thoughts can be further expanded and developed. If, however, incongruence, discontinuity, incompatibility, or incompleteness exist, these conclusions will require further analysis integration or reformulation.

One nurse commented on some insights gained from the process:
When I sat down to think about my own view of the person, I realized I felt strongly about the spiritual dimension and the importance to living one's life in a way that is compatible with one's own cultural experience (Step 1). I went on to think about the typical problems with which our clients present (Step 2). Next, I thought about the interventions characteristically carried out by nurses on our unit (Step 3). I felt we were reasonably successful in giving psychosocial care and that we did give sufficient attention to physical care as well. However, it suddenly occurred to me that we tended to neglect the spiritual needs of the client and we were less than sensitive to the way in which culture affects the expectations and experience of the client, even though many of our clients were members of ethnic groups. As a result of this insight, I raised my concerns with my colleagues, and there is now general agreement that these are important areas that we could be addressing more satisfactorily. I think, for us, a relevant model will have to provide opportunity to deal with these aspects.

Selecting and Testing of the Appropriate Model. The first step in this phase is to begin a search of the literature with a view toward developing a short list of nursing conceptual models that appear to have the greatest probability of being relevant to practice needs. Although it is beyond the scope of this article to offer a content analysis of nursing conceptual models, the reader is referred to sources that have found particularly helpful (Buchanan, 1987; Capers, 1986; Fawcett, 1989; Fitzpatrick, 1982; Meleis, 1985; Pearson, 1986b; Riehl, 1980). It is advisable to postpone a literature search until the third and final phase of the process is completed (Figure). By so doing, a specific list of criteria will have emerged with which to judge the usefulness for clinical practice of various nursing models. With specific criteria in hand, nurses are much less likely to be overwhelmed by the diversity of available choices.

In establishing a goodness of fit, an assessment is made of the extent to which the short-listed nursing models are compatible with other non-nursing models. In some situations, such as private practice, nurses provide the client's only professional therapeutic contact. In these cases, the nurse contracts with the client to provide a special type of service, the nature of which is usually fairly well understood by the client. In these practice settings, compatibility of approach with other disciplines may be of little concern or interest. However, in most mental health clinical situations in North America, nurses work closely with members of other disciplines. A certain set of interventions used in these multidisciplinary contexts will be shared among disciplines, whereas others will remain discipline specific. In the interest of greater and more effective collaboration with all professions represented on the multidisciplinary team, and especially where the contributions of other disciplines are highly relevant, effective, and necessary, choosing a nursing model that allows for a high degree of compatibility may be an important consideration.

Once nurses have clearly articulated their beliefs and assumptions about the nursing process, have categorized the attributes of clients, analyzed the qualities of effective interventions, conducted a search of the literature, and determined the degree to which compatibility with other therapeutic models is desirable and possible, they are in a position to establish a goodness of fit. Taking into consideration truths attained through personal and clinical experience, they are able to evaluate the ability of existing nursing practice models to deliver a framework that resonates with what is viewed to be true (congruent), is useful in guiding practice (relevant), fits with other non-nursing models (compatible); and is easily understood and communicated (comprehensible).

When these criteria have been successfully met, an existing nursing model can be selected for testing on a trial basis. Nurses who have developed an elaborate and distinct approach may decide that existing models lack the critical ingredients necessary to meet their particular practice requirements. These nurses should be encouraged to refine or adapt existing models, or alternatively develop a nursing practice model that will more adequately meet their practice needs. Reed (1987), recognizing the need for nursing models to be developed for and by nurses having particular needs, has described a method that can construct a conceptual framework for psychosocial nursing. She states:

The intent...is to provide just enough structure in the development of a conceptual framework to ensure congruity with nursing's metaparadigm without constricting the theoretical creativity and practical wisdom of a clinical specialty.

Nurses working with persons from cultures other than the mainstream North American culture should critically evaluate currently existing nursing conceptual models for cultural relevance and sensitivity. McFarlane (1986) has queried, for example, whether American models are transferable to nursing practice in Britain. Wright (1986) suggests that although the process of intellectual exchange with nurses from different nations is laudable, the transfer of one group's practice to another may not always be appropriate. It has also been widely recognized that nursing models from the United States have their roots in a different culture, a different health care struc-
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KEY POINTS


Nursing models offer a structure whereby the nature of nursing is described and for thinking, observing, and interpreting what is seen. They play an integral role in providing a frame of reference for practice.

1. A common criticism expressed by psychiatric nurses is that nursing conceptual models lack the degree of specificity needed for intervening in discrete, highly individualized, clinical situations. Therefore, psychiatric nurses have had to rely primarily on non-nursing models.

The use of a model selection process will reap significant rewards; it is a deliberate, rational decision-making process, leading towards greater articulation of one’s beliefs and values as well as defining one’s practice.

References