individual microscopic approaches to community health nursing problems; one originates within nursing and one is based in social psychology. Two other theories demonstrate the examination of nursing problems from a macroscopic perspective; one originates from nursing and another has roots in phenomenology. The format for this review is as follows:

1. The individual is the focus of change (i.e., microscopic).
   a. Orem's self-care deficit theory of nursing
   b. The health belief model (HBM)
2. Thinking upstream: Society is the focus of change (i.e., macroscopic).
   a. Milio's framework for prevention
   b. Critical theoretical perspective

The Individual Is the Focus of Change

Orem's Self-Care Deficit Theory of Nursing

In 1958, Dorothea Orem, a staff and private duty nurse who later was a faculty member at Catholic University of America, began to formalize her insights about the purpose of nursing activities and why individuals required nursing care (Eben et al., 1986; Fawcett, 2001). Her theory is based on the assumption that self-care needs and activities are the primary focus of nursing practice. Orem outlined her self-care deficit theory of nursing and stated that this general theory is actually a composite of the following related constructs: the theory of self-care deficits, which provides criteria for identifying those who need nursing; the theory of self-care, which explains self-care and why it is necessary; and the theory of nursing systems, which specifies nursing's role in the delivery of care and how nursing helps people. Major concepts from Orem's self-care deficit theory are listed in Box 3-2.

BOX 3-2 CONCEPTS FROM OREM'S SELF-CARE DEFICIT THEORY

- *Self-care:* "The production of actions directed to self or to the environment in order to regulate one's functioning in the interest of one's life, integrated functioning, and well-being."
- *Therapeutic self-care demand:* "The measures of care required at moments in time in order to meet existent requisites for regulatory action to maintain life and to maintain or promote health, development, and general well-being."
- *Self-care agency:* "The complex capability for action that is activated in the performance of the actions or operations of self-care."
- *Self-care deficit:* "A relationship between self-care agency and therapeutic self-care demand in which self-care agency is not adequate to meet the known therapeutic self-care demand."
- *Nursing agency:* "The complex capability for action that is activated by nurses in their determination of needs for, design of, and production of nursing for people with a range of types of self-care deficits."
- *Nursing system:* "A continuing series of actions produced when nurses link one way or a number of ways of helping to meet their own actions or the actions of people under care that are directed to meet these persons' therapeutic self-care demands or to regulate their self-care agency."

From Orem DE: *Nursing: concepts of practice,* ed 6, New York, 2001, Mosby, p 31.

The basic concepts of this theory evolved from observing the chronology of illness in hospitalized patients. The self-care deficit theory is based on the premise that nursing is a response to a sick person's inability to administer self-care. Nursing assumes the role of providing some or all self-care activities on the patient's behalf (Orem, 2001). This focus makes the content and scope of the theory most useful to nurses practicing within an institutional setting. Orem briefly specified the role of population-based nursing in the sixth edition of her book, *Nursing: Concepts of Practice* (2001). However, some of her concepts are so specific to an individual orientation to disease that applying them to a population can be awkward at best. Individual patient deficits (and nurses' efforts to address them) are central to this theory; thus, its ability to inform community-level problems and health promotion strategies is limited.

Application of self-care deficit theory. During a discussion about theory-based initiatives, a British occupational health nurse lamented over her nursing supervisor's intention to adopt Orem's self-care deficit theory. She was frustrated and argued that much of the model's assumptions seemed incongruous with the realities of her daily practice. Kennedy (1989) maintained that the self-care deficit theory assumes that people are able to exert purposeful control over their environments in the pursuit of health; however, people may have little control over the physical or social aspects of their work environment. On the basis of this thesis, she concluded that the self-care model is incompatible with the practice domain of occupational health nursing.

Kennedy exemplified the dissonance that nurses feel when a particular theory is inappropriately imposed in a work setting. Although it is easy to recognize the importance of Orem's concepts to many arenas of nursing practice, it is also apparent that her perspective would not lend itself well to understanding the diverse health needs of people in a worksite. Kennedy (1989) clearly articulated this position when she stated that "the many facets of the occupational health nurse's role may 'fit in comfortably with Orem's self-care model.' But will Orem's model fit into the many facets of the occupational health nurse's role? That is the key question we should be asking" (p. 354).

The Health Belief Model

The second theory that focuses on the individual as the locus of change is the health belief model (HBM). The model evolved from the premise that the world of the perceiver determines action. The model had its inception during the late 1950s when America was breathing a collective sigh of relief after the development of the polio vaccine. When some people chose not to bring themselves or their children into clinics for immunization, social psychologists and other public health workers recognized the need to develop a more complete understanding of factors that influence preventive health behaviors. Their efforts resulted in the HBM.

Kurt Lewin's work lent itself to the model's core dimensions. He proposed that behavior is based on current dynamics confronting an individual rather than prior experiences (Maiman and Becker, 1974). Figure 3-1 outlines the variables and

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