Conceptual Framework

The Orlando Theory and its Application

The diagnosis of schizophrenia requires considerations of age, gender, and cognitive-affect norms. Symptoms of premorbid and social functioning may be periodically absent, requiring an awareness of variable clinical presentation and the predictable course of the disease. The theory of schizophrenic disorder involves diagnostic assessment of marked behaviors of anxiety, disorganization, illogical thinking, markedly inappropriate affect, a pattern of bizarre behaviors, and depression (Orlando). Social functioning presents as negative psychosocial indices prompted by stress levels below the societal, cultural, age, and gender norm. Cognitive functions demonstrate ineffective attention focus, confused language, and memory retention.

Given those health issues now at hand, the Ida Jean Orlando Deliberative Nursing Process Theory will be applied. Under these precepts, manifold assumptions are promulgated:

1. Patient distress is exacerbated by the stress and helplessness created by coping failures.
2. The nature of professional nursing generates patient stress.
3. Patient presentations and responses are unique.
4. Nursing by its very nature is “mothering”.
5. Nursing involves people, environment, and health.
6. Patients require assistance in communicating needs and expressing dependency.
7. Patient expressions of need, thought, and feelings can be secretive or explicit.
8. Patient-nurse relations are fluid, affected by either or both parties.

9. Individuals presume meanings unrealized by others.
10. Patients come into contact with nursing care through medical stress.
11. An effective nurse-patient relationship best influences patient communication; communication can be positively affected with nursing help.
12. Shared observations inspire patient feedback.
13. Nurses focus upon those needs outside of patient control.

The proponent of these principles, Ida Jean Orlando, came to them following a career as a nurse practitioner and educator with a primary focus in the realm of mental health and psychiatric nursing. Following research work at the National Institute of Mental Health in which she published the seminal work *Integration of Mental Health Concepts in a Basic Curriculum*, she became director of the graduate program in psychiatric nursing at Yale University and began a lifelong study of nurse-patient interactions and patient outcomes. Pursuant to a study conducted while at Yale, in 1961 Orlando published her theories of nurse-patient relationships as underpinning effective treatment modalities as *The Dynamic Nurse-Patient Relationship: Function, Process, and Principles* which she followed a year later with *The Discipline and Teaching of Nursing Process.* Recognized by the Massachusetts Registered Nurse Association as a "Nursing Living Legend", Orlando's influence in the treatment of the mentally ill patient stands as a cornerstone of professional nursing education and care (Orlando).

As is apparent, the Orlando Theory finds its focus in an appreciation of patient individuality and of the vigorous, purposeful dynamics of a fluid patient-nurse relationship. It is submitted herein as presenting the professional mindset most

appropriate for the treatment subject now considered as suffering from apparent symptoms of schizophrenia.

The nursing metaparadigm, involving the application of the proffered theory and its application to the four critical components of care involves, initially and globally the person component, which brings focus primarily upon the patient undergoing care, and requires an integrated approach to patient support systems, family members, social and spiritual needs (Cody 2006). How the patient responds to these somatic and social influences drives patient healing and positive outcomes (Liehr 2008). The Orlando Theory emphasizes the evolution of the nurse-patient relationship, describing the patients as "humans in need" (Orlando).

The environmental component within the general metaparadigm presages treatment planning and symptom diagnostics, for patient surroundings—including both internal and external inputs—can dramatically influence wellness outcomes or predict treatment challenges. Those environmental elements include economics, housing, treatment environments, familial and staff interactions, as well as geographical, cultural, and technological factors (Masters 2004). As a patient exercises degrees of control over many of these factors, health status will be positively affected. Uniquely among both compatible and contradictory theories, Orlando dismisses such concerns, again maintaining primary focus upon the individual patient, even to the exclusion of such "environmental" factors as family members or other social relations. Orlando resolutely maintains, in this metaparadigm category, sole focus upon the individual patient within the controlled and exclusive nursing environment.

An individual patient's health component within the metaparadigm generally presents as dynamic and multi-dimensional within the individual's life timeline (Potter 2012). Certain elements within the metaparadigm component are intractable: genetic makeup, family history, prefacing environmental exposures, and personal health profile. The integration of patient physical, emotional, intellectual, and social well-being is presented as underlying all care modalities and as contributing to overall well-being and treatment outcomes. Again somewhat contradictorily and stridently, Orlando posits that nursing is professionally provided to those who need care, and who have manifested a degree of helplessness that is subsequently diagnosed as a pronounced need for nursing. Certainly our schizophrenic patient, with a pattern of symptoms generating a professional diagnosis, would qualify for such care under the Orlando theory.

The nursing component of the overarching metaparadigm requires a relationship of nurse-patient mutuality for care outcome. There is an assumption of a concentration upon high levels of patient service to generate expectations of positive outcomes and shared responsibilities. Pursuant to that, nurse practitioners presumably personify and practice principles of skills, knowledge, technological prowess, collaborative engagement, educated and professional judgment, and effective communication ability and protocols (Conceptual models). Not that the Orlando Theory entirely rejects these suppositions, but it does appear to stand arms akimbo above principles of independence and discipline in its approach to patient needs in those situations demanding care by those properly trained to provide it.

Pursuant to Orlando's precepts, the organizing principle of what she refers to as "professional nursing" requires an immediate assessment of the individual patient's

requirements for relief, assistance, comfort, or care. The root concern here is always providing direct and immediate help to alleviate any sense of despair or helplessness on the part of the patient (Orlando). This surely motivates the assignment of this theory for the care of our schizophrenic, reasonably desperate, confused male patient.

The Orlando Theory further prescribes a systematic approach to care, calling for nurse practitioners to assess patient behaviors and to—in our instant patient profile—to be aware of symptom indicators that fall outside of strict symptomology but within the nursing metaparadigm. The specific individual patient profile is instructive as to the somatic basis of individual symptoms; its careful construction is required before rendering a preliminary diagnosis and should include factors of age, gender, family history, pharmaceutical influence, substance abuse, age of onset, premorbid, social and cognitive functioning, metabolic complications, physical health, and disease course as basic fundamentals to effective assessment. Because, under Orlando, all presenting behaviors are an expression of patient need and distress, deliberative nursing responses are favored over any automatic responses. This requires a significantly disciplined process-approach on the part of the professional and an awareness of countervailing communication styles. That process approach is further distinguished by five separate stages under the Orlando Theory:

1. Assessment-a holistic analysis of patient needs with data collection.
2. Diagnosis-a clinical judgment of the health problem pursuant to training.
3. Planning-goal setting for the resolution of problems to achieve positive outcomes.
4. Implementation-bringing the nursing care plan into operational focus.
5. Evaluation-progress analysis and recognition of success or new problems.

The predominant advantage of applying the Orlando Theory to the treatment of diagnostically apparent schizophrenia in the subject 32-year-old male with observable first-episode psychotic symptoms is the creation of a modality of give-and-take between the patient and his nurse. Orlando's "deliberative nursing" process works within the metaparadigm here because the patient in this case has a *need to be understood* and to have his concerns met with understanding and with the development of an actionable plan of care. Under this protocol, patient behavioral improvements can be reasonable anticipated as stresses are acknowledged, treated, and ultimately resolved.

References

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