

1 Preventive role supplementation

a grounded conceptual framework

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One of the major issues confronting nursing today is whether nursing will survive the many turmoils with which it is beset. Questions raised around the profession of nursing continue. What are the goals of nursing? Does nursing possess a body of knowledge? How different is that body of knowledge from that of other health professions? Is what nursing offers unique? Although we will not and could not possibly answer these questions in this chapter, we will demonstrate an aspect of a systematic body of knowledge in nursing. A conceptual framework with potential for focused research in nursing has been operationalized and implemented in a clinical situation. The conceptual framework was reported theoretically (Meleis, 1975) and empirically (Meleis and Swendsen, 1978; Swendsen, Meleis, and Jones, 1978). This chapter presents all parts of the framework clinically. Other clinical situations could utilize the framework.

The major assumption here is that conceptual frameworks offer structure for nursing knowledge. Without such frameworks, knowledge of various phenomena cannot be interrelated and fractions of knowledge may be isolated and, most likely, lost. Thus, an integrative framework is essential to the development of a body of knowledge encompassing theory, practice, and research.

Chin (1962) views models as an orientation to practice, to be used for diagnosis and treatment (or assessment and interventions). Even though many practitioners question the utility of a model for practice, Chin maintains that no one can observe without a preconceived notion of the elements to be observed and how those elements can be interpreted. Such preconceived notions, when systematized, are referred to as *conceptual models*. Inkles (1964) maintains that a scientist needs a "mental" image of how a "realm" is "put together and how it works." Without such preconceived images, a scientist could not raise appropriate questions.

Models are essential for practitioners in diagnosing and treating (assessment and intervention), for teachers in classifying phenomena, and finally for researchers in asking and interpreting questions and establishing a "foundation for continuing development of relevant research and significant utilizations of investigatory findings" (Rogers, 1970). We will show how a conceptual framework can suggest and help structure a particular nursing intervention. While many practicing nurses shrug away the notion of using nursing models, the mere fact that they observe, assess, intervene, and ask questions evidences the fact that they are

guided by "a mental image." Public health nurses and maternal-child health nurses, for example, are often involved in preventive role supplementation, although their work may not have been conceptually organized to provide a framework for nursing intervention and research. This presentation is rooted in the conviction that nursing practice must flow from theory and substantive knowledge.

In the course of a lifetime an individual undergoes many transitions that entail extensive mobilization of personal resources to cope with resulting stresses. Therefore, the loss of some roles and the acquisition of new ones are of particular significance to nurses. The developmental stages of a life cycle, along with health and illness, are the occasions for a number of important role changes. To demonstrate preventive role supplementation (Meleis, 1975), a number of couples expecting their first child were chosen. As will become apparent, many other types of clients, such as chronically ill patients, parents of a handicapped child, mastectomy patients, and others could also benefit from role supplementation.

LeMasters (1969), in his study of middle-class couples, confirmed that the birth of a first child constitutes a crisis event and that most couples find the transition to parenthood difficult. This finding was confirmed by Dyer (1969), who said a majority of the couples he studied experienced extensive or severe crisis. The conflict aspects of adaptation to early parenthood and the association with severe stress have been described by many (James and Benedick, 1970; Sheresfsky and Yarrow, 1974).

During crisis the normal coping mechanisms of individuals are inadequate. In this study, the nurse clinicians used preventive role supplementation to augment the expectant parents' adaptive capacity during the transitional crisis. Whether transitions are viewed as mere developmental stages or as crisis periods would not affect the proposed framework. It is assumed that the situation of the unit of study (be it a family or group) will determine whether a crisis model or a transition model is more suitable. Since preventive role supplementation is an interactional conceptual framework, the perspective of the clients will help determine the most appropriate content included.

The conceptual basis of nursing intervention discussed in this chapter is that of preventive role supplementation as proposed by Meleis (1975). It is defined as "the information or experience necessary to bring the role incumbent and significant others to full awareness of the anticipated behavior patterns, units, sentiments, sensations, and goals involved in each role and its complement" (Meleis, 1975). Preventive role supplementation may be a means to achieve role mastery for the novice who is to acquire and master the appropriate behaviors and sentiments by learning (1) the behaviors that are expected, (2) the sentiments and goals appropriate to the role, and (3) the costs and rewards to be anticipated, including whether or not significant others provide negative or positive reinforcement. Preventive role supplementation can be a way in which significant others clarify roles for persons *anticipating* transition and through which the individual can master the anticipated transition by means of role rehearsal and role modeling.

The goal of the preventive role supplementation program (ROSP)* is to pre-

*ROSP is the acronym used to refer to the preventive role supplementation program as outlined by Meleis (1975).

vent the development of *role insufficiency*. Role insufficiency is defined by Meleis (1975) as behavior that indicates " . . . any felt disparity in fulfilling role obligations or expectations of significant others' roles in a health-illness situation. It denotes the incongruency of the self-concept and the role anticipations of others." Further, role insufficiency characterizes an ego confronted with expectations that it cannot articulate.

CONCEPT OF ROLE

A *role* is a set of behaviors or expected behaviors as well as a sentiment or goal that provides unity to a set of potential actions (Turner, 1962). More recently Turner (1967) has suggested:

In any interactive situation, behavior, sentiments, and motives tend to be differentiated into units, which can be called roles; once roles are differentiated, elements of behavior, sentiments, and motives which appear in the same situation tend to be assigned to the existing roles.

Thus, role, as utilized in the development and conceptualization of role supplementation, will be based on the symbolic interactionist use of the concept (Morris, 1934). Role in this sense is conceptualized as a way of coping with an imputed other role (Cottrell, 1942; Turner, 1967).

Components of ROSP

In this section each component of ROSP, as outlined by Meleis (1975), is presented as a concept, followed by a discussion of an implementation program with expectant parents and examples drawn from actual experience with the program. It must be emphasized that a "viable role supplementation program should capitalize on the importance of a significant other and/or others in reinforcing new roles and counter roles" (Meleis, 1975).

The program was developed within the "context of an appropriately designated reference group involving the self and appropriate significant others" (Meleis, 1975). On this basis, twelve couples expecting their first child were invited to participate in ROSP. Their ages ranged from 19 to 32 years. Their ethnic backgrounds included white, black, oriental, and Spanish-American. Their education ranged from high school to postgraduate. They included blue-collar workers and professionals, working and nonworking mothers, and those who planned their pregnancies as well as those who did not. The members held varied opinions and interest in natural childbirth. They were divided into two groups. Starting around the beginning of the third trimester, each group attended 2-hour group meetings each week for 8 weeks.

Since roles develop in pairs to complement each other, it was essential to include both wives and husbands in the group meetings and in the individual family sessions with the nurse clinician. Therefore, only couples in which both husbands and wives could attend most of the sessions were invited to take part.

The content and the process of ROSP were derived directly from the conceptual framework mentioned previously. The components are discussed next.

Communication and interaction are central concepts in the symbolic interactionist school and are " . . . important components of role supplementation,

because it is through open and clear communication of symbols that roles evolve" (Meleis, 1975).

Interaction was emphasized as the means whereby feelings were explored, uncertainties were discussed, information was gathered, and expectations about the parental role were aired. The interaction occurred among and between all the couples, between the couples and the nurse clinicians, and between the individual husbands and wives. Open communication was encouraged as the basis for incorporating the various components of role supplementation in the program as it functioned.

PLANNING AND IMPLEMENTING OF ROLE SUPPLEMENTATION

Reference groups

The *reference group* is a group whose viewpoint is used as a frame of reference. Reference groups are essential in providing the means by which a person's identity is formed. In such groups alternative ways of coping with life changes and divergent viewpoints are explored, discussed, and, through a reflective process, adopted or discarded. In this environment, positive and negative reinforcements are provided for an individual's values and beliefs. Through reference groups, an individual can identify the range of normal behavior in a certain role and ascertain his or her position on the continuum.

Each preventive role supplementation reference group should be organized with individuals of similar developmental stages, even though these same individuals may exhibit a wide range of perspectives. Reference groups in cultures are formed informally, but because of the many social variables in this society (numerous subcultures, lateral and vertical mobility, residential mobilities, and alienation and apathy), there is a need to consciously and formally organize appropriate reference groups.

Aside from the many sociological and educational advantages of reference groups cited in the literature, a reference group has the advantage of providing a social function for its incumbents. It also is easier to change behaviors in a group setting than in an individual setting. Group members can reinforce, clarify, and support one another during the transition process.

The reference groups are a major component of ROSP. In this program, reference groups serve as forums for obtaining knowledge and exploring alternatives so that clients will have a basis for formulating their own decisions. Several couples said they joined the program to find out whether their own values, attitudes, and feelings were similar or dissimilar to those of other couples in the same situation. Many felt the need to verify the normalcy of their experience. Several prospective fathers suggested the establishment of a father's reference group to focus on paternal feelings and concerns. Most couples wished to continue to meet after delivery.

The weekly meeting provided opportunities to talk and work out feelings and plans about pregnancy, labor, delivery, and parenting. Members discussed their feelings about the pregnancy, their physical complaints, emotional changes, fears for the baby and themselves, and resulting changes in life-style. The women were relieved to find that other mothers had the same complaints. After they learned to understand the physiological basis for many of their problems, they shared

suggestions for relieving discomforts. They were reassured that their mood changes were normal when they heard of similar experiences from other members of the group and expressed relief to find that others had the same concerns. They shared ideas about reasons for fears and coping mechanisms. Many expressed apprehension about labor and delivery and the anticipated pain.

Another major area of concern and topic of discussion was the father's presence during labor and delivery. Alternative father roles were presented by both the group leaders and the parents. Much of the discussion centered on this controversial area and formed the basis for what evolved as *this* group's standard of behavior and expectations about the father's role during labor and delivery. His presence was expected, although he might or might not be responsible for pain control through coaching. Feelings about the father's role in labor coaching varied among the couples. A feeling of helplessness was expressed in the beginning, but after discussion most expectant fathers clarified the roles with which they were most comfortable. Some even said they had already discussed with other expectant fathers their notions of what to expect and what their role toward their wives could be. Many said their coworkers expressed astonishment and even some ridicule that they chose to be with their wives in labor and delivery. These men were relieved to find support in the reference group. One father did not perceive his role to be with his wife during labor and delivery, but he hesitated to express this in the group meetings. He preferred to share and discuss his concerns with the nurse clinician, whom he saw as a significant other. The reference group helped this father to become aware of some of his concerns and of his need to clarify them with the help of a significant other. He did not feel pressure to conform to the standard of the reference group; he was already an accepted group member.

The reference groups provided a forum for sharing concerns about parenthood and an opportunity to explore alternative parenting styles. One of the most important functions of the reference group was to help new parents develop ongoing cooperative relationships for future reference. After the weekly classes had ended and each couple had delivered, many called each other to report the birth and to exchange information and ask questions. Mothers who delivered earliest gave anticipatory guidance to those whose babies came later. Soon they called each other to confer about questions that arose. Many said they received support from other couples in making decisions about infant care.

Significant others

Roles are formed and imputed through a process of definition and redefinition in interaction with significant others. The responses of significant others are important to the self-concept and for the support an individual needs. The support of significant others is highly important in judging and reducing the anxiety of an incumbent. Some significant others may already be intimately related to the role incumbent while others may become influential in the course of role assumption, such as nurses, teachers, priests, and social workers.

ROSP was designed to allow each client family an opportunity to confer with an expert clinician who could become a significant other and provide support during the role transition process.

The nurse clinician helped the families explore many viewpoints, alternatives,

and possible consequences of decisions they had to make, but ultimately left the responsibility for the final decision to the family. The nurse clinician's role was not only to offer alternatives, but also to help each family feel more confident of its ability to make decisions and to orient it to the health care system. One couple said they had decided to take their 7-day-old baby shopping. The mother said they were confident in making the decision based on the knowledge she had gained learning the problem-solving approach. She said, "I didn't feel I had to read a book or that I had to call anyone to ask if it was all right to take my baby out. I felt we could decide that for ourselves and that felt good." They had received reinforcement of their ability to solve problems systematically from significant others. This confidence helped them approach other significant decisions. In discussing the shopping incident with the nurse clinician (her significant other) this mother was seeking reassurance about her problem-solving and parenting abilities.

The nurse clinician also served as a source of technical assistance. Many of the expectant mothers "did not want to bother a physician with their questions or concerns" and were more comfortable discussing their concerns with the nurse clinicians. These transactions often took place during the group meetings, although such discussions also occurred during prenatal home visits and in the course of client-initiated telephone calls to the nurse clinicians.

The first postpartum visit, scheduled within 24 hours after delivery, offered the couples an opportunity to discuss in detail their recent labor and delivery experience with the nurse clinician. Sharing a birth experience with a significant person seems to be a most important step. It was observed that all couples must describe the birth experience before they can focus on the next developmental stage of parenthood, such as infant care, plans for hospital discharge, and so forth.

At each subsequent postpartum visit, the parents sought reassurance about their infant care techniques by asking questions or by describing what they had done.

Role taking

Role taking is a key concept in the symbolic interactionist theory of George Herbert Mead (Morris, 1934). The individual plans and enacts his or her role by vicariously assuming the role of another. As Turner (1970) indicates, individuals learn roles in pairs and not in isolation.

Role taking is defined as "imaginatively assuming the position or point of view of another person" (Lindesmith and Strauss, 1956). Thus, in order to develop any form of cooperative activity, each individual must have the ability to take on the role of another. The incorporation of a role-taking component in the ROSP is based on the assumption that (Meleis, 1975):

Effective role transition is theoretically less difficult for persons who have learned to enact a role and counter role imaginatively and if the other understands the salient components of the transitions as they involve each of them.

Couples were introduced to the different behaviors and feelings of the roles and the counter roles they would encounter during the transitional period. Even though roles might (and most probably would) be modified in the course of actual interaction, the salient features of roles unique to each couple could be anticipated, constructed, and communicated before the actual transition was to occur.

Successful transition to the parental role depends on sensitivity and awareness of the feelings and behavior of each spouse. The importance of open communication between the two was emphasized as essential to the role-taking process, and the significance of role-taking ability was explored.

The group members explored potential changes in the mother's mood as a result of physiological changes associated with pregnancy and of emotional responses to her anticipated role changes. The father was encouraged to acknowledge and understand these changes so that he might become more sensitive to her needs.

Similar changes were anticipated in the behavior of prospective fathers with stresses unique to fatherhood. At first some fathers were reluctant to share such feelings in the group setting; however, they did so before the series of group meetings was over.

Various incidents that might be stressful to the new parents were explored. Alternative approaches to coping and their effect on interactions in the family were discussed and explored. Several other anticipated situations were discussed in the reference group, including postpartum depression. The couples were encouraged to attempt to role take the feelings of the spouse, especially when they observed behaviors indicating stress in the other, and to be supportive in an attempt to alleviate the stress. As a result of the emphasis on role taking, many fathers took on tasks they had not done before, such as grocery shopping, cooking, dishwashing, and house cleaning. Husbands took turns getting up with the baby during the night. One husband offered his wife frequent back rubs—something he had not done previous to the delivery. Some wives noticed signs of stress in their husbands and discussed with them their feelings and concerns about having to work as well as adapting to the new baby. Some husbands offered to care for the baby occasionally during the first 3 weeks after delivery so that their wives could leave the house to visit friends or go shopping. Couples' frequent use of role taking to empathize with and assist the spouse was one of the most rewarding aspects of the program for the participants.

Both parents were encouraged to "role try out" the experience of the newborn baby to anticipate some of his needs. They were helped to become aware of the baby's intrauterine life, security, feeding environment position, and experience through labor and delivery. Using this as a guide they could anticipate and plan for the baby's needs, their own counter needs, and probable coping mechanisms.

Role clarification

Role clarification is the identification of role-linked behaviors, sentiments, and goals associated with a role vis-a-vis significant others in the context of particular situations. As was indicated earlier, in the course of a lifetime a person must discard old roles, assume new ones, and modify existing roles or simultaneously manage several roles involving incompatible demands. Furthermore, "One develops competency in a role as one acquires the knowledge and resources to carry out that role" (Shaw, 1974).

The nurse helped the parents during pregnancy to understand better their roles as expectant parents by helping them identify and become aware of their feelings and thoughts and the significance of these feelings and thoughts in shaping behavior. During group sessions, the nurses and couples discussed their experiences

during pregnancy and how these were similar to or different from the way they expected pregnancy to be. The role of both the husband and wife in labor and delivery were explored. The nurses guided the couples through the process, encouraging them to think about what would be happening to the wife, then how her husband, as her significant other, might best support and assist her. The explorations and sharing included his role behaviors (such as giving her a back rub or wiping her face with a wet washcloth) and their meaning to his wife. The husbands were especially encouraged to experience their wives' roles in an attempt to heighten their awareness of what the wives were to experience and how the fathers might complement this experience.

Besides discussing feelings and expectations, role clarification was enhanced when the group leaders shared knowledge about physiological changes in the mother and fetus during pregnancy, thereby providing a rationale and prognosis for the discomforts the mothers were having. Further clarification of present and anticipated role behavior called for information on the processes of labor and delivery. Further, along with prenatal experiences and breathing techniques for labor and delivery, analgesia and anesthesia were explained. A film showing a couple's labor and delivery, a tour of the hospital, and slides showing characteristics of the newborn helped provide information for role clarification. Although such information has always been part of prenatal classes, the reason for including it in this program was derived from the framework under discussion. The information and exploration of role expectations and feelings gave each couple an opportunity to anticipate more appropriately the transition to a parental role.

Couples were most concerned about infant care behaviors. Most had never held a baby and their anxiety was evident in their repeated questions about how to pick up a baby, feed him, bathe him, and change his diaper. The nurses demonstrated these actions during the group sessions, and explained that all couples would have rooming-in in the hospital so that the father and mother could learn these activities with their own infant under the direction of the nursing staff. After the rooming-in experience and the postpartum home visit by the nurse, all couples said that they felt confident. Nevertheless, their initial hesitancy, before rooming-in, about whether they would be able to care adequately for the infant led us to believe that some role rehearsal with a doll helped relieve some anxiety.

In addition to infant care, the group members discussed the changes a baby might bring about in their lives. Each mother and father attempted to identify changes that they expected in life-style and to discuss how they would adapt to these changes. Most couples talked about their social activities outside of the home; they discussed how they would have to plan to take the baby with them or find a baby sitter. Finding a baby sitter would require more planning ahead than many were used to. Group members also discussed anticipated changes in sleeping patterns with night feedings and crying periods. The discussions centered on feelings they might anticipate as parents of a newborn. They discussed anger, resentment of the infant, guilt, joy, and happiness. This was an attempt to clarify the range of emotions new parents have and to demonstrate that these were considered to be "normal." Postpartum depression, its manifestations, some possible causes, the length of time, and prognosis were identified. After one such discussion, a husband asked whether or not a similar depression might be encountered

by prospective fathers. A discussion was then aimed at clarifying behaviors, sentiments, and potential role changes of new fathers.

A major portion of the program dealt with expectations one has of self as a parent. Members of the group identified their own notions of good and bad parenting and behaviors and feelings associated with each. They then compared their expectations of themselves with identified criteria. Thus, in addition to role identification, couples also identified counter-role expectations. The discussion centered on the idea that each expected his or her spouse to be what he or she considered to be a good parent. The prospective parents were especially concerned about the way their spouses might discipline a child. One mother said she was concerned that her expectations of her husband were unrealistic when she saw him discipline his niece during a recent visit. She felt he might be a more strict disciplinarian than she had expected or believed necessary. She said that they needed to discuss their views and this discussion led later to clarification with each other.

One mother phoned 4 days after hospital discharge to ask that the nurse help her husband cope with his feelings after he had become angry with the baby for crying incessantly the night before. He felt extremely guilty about his anger. When the nurse arrived he said, "I now realize that I was angry at myself for my inability to comfort him in his distress. The guilt was so heavy I didn't realize that I could become so angry at my helpless little son whom I love so much." The discussion went on from there and enabled the father to see his feelings of guilt in proper perspective as a part of the range of feelings parents experience.

The example just discussed demonstrates the need for follow-up home care on an individual basis to fully implement ROSP, especially when the follow-up is designed to alleviate a crisis. The example also illustrates the importance of such intervention in enabling the individual to resume an adult role with minimal disruption after a crisis. Unless the client is able to work through feelings in relation to the role, he or she will be unable to resume other more familiar roles adequately.

Role modeling

Role clarification and role taking may be accomplished through role modeling and role rehearsal. Both techniques facilitate the process of communication. In order to practice role modeling and role rehearsal with relative ease, it is essential that the actor be able to identify appropriate significant others and reference groups, as ROSP is intended and designed to do.

Sometimes the reference group as a whole served as a role model as each member discussed ideas and thoughts on a particular topic. The role model might be the nurse who demonstrated a procedure such as diapering, feeding, or holding a baby. The nurse also acted as a role model while leading the discussion on role expectations and demonstrating how the father and mother could facilitate communication between themselves. Members of the group served as role models for each other. Members also discussed the experiences of friends and relatives who thus served indirectly as role models.

Significant role models in the ROSP program were a couple who had recently had a baby. They were invited to the group to discuss their labor and delivery experience as well as their experiences as new parents. They shared their feelings of ineptness, awkwardness, helplessness, and, finally, competence. Group mem-

bers raised such questions as, "What changes has the baby made in your lives?" and "How do you feel about those changes?" These two new parents enabled the prospective role incumbents to anticipate some of the experiences and to understand how others might cope with certain situations. This served to broaden the alternatives available to potential role incumbents.

Role models are essential to the process of role transition. A few of the couples mentioned that they did not know anyone who had a baby. One couple said that they had two friends who had recently had babies, who were well prepared for childbirth, and who believed they had had a wonderful experience during labor and delivery, but "it had been a horror ever since, with a dependent creature who interrupted their lives in many ways." The couple thus questioned the wisdom of their decision to conceive and expressed the need to explore these feelings with those who could be their role models. It became apparent to the members of the group that each had formulated ideas about their own experience based on input they had received from others who were significant in their lives.

There are many advantages in utilizing both the nurse and the new parents as role models. The couples in the group provided an opportunity to identify and share their experiences with each other. The couples generally provided some, but not all, alternatives for a situation, while the nurse could provide many more based on professional knowledge. Members of the group explained what the experience was like for them; the nurse helped interpret the situational meaning and the implications and raised questions about feelings, behavioral effects on partners, and parameters of the range of experiences in any given situation. Many couples had no other role models aside from the reference group and the nurse.

Role rehearsal

Role rehearsal as a concept refers to internal activity preceding overt interaction, in which the individual fantasizes, imagines, and mentally enacts how an encounter might take place and how a role might evolve. In other words, the individual mentally acts out the role, anticipating in imagination the responses of significant others.

Role rehearsal thus serves a crucial function in anticipating and planning the course of future actions and is an important prelude to role taking. Role rehearsal does not proceed on the assumption that roles will be rigidly structured. The roles that will finally evolve in actual enactment may be quite different from those rehearsed in fantasy. However, rehearsal enables the individual and others to anticipate behavior and sentiments associated with the roles rehearsed.

Various aspects of the transition to parenthood were explored through role rehearsal. These included labor and delivery, hospitalization, the temporary assumption of a "sick" role, and early parenting.

The first night home with a new baby was taken as an example of role rehearsal for early parenting. A situation such as the following was described to the families, who were then asked to imagine how they would feel about it and to respond to it: "It's the first day home with the baby, who is 3 days old. He or she slept a great deal of the time in the hospital, and the baby's few needs were easily satisfied by feeding and changing diapers. Actually, the mother seldom even needed to

ask the nurse for help. Now home, the baby suddenly begins to cry unceasingly, rejects the mother's breast, and will not nurse."

Another role rehearsal dealt with a family situation when the baby was a few weeks old and focused not only on the specific situation, but also on the changing relationship between the husband and wife. "The father has had a rather frustrating day at work. He has been trying to concentrate on his work again after being preoccupied with the birth of his baby. It has been a long, tedious day, and he is looking forward to a relaxing, quiet dinner at home with his wife. When he arrives, the baby is crying and will not take a feeding; the mother is irritable; dinner is not ready; everything he says to her receives a sharp, curt, cutting remark from her." The parents were asked how they would respond and what feelings they could anticipate having toward each other. Various realistic coping strategies were presented and explored.

IMPLICATIONS FOR NURSING

Nurses have always been involved in group teaching and in anticipatory guidance principally aimed at providing knowledge and information to health care recipients. Parts of ROSP have been offered in fragments. A holistic program deduced from a conceptual framework has not been reported in the literature. A review of nursing literature points out the richness of work on conceptualizing nursing care and the paucity of adequate operational schema.

The insecurity inherent in the professional status of nursing could be ameliorated when clients of nursing care are able to articulate nursing interventions. This, in turn, could be promoted when nurses provide interventions that are systematically organized and empirically tested. The potential for a systematic testing increases when nurses utilize conceptual frameworks to guide the nursing process. This chapter presents an implementation of a conceptual framework into nursing practice. The same preventive framework could be utilized for episodic care.

The framework provides a direction for patient care and, hence, provides a way to organize knowledge for teaching and curriculum implementation and for the systematic inquiry desperately needed for research in nursing. Each component of ROSP might lend itself to several testable hypotheses. ROSP, as a whole, also involves a number of testable hypotheses. Accumulated knowledge and data related to each research problem area could provide a scientific basis for nursing care.

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