IEMT

IEMT Self Care Deficit Model

Based on the work of Dorothea Orem (1980)

All IEMT Practitioners are encouraged to study nursing models as good examples of highly developed and tried and tested models of systemised practice. The meta-models are excellent ways of organising and understanding therapeutic work.

Dorothea Orem[1)] developed the self-care deficit nursing theory which quickly became “a grand theory of nursing”[2)] that has been widely adopted in the field of health care provision and training.

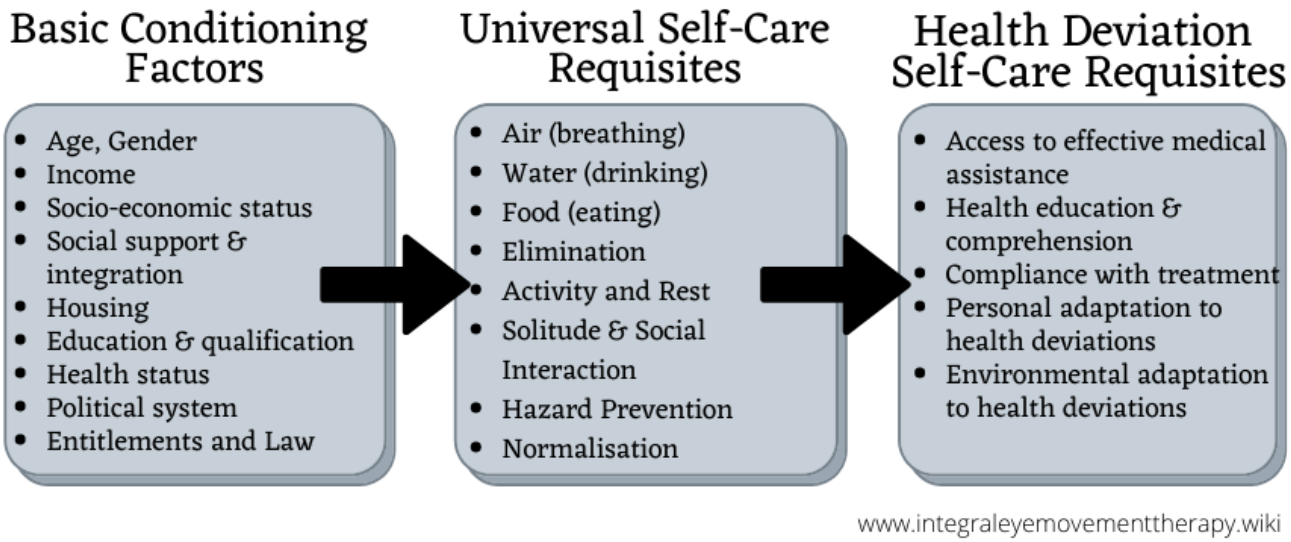
Dorothea Orem was a pioneering nursing theorist who developed an influential nursing care model. Her Theory of Self Care Deficit is one of the most commonly used models, and has had a significant impact on the field of nursing. A prolific author, she wrote two seminal works on the topic: Nursing: Concepts of Practice[3)], and Nursing Volumes I and II(Dorothea Elizabeth Orem, 1985). Published in the 1970s and 1980s respectively, these books provided practitioners with practical insight into Orem’s concepts and theories.

Her work was highly influential, influencing both current practice as well as providing important guidance for future generations of nurses. Orem’s contributions have also been recognized through numerous awards and honors bestowed upon her during her lifetime, acknowledging her monumental impact on healthcare education and research.

The model was developed between 1959 and 2001 is also referred to as “Orem's Model of Nursing”. It is most commonly implemented in rehabilitation and clinical primary care environments, where the central aim of treatment is to restore patient independence.

Dorothea Orem’s Self-Care Deficit Theory defined *Nursing* as “*The act of assisting others in the provision and management of self-care to maintain or improve human functioning at the home level of effectiveness*.” It focuses on each individual’s ability to perform self-care, defined as *“the practice of activities that individuals initiate and perform on their own behalf in maintaining life, health, and well-being*.”

When considering the model of IEMT and its role in the field of brief therapy it is clear that this definition is not restricted to just that of the delivery of nursing care. This model is most applicable when considering the chronic or dependent client with complex emotional, psychological, behavioural and psychiatric needs.



Central philosophy

The central aspect of Orem's model is that all patients wish to care for themselves and dependency is desired by very few. Dependent and incapacitated individuals may recover more quickly when encouraged and permitted to perform their own self-care to the best of their ability and within the limits of their capacity.

The self-care model is the very antithesis of the “total care” concept of the institutionalization outlined and described by Irving Goffman et al.

As a brief therapy, Integral Eye Movement Therapy (IEMT) can be taught as a self-care model where the client learns to self-apply the core principles of treatment via therapeutic remedial and generative change.

In many instances, a client's/patient's dependency on ongoing therapeutic support via “long therapy”, medication or long-term engagement with psychiatric services can be reduced and independence can be developed.

Operating Assumptions of the Self-Care Deficit Theory

Core Self-Care Theory assumptions are:

1. Effective and functional survival requires people to engage in constant communication and form connections among themselves and to their environment.
2. People necessarily behave proactively to identify their needs and to make necessary judgments.
3. As mature individuals, people experience deficits in life-sustaining and function-regulating actions for both themselves and for others.
4. Human agency is exercised in discovering, developing, and transmitting to others ways and means to identify the needs for, and offer inputs into, ones-self and to others.
5. Division of labour inevitably and necessarily occurs with groups of people arising with structured relationships clustering tasks and allocating responsibilities for providing care to

group members.

*examples needed for each of the above

Self-care requisites

Self-care requisites are groups of needs or requirements that Orem identified. They are classified as either:

- Universal self-care requisites (*objective*)
- Health deviation requisites (*subjective and changeable*)
- Developmental self-care requisites (*subjective*)

The developmental self-care requisites are further divided into:

1. maturational: progression toward superior levels of maturation.
2. situational: prevention of deleterious effects related to development.

The Universal [Objective] Self-Care Requisites:

- The maintenance of a sufficient intake of air
- The maintenance of a sufficient intake of water
- The maintenance of a sufficient intake of food
- The provision of care associated with the elimination process and excrements
- The maintenance of a balance between activity and rest
- The maintenance of a balance between solitude and social interaction
- The prevention of hazards to human life, human functioning, and human well-being
- The promotion of human functioning and development within social groups in accord with human potential, known human limitations, and the human desire to be normal
- Normalcy is used in the sense of that which is essentially human and that which is in accord with the genetic and constitutional characteristics and individuals' talents.

Developmental [Subjective] Self-Care Requisites

Developmental self-care requisites are "*either specialized expressions of universal self-care requisites that have been particularized for developmental processes or they are new requisites derived from a condition or associated with an event.*"

examples needed

Health deviation self-care requisites

The subjective health deviation self-care requisites are required in life-altering conditions of ill health (both physical and emotional/psychological/psychiatric), injury, and disease or may result from medical measures required to diagnose and correct the condition.

- Seeking and securing appropriate and effective medical/psychological/emotional/psychiatric

assistance.
- Being aware of, and attending to, the effects and results of pathologic conditions and states.
- Effectively carrying out medically prescribed diagnostic, therapeutic, and rehabilitative measures.
- Being aware of, and attending to, or regulating the discomforting or deleterious effects of treatment processes and measures.
- Modifying the self-concept (and self-image) in accepting oneself as being in a particular state of health and in need of specific forms of health care.
- Learning to live with the effects of pathologic conditions and states as well as the effects of medical diagnostic and treatment measures in a lifestyle that promotes continued personal development.

examples needed

From Dependence to Independence

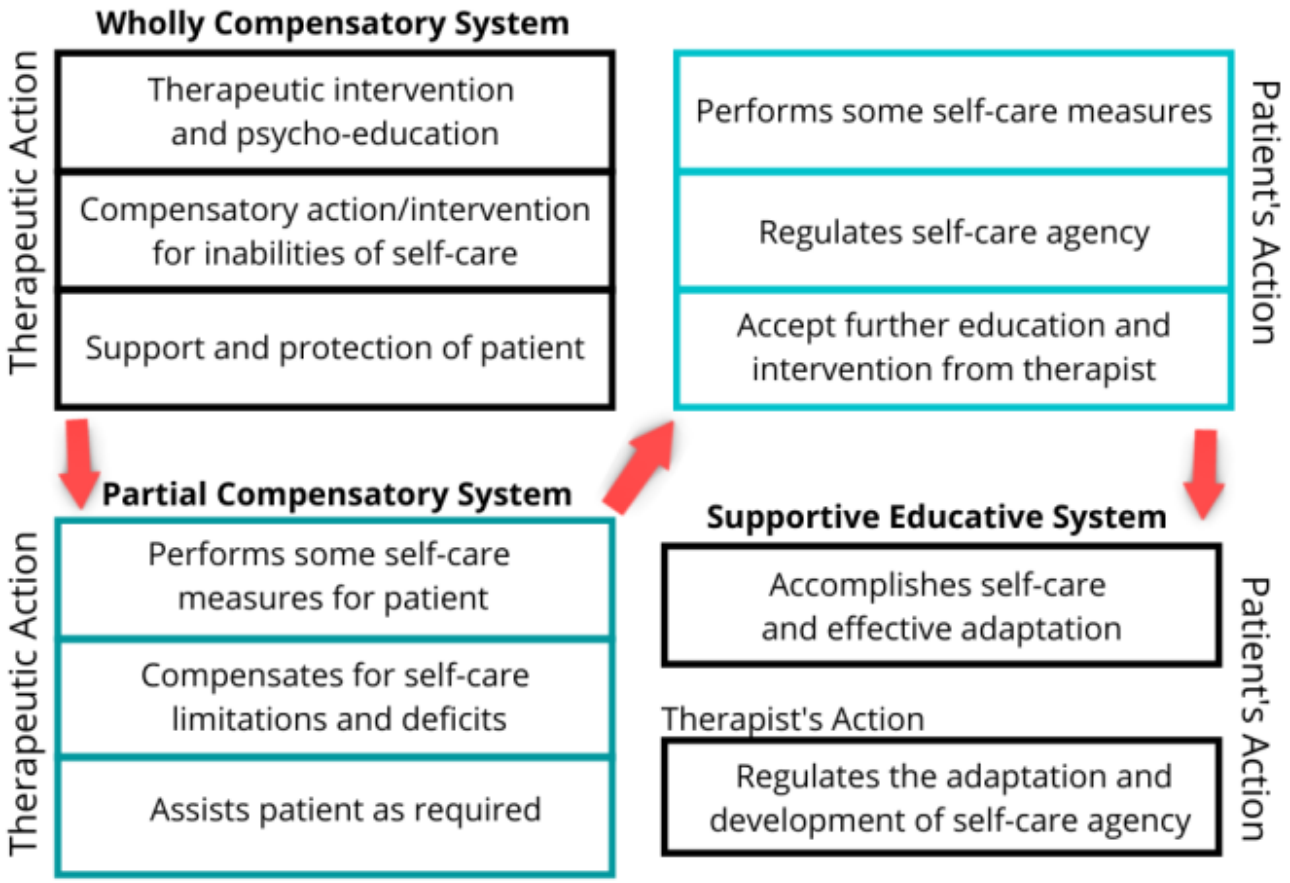
There are four clear phases involved in the move from therapeutic dependence to independence.

Phase 1. The trained therapist assesses the client and delivers intervention to compensate for the deficits.

Phase 2. Following psycho-education, the client begins to improve the quality of self-care within their capabilities with active support, encouragement, and intervention for the therapist as required.

Phase 3. The client has greater involvement in directing both self-care and the assistance and professional interventions and support required.

Phase 4. The client gains greater independence and achieves agency for self-care.



For the IEMT Practitioner, these phases involve, but are not limited to, the following:

Phase 1. Wholly Compensatory System Via the Kinaesthetic Pattern (“K-Pattern”) the practitioner addresses and depotentiates the strong negativistic emotions, alleviating the client's immediate distresses and endogenous stresses. Where necessary, other agencies are involved via referral in the initial treatment and support of the client in crisis. The client is taught to self-apply the K-pattern to problematic emotions and memories.

Phase 2. Partial Compensatory System Further intervention takes place using the IEMT Identity Patterns. The client is encouraged to self-apply IEMT processes for remedial change to problematic emotions.

Phase 3. Generative change is introduced via the identity modules and the client is taught how to explore these aspects themselves. “Homework” via tasking is set.

Phase 4. The client is now able, *and expected by the practitioner*, to self-apply and self-treat problematic emotions and further explore issues of identity themselves.

See also

- Additional nursing models
- Orders of Adaptation
- Orders of Change

[1)] Dorothea OremWikipedia
[2)] Nursing theoryWikipedia
[3)] Nursing: concepts of practice by Orem, Dorothea E. (Dorothea Elizabeth), 1914-2007; Taylor, Susan G; Renpenning, Kathie McLaughlin archive.org online library
1. ^ Dorothea Elizabeth Orem, 1985. *Nursing: Concepts of Practice.* McGraw-Hill Inc, ISBN 978-0070475250.