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Application of Peplau's Interpersonal Theory in Nursing Practice

Ramesh C.

Abstract

A nursing theory is a set of concepts, definitions, relationships, and assumptions or propositions derived from nursing models or from other disciplines and project a purposive, systematic view of phenomena by designing specific inter-relationships among concepts for the purposes of describing, explaining, predicting, and /or prescribing. A theory is a group of related concepts that propose action that guide practice. Theory refers to "a coherent group of general propositions used as principles of explanation" The importance of nursing theories in education is to reinforce the nursing practices of patient treatment and care. Students who understand why a certain procedure is performed or what to expect from particular patients and situations have a basis for learning the actual practices that make up patient care and treatment. Nursing theory also defines the role of a nurse in the medical field, hospital or medical practice. It creates what is known as a body of knowledge for both the nurse in training and the veteran.[1]

Key Words: Nursing theories; Nursing process; Pneumonia.

Peplau's Interpersonal Theory

Peplau's theory focuses on the interpersonal processes and therapeutic relationship that develops between the nurse and client. The interpersonal focus of Peplau's theory requires that the nurse attend to the interpersonal processes that occur between the nurse and client. Interpersonal process is maturing force for personality. Interpersonal processes include the nurse- client relationship, communication, pattern integration and the roles of the nurse. Psychodynamic nursing is being able to understand one's own behavior to help others identify felt difficulties and to apply principles of human relations to the problems that arise at all levels of experience. This theory stressed the importance of nurses' ability to understand own behavior to help others identify perceived difficulties.[2]

Peplau's theory of interpersonal relations provides a useful framework for investigating clinical phenomena and guiding nurses' actions. Through this interpersonal relationship, nurses assess and assist people to: (a) achieve healthy levels of anxiety interpersonally and (b) facilitate healthy pattern integrations interpersonally, with the overall goal of fostering well-being, health, and development. This relationship also provides the context for the nurse to develop, apply, and evaluate theory-based knowledge for nursing care. Nurse interpersonal competencies, investigative skill, and the theoretical knowledge as well as patient characteristics and needs are well important dimensions in the process and outcomes of the relationship. The structure of the interpersonal relationship was originally described in four phases. Her theory focuses primary on the nurse-client relationship in which problem-solving skills are developed.[2]

The four phases of nurse-patient relationships are:

1. Orientation:
   * During this phase, the individual has a felt need and seeks professional assistance.
   * The nurse helps the individual to recognize and understand his/ her problem and determine the need for help.
2. Identification
   * The patient identifies with those who can

Author Affiliation: *Assistant Professor, Noor College of Nursing, Bangalore.

Correspondance: Mr. Ramesh C., Assistant Professor, Noor College of Nursing, Bangalore.

E-mail: rameshmsn08@yahoo.com

help him/ her.

* The nurse permits exploration of feelings to aid the patient in undergoing illness as an experience that reorients feelings and strengthens positive forces in the personal ity and provides needed satisfaction.

3. Exploitation
   * During this phase, the patient attempts to derive full value from what he/ she are offered through the relationship.
   * The nurse can project new goals to be achieved through personal effort and power shifts from the nurse to the patient as the patient delays gratification to achieve the newly formed goals.
4. Resolution
   * The patient gradually puts aside old goals and adopts new goals.
   * This is a process in which the patient frees himself from identification with the nurse.

Throughout theses phases the nurse functions cooperatively with the patient in the nursing roles of:

1. Counseling Role - working with the patient on current problems.
2. Leadership Role - working with the patient democratically.
3. Surrogate Role - figuratively standing in for a person in the patient's life.
4. Stranger - accepting the patient objectively.
5. Resource Person - interpreting the medical plan to the patient.
6. Teaching Role - offering information and helping the patient learn.[5]

The orientation phase marks a first step in the personal growth of the patient and is initiated when the patient has felt need and seeks professional assistance. The nurse focuses on knowing the patient as a person and uncovering erroneous preconceptions, as well as gathering information about the patient's mental health problem. The nurse and patient collaborate on a plan, with consideration of the patient's educative needs. Throughout the process, the nurse recognizes that the power to accomplish the tasks at hand resides within the patient and is facilitated through the workings of the therapeutic relationship.[3]

The focus of the working phase is on: (a) the patient's efforts to acquire and employ knowledge about the illness, available resources, and personal strengths, and (b) the nurse's enactment of the roles of resource person, counselor, surrogate and teacher in facilitating the patient's development toward well-being. The relationship is flexible enough for the patient to function dependently, independently, or interdependently with the nurse, based on the patient's developmental capacity, level of anxiety, self-awareness, and needs.[3]

Termination is the final phase in the process of the therapeutic interpersonal relationship. Patients move beyond the initial identification with the nurse and engage their own strengths to foster health outside the therapeutic relationship. In addition to addressing closure issues, the nurse and patient engage in planning for discharge and potential needs for transitional care.[3]

Peplau's Theory and Nursing process

Peplau defines Nursing Process as a deliberate intellectual activity that guides the professional practice of nursing in providing care in an orderly, systematic manner.

Peplau explains 4 phases such as:

* Orientation: Nurse and patient come together as strangers; meeting initiated by patient who expresses a "felt need"; work together to recognize, clarify and define facts related to need.
* Identification: Patient participates in goal setting; has feeling of belonging and selectively responds to those who can meet his or her needs.
* Exploitation: Patient actively seeks and draws knowledge and expertise of those who can help.
* Resolution: Occurs after other phases are completed successfully. This leads to termination of the relationship.[4]

In Nursing Process, the orientation phase parallels with assessment phase where both the patient and nurse are strangers; meeting initiated by patient who

expresses a felt need. Conjointly, the nurse and patient work together, clarifies and gathers important information. Based on this assessment the nursing diagnoses are formulated, outcome and goal set. The interventions are planned, carried out and evaluation done based on mutually established expected behaviours.[4]

Peplau's Theory Application in Nursing Process

The nursing process for Mr. X based on Peplau's theory is as follows:

Patient Profile

Name	:	Mr. X
Age	:	36 years
Gender	:	Male
Religion	:	Hindu
Education	:	Graduate
Occupation	:	Business
Marital Status	:	Married
Diagnosis	:	Pneumonia
Theory Applied	:	Peplau's Inter Personal Relationship Theory

Nursing Process for Patient with Pneumonia[6&7]

1. Ineffective airway clearance related to presence of secretions, inflammatory process secondary to pneumonia.

Goal: To minimize the secretions, clear the airway & maintain normal airway.

Nursing Implementations

- Established rapport to patient to gain the trust and cooperation.
- Assessed patient's condition to know and determine patient's needs.
- Monitored and recorded V/S to establish base line data.
- Auscultated lung fields, noting areas of decreased/absent airflow and adventitious breath sounds to identify areas of consolidation and determine possible bronchospasm or obstruction.
- Assisted patient to change position every 30 minutes to mobilize secretions.
- Elevated head of bed and align head in the middle to facilitate breathing.
- Provided health teachings regarding effective coughing and deep breathing exercise to expel the mucous.
- Encouraged to increase fluid intake to liquefy secretions.
- Encouraged steam inhalation to moisten secretions and alleviate congestion.
- Administered meds as ordered to reduce bronchospasm and mobilize secretion.

Evaluation

- After 3-4 hours of nursing interventions, the patient's respiration was improved and difficulty of breathing have been relieved.
- The patient was able to maintain a patent airway.

2. Ineffective breathing pattern related to presence of tracheo-bronchial secretions and nasal secretions secondary to pneumonia.

Goal: To remove the secretions, to improve the breathing pattern, to relieve dyspnea.

Nursing Implementations

- Instructed patient to increase oral fluid intake to 8-10 glasses increased mucus and sputum secretions can lead to dehydration; increased water intake can help dissolve secretions.
- Instructed patient to do deep breathing exercise after demonstrating proper technique Deep breathing exercise increases oxygen intake and can help alleviate dyspnea.
- Kept environment allergen free (dust, feather pillows, smoke, pollen) Presence may trigger allergic response that may cause *further increase in mucus secretion.*

- Suctioned the airway naso, tracheal/oral to remove the secretions and to promote ventilation.
- Educated proper hand washing to prevent infections such as nosocomial infections.
- Positioned the patient in semi fowler's position a distended abdomen can interfere with normal diaphragm expansion.
- Encouraged patient to eat nutritious foods such as green leafy vegetables and lean meat to increase feeling of comfort, to prevent allergic reactions that can cause respiratory distress.
- Reviewed client's chest x-ray for severity of acute/ chronic conditions to enable the body to recuperate and repair.

Evaluation

- Patient verbalized understanding and demonstrate proper deep breathing technique to facilitate proper oxygenation to alleviate hyperventilation.
- Patient was free of cyanosis and established normal breathing pattern.

3. Impaired gas exchange related to alveolar capillary membrane changes, congestion secondary to inflammation.

Goal

- After nursing interventions the patient will demonstrate ease in breathing.
- To relieve congestion.
- To promote gas exchange.

Nursing Implementation

- Monitored vital signs and assessed patient's conditions to establish baseline data.
- Auscultated lungs for crackles, consolidation and pleural friction rub determine adequacy of gas exchange and detect areas of consolidation and pleural friction rub this signs may indicate hypoxia.
- Assessed LOC, distress and irritability determine circulatory adequacy.
- Observed skin color and capillary refill which is necessary for gas exchange to tissues.
- Encouraged rest prevents tissue oxygen demand and enhances tissue oxygen perfusion.
- Encouraged elevated head of bed to facilitate lung expansion to enhance breathing.
- Performed chest physiotherapy after nebulization to dislodge the secretions, for easy expectoration.
- Administered oxygen as ordered improves gas-exchange decrease work of breathing.

Evaluation

- The patient demonstrated ease in breathing.
- The patient's verbalized understanding of the causative factors that could aggravate the condition and appropriate factors that could help the patient relive from gas exchange impairment.
- Improved gas exchange.[6&7]

Summary of Theory Application

Orientation Phase

* Patient was initially reluctant to talk due to breathing difficulty.
* Patient was expressing that his health condition is poor.
* Nurse established therapeutic relationship with the patient.

Identification

* The patient participates and interdependent with the nurse.
* Expresses the need to get relief from breathing problem.
* Expresses need for improving the health condition.
* Expresses need to know more about prognosis, discharge and home care and follow up.

Exploitation

* Patient explains that he gets relief breathing difficulty.
* Cooperates and participates actively in performing breathing exercises.
* Patients cooperates during the nursing interventions.

Resolution

* Patient expressed that breathing difficulty has reduced a lot and she is able to breathe normally.
* He also expressed that she would come for regular follow up after discharge.

Conclusion

With the help of the theory of interpersonal relations, the patient's needs could be assessed. It helped him to achieve them within her limits. This theory application helped in providing comprehensive care to the client. Patient was very cooperative. The application of this theory revealed how well the supportive and educative in nursing care aspects.

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