

Towards a unifying caring life-course theory for better self-care and caring solutions: A discussion paper

Alison Kitson^{1,2}   | Rebecca Feo^{1,2}   | Michael Lawless^{1,2} | Joanne Arciuli^{1,2} | Robyn Clark^{1,2}  | Rebecca Golley^{1,2} | Belinda Lange^{1,2} | Julie Ratcliffe^{1,2} | Sally Robinson^{1,2}

¹College of Nursing and Health Sciences, Flinders University, Bedford Park, SA, Australia

²Caring Futures Institute, Flinders University, Bedford Park, SA, Australia

Correspondence

Alison Kitson, Vice-President and Executive Dean, College of Nursing and Health Sciences, Flinders University, Sturt Road, Bedford Park, SA 5042, Australia. Email: alison.kitson@flinders.edu.au

Funding information

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors

Abstract

Aim: To present the first iteration of the caring life-course theory.

Background: Despite requiring care from birth to death, a person's universal or fundamental care needs and the subsequent care provision, either by self or others, has yet to be presented within a life-course perspective. Accurately describing the care people require across their lifespan enables us to identify who, what type, how and where this care should be provided. This novel perspective can help to legitimise a person's care needs and the support they require from wider care systems and contexts.

Design: Discussion paper outlines theory development. We adopted an inductive approach to theory development, drawing upon existing literature and the team's diverse experiences. Our theoretical insights were refined through a series of collaborative meetings to define the theory's constructs, until theoretical saturation was reached.

Discussion: Fourteen constructs are identified as essential to the theory. We propose it is possible, using these constructs, to generate caring life-course trajectories and predict divergences in these trajectories. The novel contribution of the theory is the interplay between understanding a person's care needs and provision within the context of their lifespan and personal histories, termed their care biography, and understanding a person's care needs and provision at specific points in time within a given care network and socio-political context.

Impact for Nursing: The caring life-course theory can provide a roadmap to inform nursing and other care industry sectors, providing opportunities to integrate and deliver care from the perspective of the person and their care history, trajectories and networks, with those of professional care teams. It can help to shape health, social and economic policy and involve individuals, families and communities in more constructive ways of talking about the importance of care for improved quality of life and healthy societies.

KEYWORDS

care professions, delivery of health care, human development, models, nursing, self-care, theoretical

This is an open access article under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.

© 2021 The Authors. Journal of Advanced Nursing published by John Wiley & Sons Ltd.

1 | INTRODUCTION

Our theoretical understanding of what care is and how to do it has been relatively neglected within traditional philosophical (e.g., Martinsen, 2006; Shields, 2013; Wiesing, 2008) and scientific discourses (e.g., Cook & Peden, 2017; Turkel et al., 2018). Despite the universal need for care across the lifespan—from birth to death—existing work has often been undertaken through a unidisciplinary lens or has focused solely on specific conditions, a distinct period of time along the developmental trajectory, or care provided in a specific setting by professional groups. Such approaches have served to limit the integration and spread of such work into professional and everyday caring activity, where care inevitably transcends multiple health disciplines, care contexts, and care needs (CNs) and conditions, and involves networks of people. Here, we define care as the provision of what is necessary for every person's survival, health, welfare, maintenance, protection or peaceful death.

Historically, caring practices have developed out of familial or community responsibilities, typically identified as women's work (Baines & Armstrong, 2019; MacDonald et al., 2005). In Western societies, care and caring moved into a wider societal or industrialised context with associated theoretical models, albeit unidisciplinary, emerging for understanding, describing and analysing care processes (Rehnsfeldt et al., 2017). Major paradigm shifts took place in the nineteenth century in industrialised societies when nursing became the professional group claiming caring as its core element (Rafferty et al., 2005). Indeed, several seminal nursing theories of self-care (S-C) and caring have been developed and continue to be taught as part of pre-registration nursing programmes globally. Examples of such theories include Orem's (2001) Self-Care Deficit Nursing Theory and Watson's (2008) Theory of Human Caring Science. These nursing theories have come under criticism for their limited relevance at the point-of-care and for providing little guidance on how caring can and should be achieved in practice (Mudd et al., 2020). These criticisms are not unique to nursing theories, with a theory-to-practice gap widely acknowledged across many health disciplines, including in medicine (Makransky et al., 2016), psychiatry and pharmacy (Pittenger et al., 2019) as well as in health policy and management (Chinitz & Rodwin, 2014).

Whilst discipline-specific theories in healthcare still have a role to play in providing professional autonomy, coherence of purpose, common professional communication and a rationale for practice (Colley, 2003; McCrae, 2012), unidisciplinary approaches to conceptualising care have their limitations. Unidisciplinary approaches can fail to fully explain the complex and dynamic factors affecting the delivery and enactment of care in different contexts and points of time and instead perpetuate siloed thinking and practice (Archibald et al., 2018; Urquhart et al., 2013). In comparison, interdisciplinary approaches have the potential to produce holistic conceptualisations of caring that synthesise and extend beyond discipline-specific perspectives and facilitate a more integrated understanding of CNs and care delivery. Importantly, many health disciplines in addition to nursing are becoming increasingly interested in the concept and

articulation of caring as the basis of healthcare delivery. For instance, in health economics and policy, the notion of a 'care economy' outlines the importance of measuring, valuing and investing in paid and unpaid care work that occurs within professional settings and across families and communities (Folbre, 2018). Developing a strong, equitable care economy is argued to be crucial for ensuring safe, appropriate care for an ageing population and people with disabilities, chronic conditions, or multimorbidity, as well as to support gender equality relating to employment and economic empowerment (International Labour Office, 2018; Power, 2020). However, we have yet to find a systematic way of integrating diverse disciplinary perspectives on caring to achieve the vision of integrated, holistic person-, family- and community-centred care.

Further, although care has emerged from the privacy of personal relationships and households and is now embedded within the epistemological foundations of different health disciplines, it continues to be perceived as a 'soft' skill, linked to innate qualities (e.g., patience and empathy) or even to common sense, rather than a validated empirical base of caring practices (Feo et al., 2019; Treiber & Jones, 2015). As a result, the systematic study of care and caring practices has been little evident in many health and medical curricula, despite the trend to move such curricula from a traditional biomedical structure to more person-centred, biopsychosocial models of care that focus on relationships, trust and participation (Borrell-Carrió et al., 2004). This is coupled with a pervasive narrative in current policy that care interventions constitute costs to society rather than constructive humane solutions for social and economic prosperity (Ratcliffe et al., 2020). Investing in a 'care economy' is therefore not seen to deliver financial benefits, with much-needed funds instead diverted elsewhere (De Henau et al., 2016). However, with the advent of person or patient-centred care (Kitson, et al., 2013); the need to promote better S-C and self-management practices (Grady & Gough, 2018; Jaarsma et al., 2020; Richard & Shea, 2011); and the unprecedented changes brought about by COVID-19, including new ways of providing care, such as telehealth, and the increased care burden on women, families and communities (Power, 2020), we must clarify what we mean by care and S-C and how these can best be operationalised from an interdisciplinary perspective and drawing upon relevant theoretical insights.

In addition to reconceptualising and providing a stronger theoretical foundation for S-C and caring that transcends health disciplines, there is an imperative to advance our theoretical thinking about the antecedents, interdependencies and consequences of care specifically from a lifespan perspective. Our ageing population, embedded ageist attitudes, increasingly complex health and CNs, and growing evidence that chronic disease risk starts from birth are well known facts (Ham et al., 2017; Masic, 2018; World Health Organisation, 2018). Yet we have not systematically embedded this evidence into theoretical conceptualisations of care. Instead, robust care theories tend to focus on condition- or situation-specific scenarios (e.g., Riegel et al., 2012, 2016). In turn, this has limited our ability to develop effective solutions to balance CN across the lifespan with affordable and appropriate care

provision (CP). Whilst life-course perspectives have been used to explain childhood and adulthood development (e.g., Elder & Shanahan, 2007), chronic disease epidemiology (e.g., Ben-Shlomo et al., 2016), sociological responses (e.g., Shanahan, 2000), human cognitive abilities and decline (e.g., Anstey, 2012), and ageing (e.g., Cooney & Curl, 2019), such perspectives have not, to date, been used to frame how individuals learn to care for themselves and for others.

As a response to the unprecedented changes in individual and global health and CNs, and the changing nature of CP, this paper presents a novel, theoretically robust way of describing a person's CNs across the life course, both from their own perspective and from the perspective of care providers. Life course in the context of our proposed caring life-course theory (CLCT) refers to the life stages a person transitions through across the lifespan, taking into account structural, cultural, social, health and temporal factors that affect care (cf. Elder, 1994). The dual emphasis on social structure and (individual and collective) human agency, as well as the interdependencies across multiple levels of analysis (i.e., from 'micro' to 'macro'), life domains (e.g., education, family and work) and interrelationships between people (e.g., the linked lives of family, friends and colleagues) are compatible with the central principles of a care life-course perspective. We build upon the empirical work of Kitson and colleagues around the fundamentals of care framework (Kitson, et al., 2013; Kitson & Muntlin Athlin, 2013), which provides the practical scaffolding for defining a person's universal CNs (i.e., CNs essential for survival, health, well-being, maintenance, protection or peaceful death) across the lifespan and which also has its provenance from seminal nursing work such as Henderson (2004) and Roper et al. (2001).

2 | DESIGN

We drew on inductive approaches to theory generation and refinement and upon the authors' diverse clinical, research and academic experiences to critically challenge our assumptions and knowledge around care. We wanted to explore more integrated, theoretically robust ways of describing S-C and caring interventions that would not just reflect the complexity and contingent nature of caring relationships but also offer new insights into more transparent, sustained and collaborative ways of working between informal and professional carers and people needing care.

We also used the empirical methods from previous work (Feo et al., 2018; Kitson, et al., 2013; Kitson & Muntlin Athlin, 2013) as the basis upon which to define CNs. The first author was responsible for proposing that the fundamentals of care framework be located within a life-course perspective and presented several ideas to the wider group at a series of collaborative weekly meetings over a 6-month period (March 2020–August 2020).

During these meetings, the wider interdisciplinary team shared their knowledge and experiences of thinking about and researching care and S-C. The lead author presented initial constructs and

these ideas were interrogated and challenged by the whole team until such time consensus was reached and no more new ideas or perspectives emerged. This constant refinement and interrogation were supplemented with a targeted review of relevant theories from a range of disciplines (e.g., Sen's Capability Approach, Theory of Planned Behaviour, Erikson's stages of psychosocial development). Detailed notes were taken at each meeting with a synthesis of ideas presented at the following meeting together with the critiquing of relevant literature appropriate to the construct being interrogated.

The meetings provided rich discussions, which were documented in detail by the first and second authors. Meetings continued until the team had reached saturation in terms of ideas and consensus on the core concepts of the theory, with empirically derived examples (where possible) used to illustrate the constructs and test the face validity of the emerging theory.

3 | PRESENTING THE CLCT: THE BASIC BUILDING BLOCKS

From our deliberations, using the empirical work of the fundamentals of care framework as the starting point, we generated several core constructs, summarised in Table 1. We define these constructs sequentially, building up a narrative that explains how the theory could be used to articulate the contribution of care to people's health and well-being across the lifespan.

3.1 | Fundamental care

The primary building block of the CLCT, which provides the theory its scaffolding structure, is the fundamentals of care framework (Kitson, Conroy, et al., 2013). *Fundamental care* refers to the care required by everyone for survival, health, welfare, maintenance, protection or peaceful death regardless of the presence or type of clinical condition or the setting in which care is taking place. The framework is designed to conceptualise and articulate these fundamental—that is, universal—needs and how care for these needs is best provided. The framework defines fundamental care as involving three key dimensions: (1) the relationship between care provider(s) and recipient(s); (2) the integration and meeting of a range of CNs simultaneously (physical, psychosocial and relational); and (3) the context in which CP is taking place (Figure 1). The framework can be used to identify both CNs and provision as they occur in each life stage or pertinent transition across the life course (e.g., infancy, adolescence and parenthood).

3.2 | Life course

The term *life course* refers to the life stages, transitions and trajectories in care across the lifespan from birth until death (cf. Elder,

TABLE 1 Summary of caring life-course theory building blocks/constructs

Construct	Definition
Fundamental care	The care required by everyone for survival, health, welfare, maintenance, protection or peaceful death, regardless of the presence or type of clinical condition or the setting in which care is taking place.
Life course	The life stages, transitions and trajectories in health and well-being across the lifespan from birth until death.
Care network	The relationships and support mechanisms surrounding individuals and their families and friends.
Care need (CN)	A fundamental care need—physical, psychosocial or relational—throughout the lifespan met by oneself or by others.
Care provision (CP)	How care needs are met—i.e., through the enactment of care activities either by oneself or by others.
Self-care (SC)	Tasks intentionally performed by individuals to address their own care needs, maintain health and well-being, prevent and manage illness and attain specific goals.
Care-from-others (C-Fm-O)	Care actions or processes received from others to address a person's care needs.
Care-for-others (C-Fr-O)	Care actions or processes provided to address another's care needs.
Care Provision Package	The full complement of care required to be provided for a person, made up of a combination of self-care and care from informal, formal or professional carers.
Capability	The ability (skills, knowledge and motivation) to care for oneself and others throughout the life course.
Capacity	The amount/volume of care available to oneself and others throughout the life course.
Care transition	An event or life stage that triggers a change in a person's care needs.
Care trajectory	The potential impact a life event might have upon a person's self-care and care-for-others capability and capacity.
Care biography	A personalised history of an individual's self-care and caring capability and capacity and their understanding of the care they have and should receive from other people.

1994). A life-course perspective necessitates attention to the passage of time and temporal phenomena. At an individual level, time is constituted in chronological age and life stages. Broadly speaking, life stages span: infancy, early childhood, middle childhood, adolescence, young adulthood, middle adulthood and late adulthood, reflecting Erikson's stages of psychosocial development (Erikson & Erikson, 1998). At a societal level, time might be represented in

terms of family and historical generations (i.e., intergenerationality). The CLCT therefore takes account of structural, cultural, social, health and temporal factors that affect care and CP.

3.3 | Care network

The CLCT acknowledges that people are inherently social beings and hence health and well-being, as well as CNs and provision, must also be understood as inherently social activities, predicated on and impacted by a person's relationships. *Care network* thus describes the set of relationships and support mechanisms surrounding individuals, their families and friends. These care networks are linked to social and familial bonds as well as cultural, generational and other ties.

3.4 | Care need

A CN refers to a fundamental CN—which can be physical, psychosocial, or relational, or in any combination—occurring at any point in the lifespan. As outlined above, a fundamental CN refers to a need that all individuals have, irrespective of age, health or context, to keep a person alive and in optimum health and well-being or to support them in a peaceful death. CNs can be met by oneself and by others. Consistent with the fundamentals of care framework (Kitson, Conroy, et al., 2013), this conceptualisation of CN takes account of the context where care is delivered, whether it be in one's own home, the community or in a formal care setting. A person's CNs vary across the life course and are influenced by intrinsic (e.g., genetics and behaviours) and extrinsic factors (e.g., environment, medical care and social). Importantly, a person's CNs do not diminish their intrinsic worth or ability to lead a fulfilled life; rather, the lack of appropriate care impacts their lived experience.

3.5 | Self-care

We define S-C broadly as tasks intentionally performed by individuals to address their own CNs, maintain health, prevent and manage illness or directed towards other specific goals (Grady & Gough, 2018). S-C encompasses skills, knowledge and attitudes around fundamental CNs, forming and sustaining positive relationships and managing resources to promote the meeting of S-C needs (Matarese et al., 2018). S-C can also be supported by digital health technologies, including gamification, behavioural nudging and incentivisation strategies designed to enable the adoption and maintenance of health-seeking behaviours and lifestyle choices (Johnson et al., 2016).

3.6 | Care-from-others

Care-from-others (C-Fm-O) refers to actions or processes received from others to address a person's physical, psychosocial and

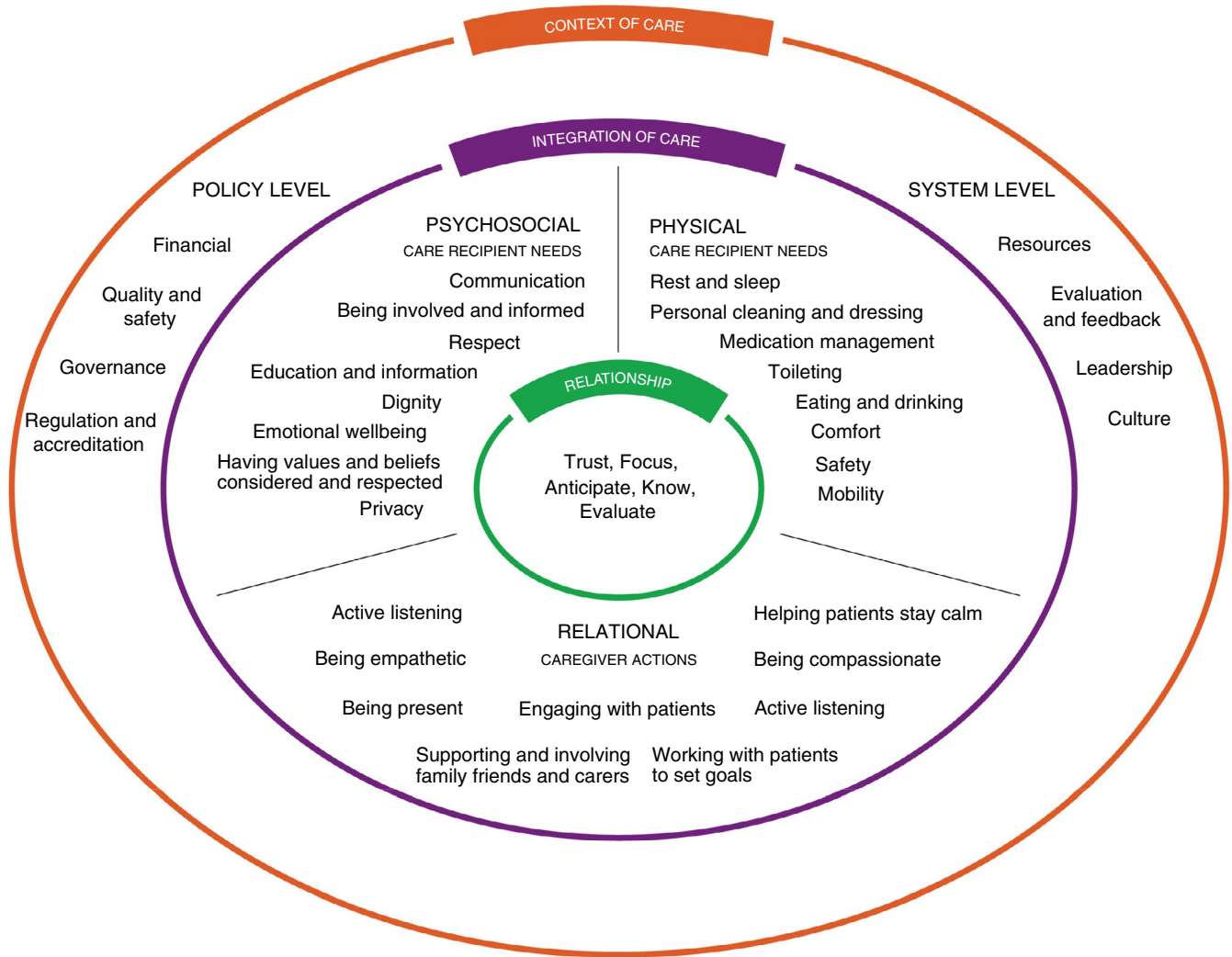


FIGURE 1 The fundamentals of care framework (Kitson, Conroy, et al., 2013)

relational CNs. C-Fm-O encompasses a person's willingness to accept and receive care from another, and their ability to articulate how that care should be delivered. It is CP from the care recipient's perspective. There are different sources of 'other carers': informal (e.g., family); formal (i.e., paid); and professional carers (e.g., health and social care workforce), with each supported by technology where relevant.

Taking the above into consideration, CNs can be represented across the lifespan as in Figure 2.

Figure 2 offers a novel way of thinking about the proportionality of CNs that can be met by oneself and by others, across the lifespan. Moving from the private world of care from parents and families, we suggest there is a pattern of developmental trajectories with typical/atypical attributes and associated CNs. In the early stages of life, it is self-evident that infants and young children are highly dependent upon C-Fm-O (e.g., mother, father, grandparents, extended family and professionals) to meet their CNs. In Figure 2, at this stage, the proportion of C-Fm-O is depicted as high relative to the individual's S-C capability and capacity. Childhood development theories (e.g., Bandura, 1997; Bowlby,

1988; Erikson & Erikson, 1998; Piaget & Inhelder, 1969; Vygotsky, 1994) outline the expected trajectories of the development of S-C capabilities and capacities, theoretical perspectives that the CLCT can build upon.

Equally, there is an expectation that as children develop into adolescence and early and mature adulthood, they will have mastered the skills of S-C sufficiently such that they require less help from others. CNs then increase as individuals age and require more support to help with the various comorbidities and life events that might compromise their ability to care for themselves or when established care networks can no longer provide the care needed by the individual.

Successful or appropriate CNs being met for individuals could be summarised in the following way:

$$\text{Care Needs} = \text{Care Provision} \\ (\text{appropriate proportion of self-care and care-from-others})$$

OR

$$\text{CN} = \text{CP} (\text{S} - \text{C} + \text{C} - \text{Fm} - \text{O})$$

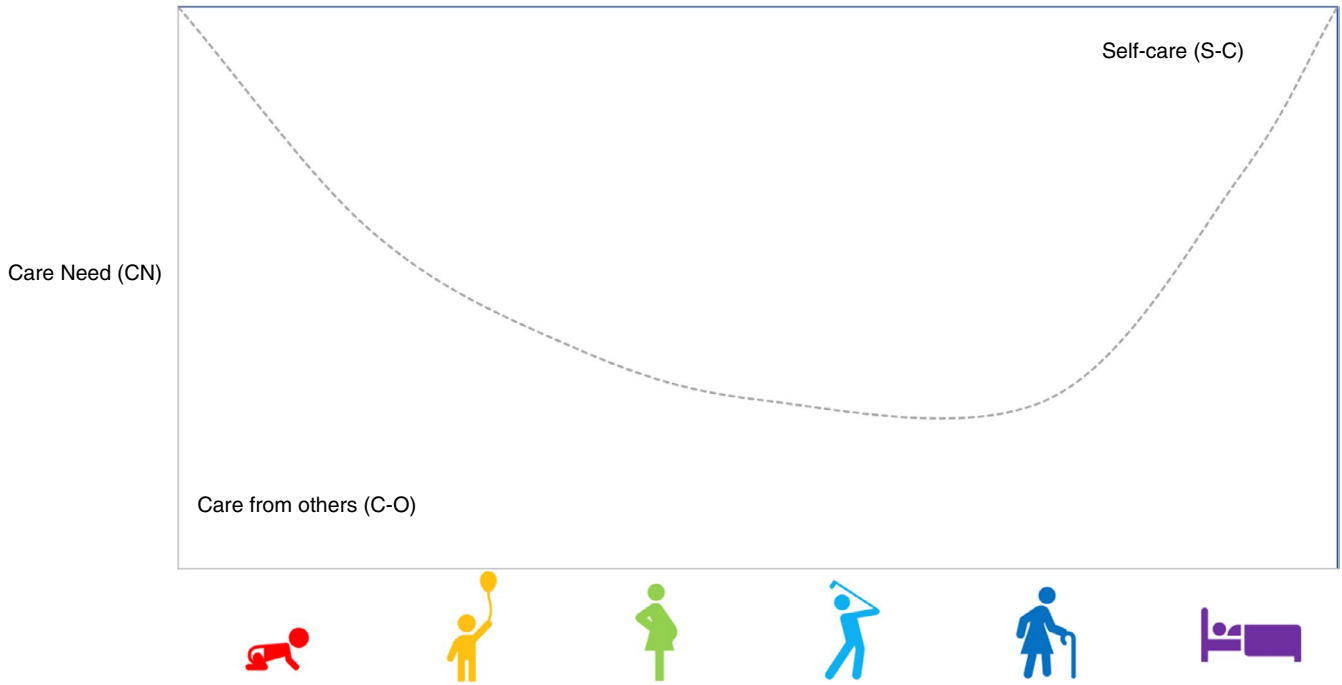


FIGURE 2 Proportion of care needs (CNs) met through self-care (S-C) and care-from-others (C-Fm-O) throughout the lifespan

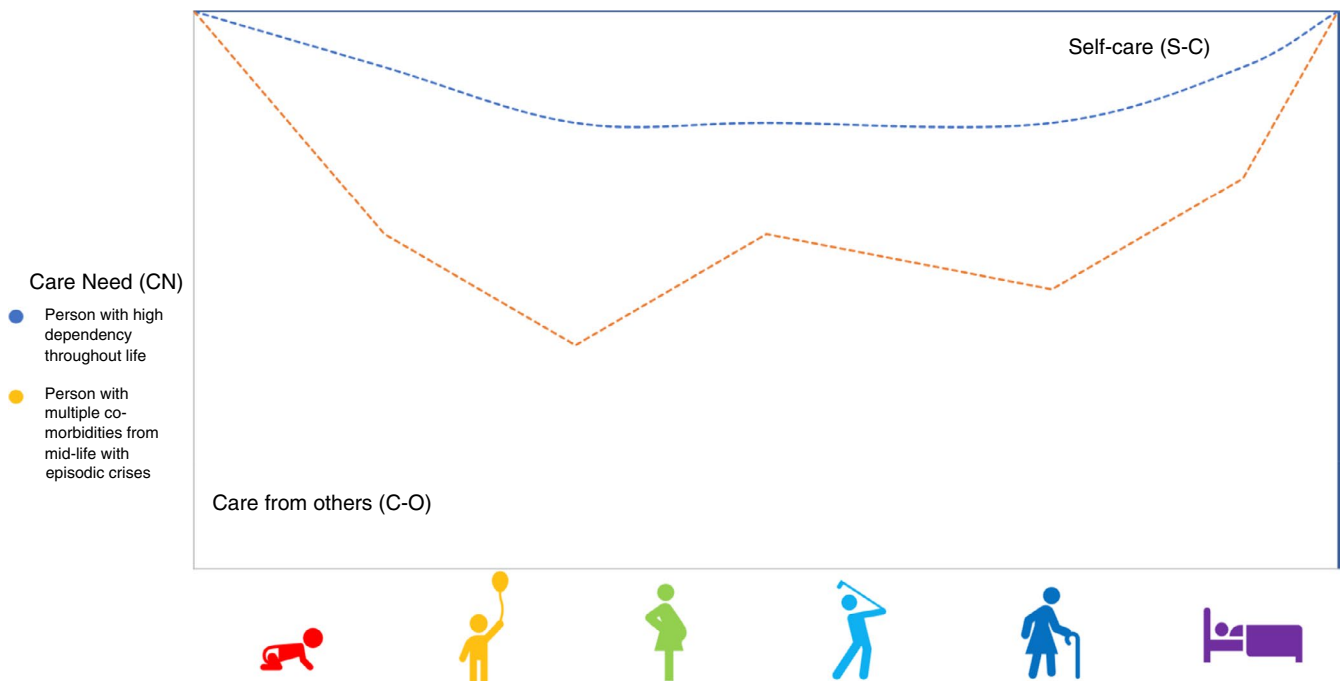


FIGURE 3 Proportion of care needs (CNs) met through self-care (S-C) and care-from-others (C-Fm-O) throughout the lifespan, taking account of intrinsic and extrinsic factors

In other words, a variable proportion of a person's CNs will be met by themselves and others according to their capabilities, developmental level and available support networks.

3.6.1 | Under what conditions would we expect CNs to vary?

CNs vary according to a range of intrinsic and extrinsic factors related both to the person who needs the care and the care network that surrounds them, within a particular spatial and temporal context. We know that CNs vary across different clinical populations and health conditions (e.g., people living with multiple comorbidities, or disabilities, or mental health issues) and that socio-economic conditions, such as poverty, unemployment, migration or isolation, impact care (Nelson et al., 2019; Rasanathan et al., 2011; World Health Organisation, 2015).

Figure 3 represents two 'archetypes'—a person whose majority of CNs are required to be met by others rather than by themselves (top line) due to several intrinsic factors that could relate to genetic or behavioural pre-dispositions. The bottom line represents a care trajectory that might reflect the CNs of a person living with multiple comorbidities from middle life, where several extrinsic factors have shaped their ability to S-C and their need for C-Fm-O.

These variations in the proportions of S-C and C-Fm-O required to meet a person's CNs could also be represented in the formula:

Care Needs = Care Provision
(appropriate mix of self-care and care-from-others)

OR

$$CN = CP (S - C + C - Fm - O)$$

However, the proportions of S-C and C-Fm-O would differ between groups, across the life course and at specific points in time. Regardless of these differences, the CLCT operates from a position that every person has the right to have their CNs met, regardless of the proportion of S-C or C-Fm-O. This means there is no discrimination towards individuals who need more help from others; rather, it is a societal responsibility to allocate resources and support accordingly.

3.7 | CP: How CNs are met

In the CLCT, CNs are met through adequate and appropriate CP. CP is defined as the enactment of care abilities and activities either by oneself or by others to address individuals' physical, psychosocial and relational needs at a given point in time in a wider historical and socio-political context.

An optimal care scenario could be summarised as follows:

$$CN = CP (S - C + C - Fm - O)$$

That is, an individual's CNs are satisfied through a combination of S-C and C-Fm-O provision. Figure 4 considers two hypothetical situations: what happens when the CNs of an individual are not met—that is, there is a deficit in terms of S-C or C-Fm-O. The top hatching represents S-C deficits, and the bottom hatching illustrates deficits in C-Fm-O.

The deficit in either S-C or C-Fm-O influences how the person's CNs are met across the lifespan. For example, if we consider the top left-hand hatched area in Figure 4 (labelled 'A'), this S-C deficit emerging in infancy might be related to developmental delays leading to the child being unable to self-feed or to articulate CNs effectively. If this S-C deficit is not recognised or addressed by additional C-Fm-O to compensate, then the S-C deficits are likely to continue and affect other S-C capabilities, potentially manifesting in additional issues and needs at subsequent developmental stages.

If C-Fm-O at infancy (Figure 4; labelled 'B') was deficient, either in terms of meeting self-CN or a more complex set of delayed developmental issues, then the CNs of the infant would be considerably compromised. Such a scenario could be a teenage mother who gives birth to a pre-term child and has little support to care for their child, loses her job and/or experiences homelessness. What will the caring trajectory of this scenario look like across the lifespan for mother and child? What additional education and support would be required to enable the infant, mother and wider care network to provide optimal care across the life course?

The situation in Figure 4 could generate three possible scenarios: **i) $CN > CP (S-C^{low} + C-Fm-O^{acceptable})$** , as illustrated by hatched area 'A' (Figure 4).

Here, we conjecture that a person who has deficits in S-C, which are not detected early or throughout their life course, will generate a continued S-C deficit throughout the lifespan and, potentially, across different life domains. Consider, for example, a young child who has diabetes and whose parents take primary responsibility for his care in relation to disease management. Despite this support, the child is not taught by his parents or other carers how to manage his condition independently. The child therefore does not develop requisite S-C skills that will ensure his health and well-being when his parents no longer have primary responsibility for his care. As such, he will likely have CNs that are not met in later life because of a limited ability to enact appropriate S-C behaviours.

ii) $CN > CP (S-C^{acceptable} + C-Fm-O^{low})$, as illustrated by hatched area 'B' (Figure 4).

Here, we can consider the possibility of a teenager who, through her schooling, learns the importance of diet and exercise for maintaining physical and mental health. Through this knowledge, she can undertake appropriate S-C activities to support her health and well-being, including making healthy food choices at school. However, the ability to maintain these behaviours is impacted by her home life and an unstable job market, which limits the family's finances, ultimately impacting food choices.

iii) $CN > CP (S-C^{low} + C-Fm-O^{low})$

Our earlier example of the infant with developmental delay and with a primary carer who is experiencing significant challenges in

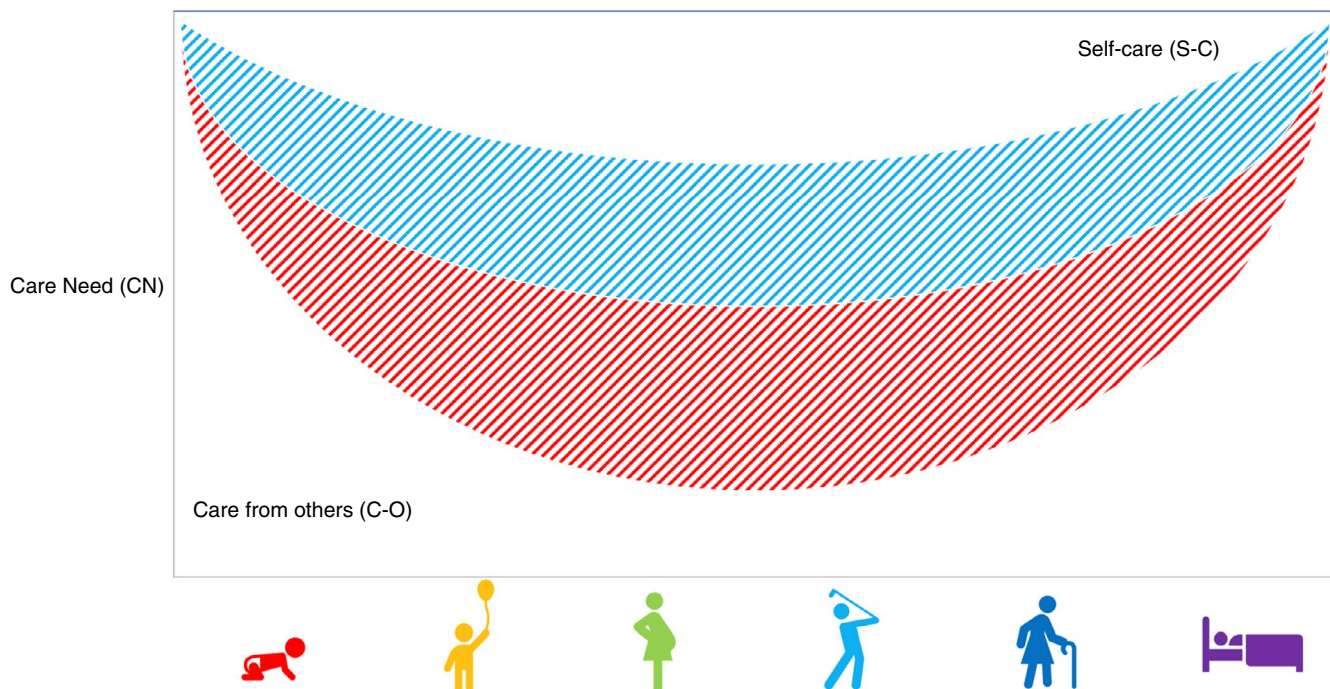


FIGURE 4 Unmet care needs highlighting self-care (S-C) and care-from-others (C-Fm-O) deficits

S-C, would exemplify the situation where CNs are greater than both S-C and C-Fm-O. When these care deficits emerge early in a child's life and are not mitigated, they can have lasting effects upon their S-C, leading to potential health and well-being challenges later in life and impacting their ability to care-for-others (C-Fr-O). Equally, the deficits in CP from others, whether informal, formal, or professional carers, will generate a series of consequences that build momentum over time.

There are also three scenarios that are theoretically possible around CP being greater than CNs:

$$\text{i) } CN < CP (S-C^{\text{acceptable}} + C-Fm-O^{\text{high}})$$

This could be a situation where an individual can care for themselves but is receiving excessive C-Fm-O that is disproportionate to their CNs. An example could be a carer who is overprotective of their elderly parent and limits the amount of socialising their parent engages in for fear of them falling. This behaviour not only provides excess care but also has the potential to undermine the S-C of the older person.

$$\text{ii) } CN < CP (S-C^{\text{high}} + C-Fm-O^{\text{acceptable}})$$

In this scenario, we might think about a young adult who is overly conscious of hygiene issues, such that they develop compulsions around hand hygiene and cleanliness and subsequent fears of socialising. Whilst they might have successfully hidden this emerging S-C challenge from others in their care network, it will reach a point where their excess vigilance in terms of S-C will start to challenge their daily life. Whilst there are known approaches to managing this phenomenon (Heyman et al., 2006), it is unlikely that a care lens has been used to understand the genesis of the behaviour or how caring practices might change it.

$$\text{iii) } CN < CP (S-C^{\text{high}} + C-Fm-O^{\text{high}})$$

This scenario could reflect a person with a tendency towards hypochondria, where they overregulate their own care and regularly seek care from informal, formal, and professional sources. Again, understanding this phenomenon from a CN and CP perspective, positioned within a life-course lens, might shed light on some S-C and care-from-other practices and importantly consider novel interventions that could be tested.

3.8 | Care-for-others

We now shift the construct C-Fm-O, as experienced by the person receiving care, to C-Fr-O, to describe the experiences of people who choose or are requested to provide care for others. This dual perspective—care from and care for—emphasises and reinforces a central tenet of the CLCT; that all care transactions must be negotiated between the person receiving care and person providing care before CNs can be met optimally. This principle is highly complex to execute given the levels of dependency, advocacy, self-efficacy, agency and social and cultural norms that must be considered as care is negotiated throughout the lifespan and between individuals and networks.

Within the CLCT, C-Fr-O is defined as care actions or processes provided by others to address a person's physical, psychosocial and relational CNs. As outlined above, people who provide C-Fr-O include informal (family, friends, unpaid carers), formal (paid carers) and professional carers (health, medical, disability and social care workforce), each supported by various types of technologies.

Figure 5 acknowledges the dominant presence of informal CP in infancy and childhood years, with an expected decline in all types of C-Fm-O throughout adulthood due to S-C abilities and resources being developed and utilised. As people grow older and acquire more comorbidity or disability, so the proportion of C-Fm-O is expected to increase from all CP types in later years. For many individuals, most CNs will be met primarily by self or by informal carers. However, a life transition such as pregnancy, puberty or retirement might create additional CNs that cannot be met by self or informal carers within the individual's care network, and formal and professional carers might be required to provide the additional care.

3.9 | Care provision package

Care is rarely, if ever, provided by an individual alone or in isolation. We thus propose the *Care Provision Package* (CPP) as a construct to describe the full complement of agents involved in CP for an individual. The CPP comprises of a combination of the individual who is engaged in S-C as well as informal, formal and professional carers. Whilst the CPP focuses primarily on the individual (or teams) providing care, this construct can be expanded to include the full scope of CP, including technological and pharmaceutical interventions.

There are two additional constructs within the CLCT that relate to CP. These are **Capability** and **Capacity**, each described below.

3.10 | Care capability

Care capability refers to the ability (i.e., skills, knowledge and motivation) to care for oneself and others throughout the life course.

Capabilities cover relationship-enabling, knowing, decision-making, operational and doing capabilities that enable people to maintain good health and prevent illness in themselves and those they care for.

Care capability comes in two main forms:

1. **S-C capability**, the ability to care for oneself.
2. **C-Fr-O capability**, the ability to care for others.

The CLCT postulates a third form of care capability: **care-from-other capability**, a person's ability to intentionally search for, ask for or acquire assistance from selected sources of care to address an identified need. The ability to identify and recognise personal CNs is dependent on a person's physical, cognitive and psychosocial developmental levels, as well as their health and digital literacy. Further, care-from-other capability is likely to be dependent on individuals' readiness to voluntarily seek and accept care from a chosen carer.

3.11 | Care capacity

Care capacity refers to the amount or volume of care available to oneself and others throughout the life course, limited by time and resources, and other factors in the context of the person's social/medical environment, such as access to services, availability of informal/formal care networks, geographic location, poverty, stigma and discrimination. Capacity focuses on the individual in their context and how that context enables or limits them to provide care for themselves or to others.

Care capacity comes in two main forms:



FIGURE 5 How care needs (CNs) are met by others

1. **S-C capacity**, the amount of care that a person can provide to themselves.
2. **Care-for-other capacity**, the amount of care that a person can provide to others.

An additional form of care capacity is **C-Fm-O capacity**, the amount of care a person can successfully seek, ask for or gain from others, limited by, for example, time, money, access to healthcare services, availability of technologies, and remoteness.

Care capability and capacity need to be evaluated and re-evaluated for each individual across the lifespan. Consider a single parent who has lost their job and is caring for two young children and an elderly relative. Whilst they might have been able to manage, both in terms of capability and capacity, before the job loss, they are now in different socio-economic circumstances. They might no longer have capacity to provide C-Fr-O in their network, and require additional support, such as from informal carers (relatives, neighbours or friends). Likewise, if one of their family members becomes more dependent (e.g., the elderly relative falls and requires restorative care), the parent might not have the capability to care for the family member's increasingly complex needs and will require formal or professional support.

According to the CLCT, a person will have a range of S-C capabilities and capacities that will vary across the life course. They might be able to cope well at one point in their life but then due to intrinsic or extrinsic factors, are no longer able (i.e., lack the skills, knowledge and/or motivation) or do not have the resources to look after themselves (e.g., they might have been made unemployed or experiencing bereavement following the loss of a partner). This is where an understanding of life-course care transitions (i.e., significant points of change) and care trajectories (i.e., anticipated CNs based on the assessment of S-C capability and capacity) add a predictive element to the theory.

3.12 | Care transition

A *care transition* is an event or life stage that triggers a change in a person's CNs. The event might be intrinsic (e.g., puberty, pregnancy and fatherhood) or extrinsic (e.g., unemployment, retirement and coping with a natural disaster) in nature. Such events impact upon a person's S-C, C-Fm-O and C-Fr-O capability and capacity.

3.13 | Care trajectory

Care trajectory relates to the potential impact a life event might have upon a person's S-C and C-Fr-O capability and capacity. Health and care professionals are most likely to be involved in life-course situations where an event triggers a need for more care (care transition) or when an event creates a different set of CNs for the future (care trajectory). To assess a person's CNs accurately at these critical points in time, it is important to collate the care information in what we call a care biography.

3.14 | Care biography

A *care biography* refers to the personalised history of an individual's S-C and caring capability and capacity and their own understanding of the care they have and should receive from other people. A care biography is equivalent to a personalised health record in that it should record, across the life course, a person's S-C capability and capacity and their preferences in how care is provided for them. It should also help them and their carers plan care following certain negotiated care trajectories. This information would be owned by the individual and used to negotiate care in each care encounter. Importantly, the care biography should also record each person's care network, identifying their key carers and those for whom they care over their life course.

4 | DISCUSSION

We propose the CLCT as a unifying theory that incorporates understandings from multiple disciplines; philosophical and epistemological orientations; and existing theories, models, and conceptual frameworks. Seminal nursing theories of care share similarities with the CLCT in that they describe fundamental aspects of caring and S-C, including the nurse-patient relationship (e.g., Nursing Process Theory; Orlando, 1961); integration of care (i.e., simultaneously addressing a persons' physical, psychosocial, and relational needs) (e.g., Person-Centred Nursing Framework; McCormack & McCance, 2006); and the context of care (e.g., Sunrise Model; Leininger & McFarland, 2002) at microlevel (individual factors), mesolevel (organisational factors), and macrolevel (environmental factors). Yet, extant theories generally do not depict these aspects collectively and often describe the integration of the physical, psychosocial and relational aspects of care poorly (Mudd et al., 2020). Comparable to the CLCT, the Self-Care Deficit Nursing Theory (Orem, 2001) posits that S-C deficits can occur when care demands exceeding S-C agency. In addition, and similar to the CLCT, the Theory of Human Caring Science is a relational theory of care that aims to "protect, enhance, promote, and potentiate human dignity, wholeness, and healing, wherein a person creates or cocreates his or her own meaning for existence, healing, wholeness, and living and dying" (Watson, 2010, p. 327) through intentional, meaningful, and authentic interactions or 'caring moments'.

Unlike these theories, however, the CLCT is designed to acknowledge and incorporate but also to transcend context or the perspective of any single agent (i.e., the person[s] receiving care vs. the person[s] providing care). That is, it is designed to explain people's care and S-C needs as they occur across the lifespan, rather than within the confined parameters of specific care contexts, health conditions or societal structures. This is achieved by focusing on a person's care and S-C in terms of both their current context (e.g., current CNs, capability and capacity for S-C, relationships, and broader socio-political context) and their lifespan (e.g., their own personal experiences and histories). We also want to generate a unifying discourse

around care and S-C that enables different professional disciplines as well as the public to get involved in tackling some of our most challenging care issues, such as improving aged care and caring for people with disabilities to enable them to have respectful, productive, fulfilling lives.

In this discussion, we reflect upon our journey around generating and refining the constructs underpinning the CLCT and highlight areas of continued debate and uncertainty. We consider potential unintended ways that the CLCT could be used, which might not improve people's experiences of care. Despite these potential misuses, we argue there are more benefits than risks in continuing to explore this theoretical path. The discussion concludes by identifying a range of issues that need to be explored if the theory is to be further refined and tested to have practical impact.

4.1 | Our reflective journey

As outlined in the methods section, we represent a diverse philosophical, theoretical and multidisciplinary research team. This diversity has helped us to generate a unique shared understanding around S-C and caring interventions. The CLCT has enabled us to understand and interpret our own research successes—and failures—in more integrated, dynamic ways.

For example, Golley and colleagues' work on child obesity prevention (Golley et al., 2011; Seidler et al., 2020) highlighted the importance of interventions that aimed to enhance parental capacity to establish healthy family lifestyle behaviours. The interactions between family members were central in this vanguard approach. More recent research in this field is consistent with the CLCT, demonstrating the role of relationships within a care network—couples, grandparents, childcare and school staff, health services—in supporting children and family health and care.

Additionally, the work of Clark and colleagues in cardiovascular disease, cardiac rehabilitation and secondary prevention demonstrates the importance of partnerships between people, their informal, formal, family and professional carers (Clark et al., 2007, 2015). Clark and colleagues have demonstrated that both caring and S-C are crucial in cardiovascular disease, reducing the growing burden of cardiovascular disease depends as much on promoting effective S-C as on medication management. Yet, attaining proficiency in cardiovascular disease S-C is difficult—it involves people becoming adept in a very wide range of skills across multiple domains daily.

Arciuli and colleagues' work on human communication is useful in thinking of the 'tools' that enhance individuals' capacity to care for themselves, negotiate C-Fm-O and provide care to others. Arciuli and her team have investigated ways to support literacy skills in children with developmental disabilities such as autism and Down syndrome (Arciuli & Bailey, 2019; Bailey et al., 2017). Functional literacy skills are linked with positive life outcomes in health, educational and social domains.

Ratcliffe and colleagues' work to develop a new quality of life and well-being measure for aged care also illustrates the need to

base the framing of questions informing tool development on a strong conceptual understanding of S-C, care expectations and networks rather than relying on questions relating to activities of daily living (Ratcliffe et al., 2019). Such work emphasises the inextricable links between care processes and outcomes and the central importance of the caring relationship for older people receiving aged care services, be it in their own homes or in a residential aged care facility.

These examples, focusing on preventative health through to C-Fm-O, S-C and self-management practices, often draw from existing behaviour change theories, such as social learning and developmental theories (Grusec, 1992) and the behaviour change wheel (Michie et al., 2011). Such theories outline individual behavioural change and are often limited in their effectiveness by the multiple contextual factors that impact real-life interventions. Our work around the CLCT suggests that rather than ignore such complexity, we need to frame the use of tried and tested single-focus theories within the larger explanatory framework of the CLCT. This means that as we move through the life course, we will be able to utilise appropriate existing theories so that we can generate more robust and integrated theory-driven interventions and programmes.

4.2 | Areas of continued debate and uncertainty

Approaches to S-C and caring that emerge from philosophical discourse around human rights, such as capability theory (Robeyns, 2005; Sen, 2009), resist attempts to reduce the richness and complexity of caring relationships. However, they have been criticised for not being easily translatable into everyday practice (Kanbur, 2016). Bringing the CLCT into dialogue with more sociological bodies of theory will be important, particularly in reconciling the ways that S-C and caring research has been used in a potentially disempowering manner, such as for people with disability. Questions remain about how the CLCT can align with rights-based perspectives for people whose rights are often abraded in policy and practice and will be a key programme of exploratory work moving forward.

Alongside this, it might be difficult to see how the CLCT can create more positive notions of care in certain sectors, including those that have been under resourced to deliver relationship-centred care and those that have lacked ongoing support from traditional research initiatives. These sectors (disability; aged care; child protection; and vulnerable communities such as homeless, prison populations, migrants, victims of family violence) are often perceived by policy makers as too challenging and complex to invest in new and integrated approaches to defining CNs and CP. We are conscious of the need for the CLCT to be accessible for all those who are already experiencing structural, societal, and other barriers to enter into dialogue about the effectiveness and appropriateness of the theory and where it can be improved, and this will be one of our implementation and evaluation challenges.

4.3 | Potential risks and misinterpretations

A potential risk for the CLCT is viewing it from a reductionist lens: one could imagine, as with the development of quality-adjusted or disability-adjusted life year measures (Parks, 2014; Soares, 2012), the generation of algorithms around an individual's contribution to society that are compared against their need for care across the lifespan. This again emphasises human rights-based debates and requires us to understand, as societies, how we invest our resources and enable members to live healthy, fulfilled lives. We argue that articulating the central importance of S-C and CP to health and well-being is significant in reframing the discourse and viewing S-C and caring as truly affirmative human qualities that define cultures and society.

4.4 | Potential benefits

The CLCT articulates the as-yet-unexplored synergistic relationship between the ability to S-C, to evaluate C-Fm-O and to identify the capability and capacity shaping C-Fr-O across the lifespan. In doing so, it outlines the complex exchange influenced by life course and shaped by the dynamic interplay of *synchronic* (pertaining to a particular context and point in time) and *diachronic* (developing and evolving over time) factors impacting on a person's S-C and care from and for others. Importantly, the theory aims to reposition the social and economic contribution of care and S-C, from one of costs and deficit to one of intrinsic benefit to individuals', families' and communities' health, wealth, quality of life and well-being.

4.5 | Further areas of exploration

Our exploratory work around the CLCT has raised several challenges. First is the lack of consistency around collecting and storing information about a person's CNs and CP. These challenges include the diversity in how professionals record care information, the lack of a shared conceptual framework to describe CNs and CP, inconsistency in how the person or informal carers are involved, and minimal evaluation of individuals' understanding of their own CNs and how they should be addressed. There is also an emerging debate around who should 'own' these data, particularly if they become part of a person's care biography. Such highly private data will require thoughtful consideration from legal, ethical and confidentiality perspectives.

A second challenge is how to ensure that the fundamental constructs of the theory translate to more integrated ways of optimising care. We also need to acknowledge the limitations and boundaries of care as it affects and influences other life-course narratives so that the CLCT does not claim to be the solution for every social or medical malaise. These issues require further exploration before we can confidently assume that better caring processes can be introduced into society.

Our future work will focus on refinement, testing and operationalisation of the theory, namely, how it can be used, by whom and in what circumstances. We will tackle issues such as how it might be used by an individual needing/receiving care, by informal, formal or professional carers, and how it can be incorporated into relevant curricula and policies. This will include testing and refining the theory with consumers, lay carers, health professionals and understanding how it could be distilled or packaged into palatable forms or resources.

We are also developing research programmes around each of the theory's building blocks with a view to understanding how these building blocks interconnect to form the unifying CLCT. We are currently developing interdisciplinary theoretical understandings of S-C and related concepts (e.g., self-management) and the implications for S-C research. We are furthering our understanding of CP for fundamental needs. For instance, we are exploring how fundamental care should be delivered across a range of contexts, such as acute and aged care, and how professional carers (nurses in leadership positions and other members of the interdisciplinary team) facilitate fundamental care delivery across these contexts. We are also building a programme of work around help-seeking and C-Fm-O during pivotal transition points across the lifespan, such as the transition to fatherhood.

5 | IMPACT TO NURSING SCIENCE, PRACTICE, AND DISCIPLINARY KNOWLEDGE

The novel contribution the CLCT makes to nursing science is in recognising and embedding the seminal contribution of earlier nursing theories and building this into a more interdisciplinary approach to normalising care into our health and social care systems. Furthermore, the CLCT offers a game changing way of thinking about care across the lifespan. This has never been done before in a systematic, theory informed way. Our claim is that a person's ability to S-C or C-Fr-O is related to their own experiences of care from birth throughout their life, and if we want to build care capability and capacity (which we need to do), then we have to explore this in much more detail.

We also are promoting a novel way of capturing a person's care experiences through what we are calling a care biography. This care biography could be the equivalent to, and complement, a person's medical history. Such an approach articulates the complexity but also centrality of caring relationships to CP from a range of care providers and how these relationships inevitably impact and are impacted by a range of intrinsic and extrinsic factors. Whilst other nursing theories have attempted, to some extent, to elucidate these various factors (Mudd et al., 2020), we argue that the CLCT has both theoretical coherence as well a profound practical application. Specifically, in systematically articulating the proposed 14 constructs that make up the theory and developing several case examples, the CLCT will provide a roadmap for how nursing, other health and social care

disciplines, formal and informal carers, and people themselves, can begin to understand what care is required throughout their lifespan, who is best suited to provide it and how and where that care should be delivered.

Through the CLCT, nursing as a discipline can reclaim caring as a core skill that underpins all other therapeutic activity. By creating and testing the theoretical scaffolding presented in this paper, nursing leaders and clinicians can begin to conceptualise and articulate caring, taking into consideration not only an individual's CNs, but their wider care networks, personal histories and contexts thus generate more integrated models of care. The theory therefore offers nursing and other health disciplines, as well as informal carers, a more holistic and inclusive way to approach care. The CLCT can also create more robust theoretically informed approaches for the increasing use of technology to enhance nursing care.

6 | CONCLUSIONS

We have presented the CLCT as a unified, integrated theory to understand S-C and caring for universal needs across the lifespan. Care and S-C have yet to be afforded the sustained and dedicated theoretical and conceptual work needed to support their effective delivery across a range of contexts and for individuals, families and communities with varied needs and circumstances. The CLCT has significant potential to overcome this deficit in our theoretical and conceptual understandings.

ACKNOWLEDGEMENTS

We would like to thank Sue Gordon and Anthony Maeder for their comments on an earlier draft of this manuscript.

CONFLICT OF INTEREST

None.

AUTHOR CONTRIBUTIONS

All authors made a substantial contribution to the conception and content of this paper. AK, RF and ML were responsible for drafting and revising the manuscript. JA, RC, RG, BL, JR and SR all revised the manuscript providing crucial intellectual content and input. All authors have given final approval for the version to be submitted and published. All authors have agreed to be accountable for all aspects of the work.

PEER REVIEW

The peer review history for this article is available at <https://publons.com/publon/10.1111/jan.14887>.

DATA AVAILABILITY STATEMENT

Data sharing not applicable—no new data generated, or the article describes entirely theoretical research.

ORCID

Alison Kitson  <https://orcid.org/0000-0003-3053-8381>

Rebecca Feo  <https://orcid.org/0000-0001-9414-2242>

Robyn Clark  <https://orcid.org/0000-0002-5063-2618>

TWITTER

Alison Kitson  @alisonkitson

Rebecca Feo  @Rebecca_Feo

REFERENCES

- Anstey, K. J. (2012). Biomarkers and memory aging: A lifecourse perspective. In M. Naveh-Benjamin, & N. Ohta (Eds.), *Memory and aging* (pp. 349–372). Psychology Press.
- Archibald, M. M., Lawless, M., Harvey, G., & Kitson, A. L. (2018). Transdisciplinary research for impact: Protocol for a realist evaluation of the relationship between transdisciplinary research collaboration and knowledge translation. *British Medical Journal Open*, 8(4), e021775. <https://doi.org/10.1136/bmjopen-2018-021775>
- Arciuli, J., & Bailey, B. (2019). Efficacy of ABRACADABRA literacy instruction in a school setting for children with autism spectrum disorders. *Research in Developmental Disabilities*, 85, 104–115. <https://doi.org/10.1016/j.ridd.2018.11.003>
- Bailey, B., Arciuli, J., & Stancliffe, R. J. (2017). Effects of ABRACADABRA literacy instruction on children with autism spectrum disorder. *Journal of Educational Psychology*, 109(2), 257–268. <https://doi.org/10.1037/edu0000138>
- Baines, D., & Armstrong, P. (2019). Non-job work/unpaid caring: Gendered industrial relations in long-term care. *Gender, Work and Organization*, 26(7), 934–947. <https://doi.org/10.1111/gwao.12293>
- Bandura, A. (1997). *Self-efficacy: The Exercise of Control*. W. H. Freeman.
- Ben-Shlomo, Y., Cooper, R., & Kuh, D. (2016). The last two decades of life course epidemiology, and its relevance for research on ageing. *International Journal of Epidemiology*, 45(4), 973–988. <https://doi.org/10.1093/ije/dyw096>
- Borrell-Carrió, F., Suchman, A. L., & Epstein, R. M. (2004). The biopsychosocial model 25 years later: Principles, practice, and scientific inquiry. *Annals of Family Medicine*, 2(6), 576–582. <https://doi.org/10.1370/afm.245>
- Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. Routledge.
- Chinitz, D. P., & Rodwin, V. G. (2014). On Health Policy and Management (HPAM): Mind the theory-policy-practice gap. *International Journal of Health Policy and Management*, 3(7), 361–363. <https://doi.org/10.15171/ijhpm.2014.122>
- Clark, R. A., Conway, A., Poulsen, V., Keech, W., Tirimacco, R., & Tideman, P. (2015). Alternative models of cardiac rehabilitation: A systematic review. *European Journal of Preventive Cardiology*, 22(1), 35–74. <https://doi.org/10.1177/2047487313501093>
- Clark, R. A., Inglis, S. C., McAlister, F. A., Cleland, J. G. F., & Stewart, S. (2007). Telemonitoring or structured telephone support programmes for patients with chronic heart failure: Systematic review and meta-analysis. *British Medical Journal*, 334(7600), 942–945. <https://doi.org/10.1136/bmj.39156.536968.55>
- Colley, S. (2003). Nursing theory: Its importance to practice. *Nursing Standard*, 17, 33–38. <https://doi.org/10.7748/ns.17.46.33.s56>
- Cook, L. B., & Peden, A. (2017). Finding a focus for nursing: A caring concept. *Advances in Nursing Science*, 40, 12–23. <https://doi.org/10.1097/ANS.0000000000000137>
- Cooney, T. M., & Curl, A. L. (2019). Transitioning from successful aging: A life course approach. *Journal of Aging and Health*, 31(3), 528–551. <https://doi.org/10.1177/0898264317737892>

- De Henau, J., Himmelweit, S., Lapniewska, Z., & Perrons, D. (2016). *Investing in the Care Economy: A gender analysis of employment stimulus in seven OECD countries*. International Trade Union Confederation.
- Elder, G. H. (1994). Time, human agency, and social change: perspectives on the life course. *Social Psychology Quarterly*, 57, 4–15. <https://doi.org/10.2307/2786971>
- Elder, G. H., & Shanahan, M. J. (2007). The life course and human development. In W. Damon, & R. M. Lerner (Eds.), *Handbook of Child Psychology Vol 1: Theoretical models of human development* (6th ed.). John Wiley & Sons Inc.
- Erikson, E. H., & Erikson, J. M. (1998). *The life cycle completed (extended version)*. W. W. Norton.
- Feo, R., Conroy, T., Jangland, E., Muntlin Athlin, Å., Brovall, M., Parr, J., Blomberg, K., & Kitson, A. (2018). Towards a standardised definition for fundamental care: A modified Delphi study. *Journal of Clinical Nursing*, 27, 2285–2299. <https://doi.org/10.1111/jocn.14247>
- Feo, R., Frensham, L., Conroy, T., & Kitson, A. (2019). "It's just common sense": Preconceptions and myths regarding fundamental care. *Nurse Education in Practice*, 36, 82–84. <https://doi.org/10.1016/j.nepr.2019.03.006>
- Folbre, N. (2018). *Developing care: Recent research on the care economy and economic development*. International Development Research Centre.
- Golley, R. K., Hendrie, G. A., Slater, A., & Corsini, N. (2011). Interventions that involve parents to improve children's weight-related nutrition intake and activity patterns - What nutrition and activity targets and behaviour change techniques are associated with intervention effectiveness? *Obesity Reviews*, 12(2), 114–130. <https://doi.org/10.1111/j.1467-789X.2010.00745.x>
- Grady, P. A., & Gough, L. L. (2018). Self-management: A comprehensive approach to management of chronic conditions. *American Journal of Public Health*, 108, S430–S436. <https://doi.org/10.2105/AJPH.2014.302041>
- Grusec, J. E. (1992). Social learning theory and developmental psychology: The legacies of Robert Sears and Albert Bandura. *Developmental Psychology*, 28(5), 776–786. <https://doi.org/10.1037/0012-1649.28.5.776>
- Ham, C., Alderwick, H., Dunn, P., & McKenna, H. (2017). *Delivering sustainability and transformation plans: From ambitious proposals to credible plans*. The Kings Fund.
- Henderson, V. (2004). *ICN basic principles of nursing care* (4th ed.). International Council of Nurses.
- Heyman, I., Mataix-Cols, D., & Fineberg, N. A. (2006). Obsessive-compulsive disorder. *BMJ*, 333, 424–429. <https://doi.org/10.1136/bmj.333.7565.424>
- International Labour Office (2018). *Care work and care jobs for the future of decent work*. ILO.
- Jaarsma, T., Strömberg, A., Dunbar, S. B., Fitzsimons, D., Lee, C., Middleton, S., Vellone, E., Freedland, K. E., & Riegel, B. (2020). Self-care research: How to grow the evidence base? *International Journal of Nursing Studies*, 105, 103555. <https://doi.org/10.1016/j.ijnurstu.2020.103555>
- Johnson, D., Deterding, S., Kuhn, K. A., Staneva, A., Stoyanov, S., & Hides, L. (2016). Gamification for health and wellbeing: A systematic review of the literature. *Internet Interventions*, 6, 89–106. <https://doi.org/10.1016/j.invent.2016.10.002>
- Kanbur, R. (2016). *Capability opportunity outcome – And equality*. Charles H. Dyson School of Applied Economics and Management, Cornell University.
- Kitson, A., Conroy, T., Kuluski, K., Locock, L., & Lyons, R. (2013). *Reclaiming and redefining the Fundamentals of Care: Nursing's response to meeting patients' basic human needs*. School of Nursing, The University of Adelaide.
- Kitson, A., Dow, C., Calabrese, J. D., Locock, L., & Muntlin Athlin, A. (2013). Stroke survivors' experiences of the fundamentals of care: A qualitative analysis. *International Journal of Nursing Studies*, 50(3), 392–403. <https://doi.org/10.1016/j.ijnurstu.2012.09.017>
- Kitson, A., Marshall, A., Bassett, K., & Zeitz, K. (2013). What are the core elements of patient-centred care? A narrative review and synthesis of the literature from health policy, medicine and nursing. *Journal of Advanced Nursing*, 69(1), 4–15. <https://doi.org/10.1111/j.1365-2648.2012.06064.x>
- Kitson, A., & Muntlin Athlin, A. (2013). Development and preliminary testing of a framework to evaluate patients' experiences of the fundamentals of care: A secondary analysis of three stroke survivor narratives. *Nursing Research and Practice*, 2013, 572437. <https://doi.org/10.1155/2013/572437>
- Leininger, M., & McFarland, M. R. (2002). *Transcultural nursing: Concepts, theories, research & practice* (3rd ed.). McGraw-Hill Education.
- MacDonald, M., Phipps, S., & Lethbridge, L. (2005). Taking its toll: The influence of paid and unpaid work on women's well-being. *Feminist Economics*, 11(1), 63–94. <https://doi.org/10.1080/135457004200032597>
- Makransky, G., Bonde, M. T., Wulff, J. S. G., Wandall, J., Hood, M., Creed, P. A., Bache, I., Silhtaroglu, A., & Nørremølle, A. (2016). Simulation based virtual learning environment in medical genetics counseling: An example of bridging the gap between theory and practice in medical education. *BMC Medical Education*, 16(1), 98. <https://doi.org/10.1186/s12909-016-0620-6>
- Martinsen, K. (2006). *Care and vulnerability*. Akribes.
- Masic, I. (2018). Public health aspects of global population health and well-being in the 21st century regarding determinants of health. *International Journal of Preventive Medicine*, 9, 4. https://doi.org/10.4103/ijpvm.ijpvm_476_17
- Matarese, M., Lommi, M., De Marinis, M. G., & Riegel, B. (2018). A systematic review and integration of concept analyses of self-care and related concepts. *Journal of Nursing Scholarship*, 50(3), 296–305. <https://doi.org/10.1111/jnu.12385>
- McCormack, B., & McCance, T. V. (2006). Development of a framework for person-centred nursing. *Journal of Advanced Nursing*, 56, 472–479. <https://doi.org/10.1111/j.1365-2648.2006.04042.x>
- McCrae, N. (2012). Whither nursing models? The value of nursing theory in the context of evidence-based practice and multidisciplinary health care. *Journal of Advanced Nursing*, 68, 222–229. <https://doi.org/10.1111/j.1365-2648.2011.05821.x>
- Michie, S., van Stralen, M. M., & West, R. (2011). The behaviour change wheel: A new method for characterising and designing behaviour change interventions. *Implementation Science*, 6(1), 42. <https://doi.org/10.1186/1748-5908-6-42>
- Mudd, A., Feo, R., Conroy, T., & Kitson, A. (2020). Where and how does fundamental care fit within seminal nursing theories: A narrative review and synthesis of key nursing concepts. *Journal of Clinical Nursing*, 29, 3652–3666. <https://doi.org/10.1111/jocn.15420>
- Nelson, L. A., Ackerman, M. T., Greevy, R. A. Jr, Wallston, K. A., & Mayberry, L. S. (2019). Beyond race disparities: Accounting for socioeconomic status in diabetes self-care. *American Journal of Preventive Medicine*, 57(1), 111–116. <https://doi.org/10.1016/j.amepre.2019.02.013>
- Orem, D. (2001). *Nursing: Concepts of practice* (6th ed.). Mosby.
- Orlando, I. J. (1961). *The dynamic nurse-patient relationship: Function, process, and principles*. Putnam.
- Parks, R. (2014). The rise, critique and persistence of the DALY in global health. *The Journal of Global Health*, 4, 28–32. <https://doi.org/10.7916/thejgh.v4i1.4893>
- Piaget, J., & Inhelder, B. (1969). *The psychology of the child*. Routledge.
- Pittenger, A. L., Dimitropoulos, E., Foag, J., Bishop, D., Panizza, S., & Bishop, J. R. (2019). Closing the classroom theory to practice gap by simulating a psychiatric pharmacy practice experience. *American Journal of Pharmaceutical Education*, 83(10), 7276. <https://doi.org/10.5688/ajpe7276>
- Power, K. (2020). The COVID-19 pandemic has increased the care burden of women and families. *Sustainability: Science, Practice, and Policy*, 16(1), 67–73. <https://doi.org/10.1080/15487733.2020.1776561>

- Rafferty, A. M., Robinson, J., & Elkan, R. (2005). *Nursing history and the politics of welfare*. Routledge.
- Rasanathan, K., Montesinos, E. V., Matheson, D., Etienne, C., & Evans, T. (2011). Primary health care and the social determinants of health: Essential and complementary approaches for reducing inequities in health. *Journal of Epidemiology and Community Health*, 65(8), 656–660. <https://doi.org/10.1136/jech.2009.093914>
- Ratcliffe, J., Cameron, I., Lancsar, E., Walker, R., Milte, R., Hutchinson, C. L., Swaffer, K., & Parker, S. (2019). Developing a new quality of life instrument with older people for economic evaluation in aged care: Study protocol. *British Medical Journal Open*, 9(5), e028647. <https://doi.org/10.1136/bmjopen-2018-028647>
- Ratcliffe, J., Chen, G., Cleland, J., Kaambwa, B., Khadka, J., Hutchinson, C., & Milte, R. (2020). Australia's aged care system: Assessing the views and preferences of the general public for quality of care and future funding (Research Paper 6). A research study for the Royal Commission into Aged Care Quality and Safety. Australia.
- Rehnsfeldt, A., Arman, M., & Lindström, U. Å. (2017). Clinical caring science as a scientific discipline. *Scandinavian Journal of Caring Sciences*, 31(3), 641–646. <https://doi.org/10.1111/scs.12380>
- Richard, A. A., & Shea, K. (2011). Delineation of self-care and associated concepts. *Journal of Nursing Scholarship*, 43(3), 255–264. <https://doi.org/10.1111/j.1547-5069.2011.01404.x>
- Riegel, B., Dickson, V. V., & Faulkner, K. M. (2016). The situation-specific theory of heart failure self-care: Revised and updated. *Journal of Cardiovascular Nursing*, 31(3), 226–235. <https://doi.org/10.1097/JCN.0000000000000244>
- Riegel, B., Jaarsma, T., & Strömberg, A. (2012). A middle-range theory of self-care of chronic illness. *Advances in Nursing Science*, 35(3), 194–204. <https://doi.org/10.1097/ANS.0b013e318261b1ba>
- Robeyns, I. (2005). The capability approach: a theoretical survey. *Journal of Human Development*, 6(1), 93–117. <https://doi.org/10.1080/146498805200034266>
- Roper, N., Logan, W. W., & Tierney, A. J. (2001). *The Roper-Logan-Tierney model of nursing: Based on activities of living*. Churchill Livingstone.
- Seidler, A. L., Hunter, K. E., Johnson, B. J., Ekambareshwar, M., Taki, S., Mauch, C. E., & Golley, R. K. (2020). Understanding, comparing and learning from the four EPOCH early childhood obesity prevention interventions: A multi-methods study. *Pediatric Obesity*, 15(11), e12679. <https://doi.org/10.1111/ijpo.12679>
- Sen, A. (2009). Capability: reach and limit. In E. Chipper-Martinetti (Ed.), *Debating global society. Reach and limit of the capability approach* (pp. 15–28). Feltrinelli.
- Shanahan, M. J. (2000). Pathways to adulthood in changing societies: Variability and mechanisms in life course perspective. *Annual Review of Sociology*, 26, 667–692. <https://doi.org/10.1146/annurev.soc.26.1.667>
- Shields, J. M. (2013). Zange and Sorge: two models of “concern” in comparative philosophy of religion. In J. Karnaris (Ed.), *Polyphonic thinking and the divine* (pp. 89–96). Brill/Rodopi.
- Soares, M. O. (2012). Is the QALY blind, deaf and dumb to equity? NICE's considerations over equity. *British Medical Bulletin*, 101(1), 17–31. <https://doi.org/10.1093/bmb/lds003>
- Treiber, L. A., & Jones, J. (2015). The care/cure dichotomy: Nursing's struggle with dualism. *Health Sociology Review*, 24, 152–162. <https://doi.org/10.1080/14461242.2014.999404>
- Turkel, M. C., Watson, J., & Giovannoni, J. (2018). Caring science or science of caring. *Nursing Science Quarterly*, 31(1), 66–71. <https://doi.org/10.1177/0894318417741116>
- Urquhart, R., Grunfeld, E., Jackson, L., Sargeant, J., & Porter, G. A. (2013). Cross-disciplinary research in cancer: An opportunity to narrow the knowledge- practice gap. *Current Oncology*, 20(6), e512–e521. <https://doi.org/10.3747/co.20.1487>
- Vygotsky, L. S. (1994). Tool and symbol in child development. In R. van der Veer, & J. Valsiner (Eds.), *The Vygotsky reader*. Blackwell.
- Watson, J. (2008). *The philosophy and science of caring (revised edition)*. University Press of Colorado.
- Watson, J. (2010). Jean Watson's Theory of Caring. In M. Parker, & M. Smith (Eds.), *Nursing theories and nursing practice* (pp. 321–340). F.A. Davis.
- Wiesing, U. (2008). Immanuel Kant, his philosophy and medicine. *Medicine, Health Care and Philosophy*, 11(2), 221–236. <https://doi.org/10.1007/s11019-007-9085-z>
- World Health Organisation (2015). *World report on ageing and health*. WHO.
- World Health Organisation. (2018). *Facing the future: Opportunities and challenges for 21st-century public health in implementing the Sustainable Development Goals and the Health 2020 policy framework*. WHO.

How to cite this article: Kitson A, Feo R, Lawless M, et al.

Towards a unifying caring life-course theory for better self-care and caring solutions: A discussion paper. *J Adv Nurs*. 2022;78:e6–e20. <https://doi.org/10.1111/jan.14887>

The *Journal of Advanced Nursing (JAN)* is an international, peer-reviewed, scientific journal. *JAN* contributes to the advancement of evidence-based nursing, midwifery and health care by disseminating high quality research and scholarship of contemporary relevance and with potential to advance knowledge for practice, education, management or policy. *JAN* publishes research reviews, original research reports and methodological and theoretical papers.

For further information, please visit *JAN* on the Wiley Online Library website: www.wileyonlinelibrary.com/journal/jan

Reasons to publish your work in *JAN*:

- High-impact forum: the world's most cited nursing journal, with an Impact Factor of 2.561 – ranked 6/123 in the 2019 ISI Journal Citation Reports © (Nursing; Social Science).
- Most read nursing journal in the world: over 3 million articles downloaded online per year and accessible in over 10,000 libraries worldwide (including over 6,000 in developing countries with free or low cost access).
- Fast and easy online submission: online submission at <http://mc.manuscriptcentral.com/jan>.
- Positive publishing experience: rapid double-blind peer review with constructive feedback.
- Rapid online publication in five weeks: average time from final manuscript arriving in production to online publication.
- Online Open: the option to pay to make your article freely and openly accessible to non-subscribers upon publication on Wiley Online Library, as well as the option to deposit the article in your own or your funding agency's preferred archive (e.g. PubMed).