THEORY DEVELOPMENT: WHAT, WHY, HOW?
INTRODUCTION

The topic of theory development has been addressed by nursing leaders since Flexner's definition of a profession appeared in the 1920s. Included among its criteria was that a profession have its own body of knowledge. Since that time nursing leaders have been attempting to determine whether or not nursing did indeed have a unique and identifiable body of knowledge.

Sporadic attempts toward this end occurred until the 1960s, when a small but growing body of nurse researchers, educators, and practitioners, individually and occasionally collectively, spent a great deal of effort defining just what that body of knowledge was. As with much within the profession, this process interested and involved only a handful of nurses until recently.

The topic of theory development is now a very timely one; we are developing an increasing number of graduate programs, identifying and defining nursing's independent roles and functions, and increasingly utilizing nursing theory as a basis for curriculum development and nursing practice.

This publication is a compilation of the papers presented at a workshop on theory development, sponsored by the Division of Baccalaureate and Higher Degree Programs and held in Kansas City, October 17-18, 1977. This workshop brought together a most distinguished group of nursing leaders who have been actively involved in the development of nursing theory and whose papers speak not only to their involvement, but also to their different viewpoints.
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STATE OF THE ART OF THEORY DEVELOPMENT IN NURSING

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Research in nursing is not a new endeavor. Interest in developing the scientific bases for practice began at least with Florence Nightingale, and the need for sound knowledge has been voiced over and over again in the last seventy-five years. Twenty-five years ago we thought we had made sufficient progress to establish a journal devoted exclusively to the reporting of research findings. For twenty years we have seen large sums of money devoted by the federal government to the training of nurse scientists and to the support of investigations. In the last ten years we have seen a rapidly growing corps of trained nurse investigators, a steadily increasing volume of research reported by nurses, and an expanding interest in research conferences and symposia in the profession. It may indeed be appropriate to ask at this point: What is the state of the art of theory development in nursing, and what of the science?

The results of all this interest and effort are exceedingly difficult to assess. However, a recent, exhaustive review of research by nurses and about nursing¹ and my own cursory examination of the literature (notably in Nursing Research) suggest that only a relatively small proportion of the investigations reported even now is concerned with the development of theory basic to nursing practice. It is with this small proportion that this paper deals.

As I have reviewed research reports, I have found that investigations relevant to the direct care of patients can be grouped roughly

into three major categories. In the first category are investigations conducted by nurses or other scientists that have implications for nursing practice, but that fall essentially within the boundaries of another discipline. This category includes a fairly large number of investigations, particularly if we include those carried out by nurses but without immediate practical significance. A typical example of an investigation of this nature is a recently reported anthropologic study of illness referral among Latin American immigrants. Another investigation in this category examined the potential for clinically significant drug-drug interactions among residents in a home for the elderly. Such research may serve the cause of science, but it fails to add directly, if at all, to the body of nursing theory.

Theory is developed in any discipline by the study of phenomena or by the asking of questions that differ substantially from the orientation of other disciplines. If nursing is to emerge as a recognized science, it will do so only by following this same route. Nurses who study phenomena or, more particularly, ask questions that are specific to another discipline—even though the answers may have some meaning for nursing practice—cannot be said to be contributing to the development of theory in nursing. And to the extent that nurse scientists follow this path, theory development in nursing is hindered.

In my opinion, there are two major interlocking reasons why this problem occurs. The most important, I believe, is the failure of nursing to evolve through practice over the years and to explicate a common, ideal goal in patient care—a goal derived from an empirically sound body of knowledge about man and commensurate with the service nurses are asked to provide in society. The nurse scientist is left with only her personal beliefs to guide her as she struggles to answer the question, "Knowledge for what purpose?" Explication of a common, ideal goal for nursing would answer this question and would provide a perspective appropriate to our discipline and a clear direction for understanding its phenomena. Several conceptual models for nursing practice have been developed in recent years in an effort to deal with this problem, but they appear to have had a greater impact on education than on research. Moreover, since these models differ in the goals explicated (and thus the phenomena and perspective delineated), they, too, to the extent that they influence research, are leading us in diverse directions. I will return to this point in the next section.

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The second reason nurse researchers conduct investigations appropriate to another discipline is that most nurses are forced to take their advanced training (especially at the doctoral level) in a discipline other than nursing and have been effectively socialized into that discipline. Through the course of their training they have come to accept as their own, and thus as appropriate for nursing, the orientation of the training discipline. They have come to pay attention to the same kinds of objects or events and to ask the same kinds of questions as the sociologist or the physiologist; the major difference is that in research their subjects are usually patients rather than college students.

This acceptance of the orientation of the training discipline has perhaps been fostered by the erroneous viewpoint that the professions, as applied sciences, simply test and use the tenets of basic science and do not have distinctive bodies of knowledge of their own. Nothing of course could be further from the truth. With the exception of professional offshoots from some of the basic sciences (e.g., medical sociology), the professions study phenomena from a different perspective than do other disciplines.

When you add to these inhibitory problems the fact that there is little available knowledge recognized as specific to nursing and on which to base research in nursing, there is little wonder that the neophyte nurse investigator seeks more familiar and perhaps secure pathways. With training outside her discipline, with no scientific heritage in nursing, and therefore with no reason to identify nursing as a science, the nurse scientist finds it extremely difficult to begin at the beginning in building a science of nursing.

In the second category of research reports I include studies that attempt to describe patient behavior with some effort to couch these descriptions in terms meaningful to nursing. These studies are focused largely on patient reactions to the experiences of illness and treatment, on patient ability to cope with the situation of illness or with those life situations that might lead to illness, or on factors in the physical or social environment that facilitate or hinder coping or adaptation. One example of this type of investigation is a study focused on the identification of common psychologic needs of patients with essential hypertension. The dependence-independence levels of patients on the prehospitalization-post discharge continuum are the subject of another recent investigation of this type.

Although most of these studies attempt to delineate and clarify

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nursing problems, their theoretical frameworks range over the entire spectrum of the behavioral sciences, and there is little basis on which the diverse findings can be tied together. This is a reflection not only of the failure to explicate a common, ideal goal in patient care for all nursing practice and research, but also of the greatly diversified, mostly implicit, perspectives about man held by nurses to be appropriate for nursing. The many conceptualizations of man adopted by nurses consciously and deliberately, or unwittingly through the process of ongoing socialization in the profession, and used as a basis for identifying nursing problems, clearly cannot lead us to a single, cumulative, circumscribed, and accepted body of knowledge. These differences are also apparent in the variations in the several conceptual models for practice that are in use primarily in education. There are, for example, system models, developmental models, and interaction models; in each of these categories there are differences in the kinds of phenomena to be studied and the perspective to be used. As a basis for research, these models could serve to narrow the thrusts of our investigations, but even this is not a desirable goal.

Eventual agreement upon one model as a basis for education, practice, and research is essential if we are to develop a cumulative, cohesive body of knowledge. Such agreement will not be reached through discussion or through unilateral decision or decree by nurses. Nor will it be reached primarily through the testing of theory. Our models are, or should be, based on an empirically sound body of knowledge. Agreement will come, if it comes at all, through testing our models in practice to determine which offers the best fit with social needs and expectations. We will also want to insure that the model gives clear direction to education and research, as well as practice.

What I am suggesting is analogous to the situation that has occurred in medicine. Over a long period of years physicians and their associates in the biological sciences slowly evolved a conceptual scheme of the person as a biological system. This theoretical framework is empirically sound and is in complete accord with medicine's age-old social responsibility: "to free mankind from the ills of the flesh"?; it easily gives rise to an ideal goal of aiding the person to achieve and maintain the highest possible level of biological functioning. Medical research is thus fairly narrowly focused on the study of disorders in the structure and function of the biological system, including those disorders in which psychological and social factors play

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a contributory role; and the perspective has suggested the need for both prevention and control of these disorders.

As was pointed out in an earlier paper, the reasons nursing has no such common commitment are many and complex. Among them can be noted nursing’s peculiar historical origin as a practical, not very highly valued, diffuse kind of service, and the elusive nature of the intellectual basis for that service. Perhaps of equal significance has been the historically recent emergence of the behavioral sciences and the continued slow growth of knowledge in these disciplines. After all, medicine reached its full flowering along with the rapid expansion of knowledge in the biological sciences.

Many nurse scientists today fail to see the need for a commonly held and distinctive scientific orientation for nursing as a basis for theory development. I believe the reasons for this are two-fold. First, there is a sincere belief that a cohesive body of theory in nursing can be developed through the use of diverse schemata of the person to be served; this viewpoint is usually arrived at without a careful understanding of the bases on which the sciences are differentiated one from the other and in particular the tie between the professional sciences and their social responsibilities. Second, there is a failure to distinguish between a scientific orientation and the theories that can be developed through the use of that orientation; along with this goes a misunderstanding of the difference between theories of nursing and what are variously called conceptual frameworks, conceptual models, and theoretical frameworks.

It has already been pointed out that theory is developed in any discipline by the study of phenomena or the asking of questions that differ substantially from those of other disciplines. Let us turn this around a bit now and examine how the sciences have become differentiated from one another. Historically, the several basic sciences have developed through the study of phenomena in the natural world, each from a particular perspective. Stemming from a root heritage in philosophy, each science has become differentiated from the parent discipline by focusing on different phenomena, or by asking different questions about the same or different phenomena. Since these sciences differ one from the other in either the phenomena studied or the perspective employed (i.e., the kinds of questions asked), they give rise to different and distinctive bodies of knowledge and have recognizable, if somewhat fuzzy, boundaries. It should be noted here, as Kaplan does, that these divisions between the sciences are

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9 Ibid.
matters of convenience; they are in essence historical products and have not been governed by logical or empirical necessity.

The professional sciences are also historical products, and their bodies of knowledge have developed in essentially the same way. The professional sciences are unlike the basic sciences in one important respect, however. Where the focus of study and the perspective in the basic sciences have been determined originally by individual natural curiosity or pragmatic concerns, the focus and the perspective in the professional sciences have been in a very real sense dictated by society. The professions have been created by society to safeguard values of vital social significance—health, justice, truth. These disciplines have the obligation, then, to develop both the theoretical knowledge and the technology to prevent or control whatever deviates from that value. It is the nature of the service and the practical goals sought that dictate what is to be observed and what kinds of questions the professional science will ask. Moreover, the relevant phenomena or frame of reference tend to differ from those in the basic sciences; hence investigations in the professional discipline also yield distinctive bodies of knowledge.11 Only today in nursing are we beginning to be more precise about the service we offer, thus placing us in a position to specify what phenomena are to be studied and from what perspective. If we are to develop a distinctive body of knowledge, we must continue this course.

Let me digress for a moment to call attention to the fact that health is a value to be safeguarded by all the health professions. As we all know, health is an extremely elusive state, determined by psychological and social factors fully as much as by biological and physiological factors. To the extent it can be achieved, for the individual or for society as a whole, it requires the work of all the health professions (and indeed probably the political scientists, the agronomists, and others as well). At the very least, the division of labor among the health professions suggests that each of these disciplines makes some distinctive contribution toward the ultimate goal of health and that all of them, working together, are necessary. It is unlikely that nursing alone has been or will be given the responsibility of safeguarding health.

I would like to return now to the question of why nurse scientists do not see a need for a common scientific orientation to research, and to the problem of confusing such an orientation with what is called a theory of nursing. The labeling of conceptual models for practice as theories of nursing is widespread, and I believe represents a serious misunderstanding of the nature of professions. Nurs-

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ing as a field of service or a scientific discipline (like law, medicine, psychology, or physiology) is not a subject for scientific investigation. Like other disciplines, it is an historical product, created by man to serve his needs; it is not an invariant in the natural world. Therefore, a theory of nursing (that is, a theory that purports to describe and explain nursing as a professional and scientific discipline) is as impossible or unnecessary as would a theory of medicine, or law, or sociology. What we do need is theory in nursing; that is, theory that describes and explains disorders in patients of concern to nursing and theory that provides the rationale for the management of these problems. These might also be called nursing practice theories, and it is these theories which need to be developed to form the science of nursing.

It seems to me this confusion has arisen directly from a recognized need for a conceptualization of the person that can provide a socially appropriate and useful framework for practice, education, and research—a conceptual model or theoretical framework. Indirectly, it has arisen from a felt need to make more explicit the nature of our service. We have developed conceptual frameworks (sometimes mislabeling them as theories of nursing), when in fact these conceptualizations are drawn largely from the work of basic scientists. Furthermore, they present only a partial understanding of man; they are theories of man (not of nursing) which nurses have found helpful and have adopted, expanded, and sometimes prostituted. To the extent that these conceptual schemata have already been verified and are complete, they will not require further testing or development. The fact that further testing may be done by nurses, however, does not convert the knowledge obtained to nursing knowledge. It is clear that the more nearly complete and valid the conceptual system adopted, the more useful it is likely to be in nursing.

Let me again use an analogy from medicine. There is in medicine a common commitment to the use of a conceptual framework of man as a biological system. Study of man as a biological system begins with the undergraduate years and consumes the first two years of medical education. At this level, this knowledge is referred to as medicine's basic science, perhaps because here all the separate parts and elements are being put together into a whole system. Nonetheless, this knowledge was developed and is taught largely by basic scientists, and the body of knowledge is associated with the names of the disciplines involved: anatomy, physiology, biochemistry, and the like. Medical science properly consists of descriptions and explanations of disorders in the biological system and of the theoretical bases for prevention or control of those disorders.

Let me also cite from my own experience with a conceptual framework. Over a period of some twenty years and in the light of
my clinical experience, thinking, reading, and conversations with colleagues, I evolved the notion that one potentially useful way of viewing man is as a behavioral system. There is a rich literature, interdisciplinary in nature, to support this notion—even though it deals primarily with the parts of the system, i.e., the classes of behavioral response. To the extent that this literature provides the basis for building a theory of man as a behavioral system, even though the notion of the system as a whole is original as far as I know, the theory is basic science theory. It has been and will continue to be developed largely by the basic sciences, though nurses will contribute. Within this view, nursing science consists of descriptions and explanations of disorders in the behavioral system and of the theoretical bases for prevention and control of those disorders.

The third category of investigation includes the expanding group of experimental studies. Most often, these are concerned with the outcomes of nursing intervention. For example, Rotkamp recently reported, among other findings, a significant increase in frequency of daily changes of position and patient-initiated changes of position through the use of behavior modification techniques with spinal cord-injured patients. In another study of this type, the effect of nursing reassurance on patients’ vocal stress levels was reported. Such studies are formulated from widely differing perspectives on what to study and what kinds of questions to ask. While the findings of some of these investigations are likely eventually to be useful contributions to a science of nursing, they cannot all contribute. And these studies call attention to still another problem.

The biological or behavioral scientist can direct his attention to the relatively small number of variables deemed relevant because of his restriction of interest to more or less limited aspects of man. The scientist in the professions generally does not enjoy such a luxury. While the health professions, too, can realistically take only a partial viewpoint, it inevitably involves more variables. In essence, the health professions are concerned with a more holistic approach to man than the basic sciences; in the conceptualization of that wholeness, physical, organic, and social factors all have to be taken into account. The number of variables with which the professional scientist must deal is consequentially large, and their interrelationships exceedingly

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complex. Management of all these variables in research is a consistent, problematical issue.

Equally important is that some nurse investigators are engaging in experimental research before the variables significant to that research have been determined. In short, we appear to be neglecting what Dickoff and James\(^\text{15}\) refer to as the “factor-isolating” and “factor-relating” levels of theory; yet these levels provide the foundation for the higher levels of “situation-relating” and “situation-producing” theory. In essence, we are beginning at the wrong end. One approach to remediying this situation is possible, but admittedly unlikely. It would be to collect thousands of nursing records, records which contain data observed and interpreted from the same frame of reference. From these records, one could begin the task of isolating potentially significant variables and unraveling their relationships.

What, then, can one conclude about the state of the art of theory development and of the science of nursing? While our literature probably contains the rudiments of a science, there is no circumscribed body of knowledge that is widely recognized and accepted as nursing science. Nurses are pursuing lines of investigation that are sometimes so widely divergent that there seems to be little reason to believe that the findings can or will converge in a cohesive body of knowledge. (It may be noted that practitioners, too, are finding problems with our diversification. For example, those who attended the National Conferences on Nursing Diagnoses listed 88 diagnostic labels applied by nurses, suggesting markedly different opinions on the nature of the phenomena to be studied and the proper perspective from which to note and interpret evidence.) To me, the research task of nursing is to identify and explain patient problems accepted as falling within nursing’s distinctive area of knowledge and to develop the theoretical (and technical) means of managing these problems. If this is indeed so, and if this body of knowledge represents our science, then we have barely begun.

But the picture is not as black as I might seem to have implied. We do have trained investigators who are sincere in their interests and committed to the research enterprise. We have a rapidly expanding corps of expert clinicians. Though the foundations of our knowledge are meager and there is little on which to build, these two groups form assets with which building can begin. It will require that each practitioner and investigator adopt an empirically sound conceptual system of the person to be served, a system that can be justified as potentially congruent with societal expectations, leading to significant nursing actions and outcomes, and providing clear direc-

tion to practice, education, and research. This will allow the practitioner to accumulate a series of clinical records to hasten the research endeavor. It will encourage the investigator to develop a research program in which each investigation will build sequentially on the preceding investigations and our body of knowledge will begin to show the effects of accumulation.

Given this approach and the underlying assumption that nursing is a profession with a distinctive service to offer patients, two things might be accomplished. First, the lines of investigation in nursing would be narrowed, for those researchers who identify themselves as nurse scientists would at least have excluded those lines that are appropriate to the basic sciences. There would still be several possible lines of investigation, since there are a number of theories of man that nurses have explicitly accepted as appropriate for nursing, but the number would be smaller than currently reflected in research.

The second thing that might be accomplished is that, given greater concentration on a smaller number of conceptual schemata, we might sooner reach that point at which nurses and society agree on the precise nature of the service to be provided and the goal to be sought. At that point, when nurse researchers all begin to study the same phenomena from the accepted nursing perspective, and when nurse practitioners all begin to pay attention to the same kind of empirical objects and events and to interpret these events from a common perspective, progress will be rapid indeed. The best thing I can wish is that we live to see nursing reach that point.
THE "WHY" OF THEORY DEVELOPMENT

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Why is theory development emphasized in nursing today? Is there a need for theory in nursing? To place these questions in proper perspective, one needs to think about nursing as a science and the relationship between theory and research as a way to build scientific knowledge. A fundamental aim of science is to explain events, objects, and persons in this world. Such explanations are called theories. Kerlinger defines theory as follows:

A theory is a set of interrelated constructs (concepts, definitions, and propositions) that present a systematic view of phenomena by specifying relations among variables, with the purpose of explaining and predicting phenomena.¹

The ultimate aim of scientific theory is its utility in adding to our knowledge, understanding, and control of the world in which we live. Scientific activity associated with testing theories is called research. Research findings result in description, classification, and correlation of natural phenomena. Research is grounded in theory and theory is tested and revised through research. Theory and research are complementary and guide the way knowledge is ordered in a field of study such as nursing.

Several reasons have been given to substantiate the need for theories for nursing.\cite{1,2,3,4,5} For example, a discipline in higher education is expected to have a theoretical body of knowledge that can be taught and learned, although knowledge is increasing with remarkable rapidity. Theory organizes a multitude of separate facts into meaningful wholes. In addition, education for entrance into a profession, a practice discipline, is organized to accomplish two major purposes: (1) for learners to gain knowledge and understanding of fundamental concepts, skills, and values of the profession, and (2) for learners to acquire an ability to use the knowledge and skills and to integrate the values in the practice of the profession. Theory and research are integral parts of professional education and provide a scientific basis for practice.

Scientific theories in nursing would assist nurses to judge the effectiveness of their practice. If a theory is unacceptable, then practice based on it would be unacceptable. Theories would assist nurses to modify practices in nursing situations. Valuable practices in nursing may be preserved if they are grounded in theory. Scientific theory is a search for knowledge which provides an objective explanation of reality, and this is one of the values of theory for nursing. An understanding of the functions of theory provides information that shows its usefulness in a field of study such as nursing.

**FUNCTIONS OF THEORY**

Theory development is not only a way of discovering new knowledge, but also a way of looking at known facts and of organizing them into a system. For example, my general systems theory about human levels of functions indicates that each individual is a personal system. Individuals interact with other individuals to form interpersonal systems called dyads, triads, and groups. Interpersonal systems form social systems, which are comprehensive levels of functions of human beings. This general systems framework demonstrates one way to view man interacting with his environment.

The basic concepts of this theory include a wide range of phenomena related to human beings. The most basic concept in personal systems is perception. The most basic concept in interpersonal systems is interpersonal relations. Learning is a subconcept of perception.

\cite{1} Imogene M. King, Toward a Theory for Nursing (New York: John Wiley & Sons, 1971).
\cite{2} Martha Rogers, Introduction to a Theoretical Base for Nursing (Philadelphia: F.A. Davis, 1970).
and communication is a subconcept of interpersonal relations. The most basic concept in social systems is organization. Decision making, power, authority are subconcepts of organization. Theory provides reference points from which to describe, explain, and predict our world. My general systems theory explains three dynamic interacting systems that make up some of the essential elements in any person’s reality. Since man is the focus for nursing, this theory serves a useful purpose for developing and testing concepts in nursing. The fourth basic concept in this general systems theory is health, because systems have goals and I have defined health as the goal of nursing.

Theory guides us to collect facts in a systematic way, to formulate hypotheses, and to extend the range of useful knowledge. If science starts from observation, then in nursing we need to engage in systematic observation, description, and explanation of phenomena in natural environments. If we expect nurses to practice nursing from a scientific base of knowledge, then we have to conduct the research and test the theories to produce that knowledge. Looking for the theory at this time will thwart the creative thinking of many nurses interested in this scientific movement. We must encourage a variety of theories because knowledge and truth develop from a multiplicity of theories, each with its limited utility. The goal of theorizing is to systematize and unify knowledge. Some of these functions demonstrate the usefulness of theories in a field of study in which individuals are attempting to organize a body of knowledge and to test it in research.

USEFULNESS OF THEORY FOR NURSING

In discussing the usefulness of a theory for nursing, I will demonstrate the way my theory is guiding me to test one construct in research.

Complexity and variety in nursing demonstrate the need for theory development. The many facts that bombard us can be organized for use through the development of theories for nursing. The complexity inherent in nursing is obvious when one attempts to define a human being. Benjamin Ricci illustrated a part of this complexity when he described man: "He is a composite of chemicals in tissues (potential energy source) within a framework of bones, a series of joints, a system of muscles, and a network of blood vessels and nerves. He is designed for motion." Man is a comprehensive

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4 King, op. cit., p. 67.

concept. In nursing, we continue to discuss the “whole man” or holism; we say we take care of the total human being. Yet few theories are available to guide us in this philosophical position.

The personal systems level of function in my theory helps me look at a human being in his totality. In developing my concept of man, my definition is: “Man is an open, living system dependent upon a continuous exchange of energy and information between internal and external environments for survival and for maintaining a functional state of health.”

Moving from the comprehensive concept of man, one can deduce from levels of organization some very concrete perceptions about man. Conversely, one can begin with the concrete level of building a concept of man and move to higher levels of abstraction.

My theory defines a second level of function, interpersonal systems, in which nursing process is implemented. The nursing process is derived from a human process of interaction in which two or more individuals come together to achieve goals. The basic elements of scientific theory construction and testing indicate where I must go with my construct of the nursing process. First, observations must be controlled and ambiguity reduced in everyday nursing situations. Second, constructs must be operationally defined and empirical referents specified. Third, hypotheses are formulated and tested. I have completed the first two phases in testing nursing process, and hope to move to hypothesis formulation and testing soon. My definition of nursing process covers a wide range of substantive knowledge in nursing. For example, specific concepts are derived from this process. They are perception, judgment, communication, interpersonal relations, time, space, and decision making about goals and means to achieve them. Observation and measurement, two aspects of assessment, are implied in my nursing process definition.

A small amount of nurse-patient interaction data collected by non-participant observations has helped me describe and classify transactions. An operational definition of transactions was necessary for analyzing interactions. This definition provided the empirical referents. A summary of my data shows that in 12 of 17 cases there were transactions made. Data show .80 correlation for goals explored, .82 for disturbances, and .85 for agreement on means to achieve goals.

A third dimension in my theory shows that interpersonal systems form social systems and nurses function in social systems (such as the family, industry, or work systems) and in the health care system. It is at this level of conceptualization that I found a few missing links in knowledge for nursing. One of the functions of theory is to help us find gaps in knowledge in a field and to guide us to areas of knowledge that are relevant. Concepts of organization, decision
making, role, power, and authority are derived from social systems. This level of my theory is helping me observe and explain some of the complexity in social systems, specifically in nursing systems, that demand theory development and research. My general systems theory organizes complexity and variety in nursing, and that is what theory is supposed to do. It also guides me and, I hope, others in looking for relationships within this complexity and variety.

Another kind of variety in nursing is the fact that three different educational programs exist to prepare individuals for licensure to begin to practice nursing. The massive push for multiple continuing education programs for practitioners is another kind of variety that does not appear to be organized to advance theory or research in nursing. In addition to all types of educational programs for nurses, there are various types of organizations within which nurses are employed. The variety is obvious in the roles and functions of nurses in organizations of different sizes and structures. For example, nurses function in schools, industry, hospitals, local, state, and national health agencies, crisis centers, ambulatory-care centers, extended-care facilities, and nursing homes. Within these organizations, nurses are making decisions about the care of human beings.

Decisions in nursing situations are based on information gathered about the state of the patient or the state of the health client. Decision making at all levels of an organization influences the quality of care delivered. Decision-making theories have been published in a number of areas and especially in administration, management, operations research, and systems analysis. My nursing process definition is in fact a decision-making process.

Theories give us a way of verifying knowledge about decision making and provide a rationale for gathering reliable and valid data that are essential for effective decision making and implementation. Nurses are expected to make decisions about another person's health and care on the basis of the information gathered in concrete situations. This responsibility assumes that nurses have knowledge upon which to make these decisions. Scientific theories for nursing offer a range of knowledge from which nurses make decisions about courses of action. As soon as I analyze another set of nurse-patient observation data, I expect to design a study to test transactions in nursing situations as criterion measures of effectiveness of care. Theories, when tested in research in nursing, provide measures of effectiveness of nursing care by identifying expected outcomes and observing goal achievement. Theories should be valuable guides for nurses in developing and implementing quality assurance programs in hospitals.

In education, theories guide teachers in providing learning opportunities for students to gather reliable and valid information about the health state of the patient or client. If teachers in under-
graduate programs introduced students to theories and research, they would learn that nursing actions are grounded in theory.

Theory organizes knowledge into useful information and encourages economy of thought. As theories are developed and taught in schools of nursing, students are introduced to fundamental concepts of the field and helped to use knowledge in nursing practice. Concept learning accommodates new knowledge and provides a built-in mechanism for continuous learning. Theoretical formulations give us an organized way of viewing nursing or thinking about nursing, and a systematic way of studying nursing. Theory provides a framework for identifying essential concepts useful in developing curriculums and for teaching the future generation of nurses.

In summary, three major ideas have been discussed and my general systems theory has been used to demonstrate the usefulness of theory for nursing, to respond to the "why" for theory development and its need in nursing. First, the relationships among science, theory, and research were reviewed. Scientific knowledge for nursing is discovered and ordered through theory development and research. Second, analyzing some of the functions of theory helps us to understand its usefulness in nursing. Third, selected examples of the usefulness of theory and research were discussed. A few choice words from Abraham Kaplan state it rather clearly:

Theories are not just means to other ends, and certainly not just to ends outside the scientific enterprise, but they may also serve as ends in themselves—to provide understanding, which may be prized for its own sake.¹

It is my belief that if nursing expects to maintain itself as a profession and to continue to be represented as a field of study in higher education, theory development and research are essential activities for nurses within the profession. But first and foremost, theories help us search for the knowledge and truth that make us uniquely human.

THE "WHAT" OF THEORY DEVELOPMENT

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As nursing science evolves, the need for theory becomes more obvious and more crucial. Explicit nursing theories will provide descriptions, explanations, predictions, and prescriptions concerning phenomena related to clinical practice, research, and education.

But what is theory? And more importantly, what is nursing theory? The nursing literature contains excellent discussions of theory and its components\(^1\) and attempts to define nursing theory\(^1,2\) but it also contains misleading, if not inaccurate, presentations of nursing theory.\(^3\) This paper will review the definition and description of theory and its elements and offer a new definition of nursing theory for consideration. In addition, it will discuss some issues surrounding the empirical testing and utilization of nursing theories.

\(^3\) Catherine M. Norris, ed., *Proceedings, First Nursing Theory Conference, March 20-21, 1969* (Kansas City, KS: University of Kansas Medical Center, Department of Nursing Education, 1969).
The development of nursing theories has been a long and arduous task, and only recently has it begun to culminate in what might be termed formal sets of interrelated concepts, definitions, and propositions directly related to explicit nursing goals. However, as a prelude to theory construction, nurse scholars have successfully developed several conceptual models of nursing. Since isolated facts rarely survive in the scientific world, the systems for placement and ordering of empirical observations and research findings provided by models are especially important to the development of nursing theories and thus to the evolution of nursing science.

Currently, the recognized conceptual models of nursing represent competing paradigms; therefore there is disagreement about the theoretical, instrumental, and methodological rules to be used by nursing science. Despite this, the models are beginning to have a strong influence on decisions regarding phenomena to be studied and the precise nature of problems to be investigated, as well as techniques employed and tools used, settings for and subjects of observation, methods for analysis of data, and the nature of contributions the data make to the advancement of nursing knowledge.

CONCEPTUAL MODELS, THEORETICAL MODELS, AND THEORIES

Conceptual models should not be confused with theoretical models. Conceptual models are pretheoretic bases from which substantive theories may be derived. Nursing has only a few explicit theoretical models, but does have several conceptual models which provide strong bases for the development of unique nursing theories.

A basic distinction between conceptual and theoretical models is the level of abstraction. A conceptual model is a highly abstract

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11 Schlotfieldt, op. cit.
umbrella of related multidimensional concepts, while a theoretical model contains concepts which are narrowly bounded, specific, and explicitly interrelated. A conceptual model provides a perspective for a science, telling the scientist what to look at. In contrast, a theoretical model postulates relationships and is descriptive, explanatory, or predictive. In an applied science, theoretical models may also be prescriptive, specifying the activities necessary to achieve the desired goals of its practitioners.

Another distinction between conceptual and theoretical models is the source of data used in their development. A conceptual model is derived from unsystematic empirical observations and intuition, while a theoretical model is constructed from available theories and the findings of empirical research. A conceptual model is developed primarily through the process of induction; a theoretical model, through both induction and deduction.

Still another distinction between conceptual and theoretical models is the ability to be subjected to empirical tests. A conceptual model may be evaluated only on logical grounds, since the multidimensional nature of its concepts prevent empirical testing. A theoretical model, on the other hand, contains sufficient empirically interpretable concepts to allow empirical tests.

While "theoretical model" and "theory" are often used interchangeably, there is a formal difference between the two terms. A theoretical model refers to a group of interrelated theories which provide rationales for the hypotheses, policies, and curricula of a science. A theory encompasses fewer phenomena and is defined as "a set of interrelated constructs (concepts), definitions, and propositions that present a systematic view of phenomena by specifying relations among variables."

Elements of Theories

The elements of a theory are, as the definition above states, constructs (concepts), definitions, and propositions. The literature is replete with definitions of the term "concept." There is, however, agreement that a concept is an abstract idea expressed in words, a

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13 Reilly, op. cit.
generalization from observed events. Concepts are categories into which things can be classified. They refer to properties of things, not to the things themselves. ("Things" as used here refers to events, situations, groups, or individuals.)

Kaplan has suggested that concepts may be classified on the basis of the extent to which they are observable. One type of concept, the observational term, refers to a property which is a directly observable empirical referent. A pregnant woman's report that she is in labor is an observational term; the report of labor can be directly observed. A second type of concept, the indirect observable term, refers to a property that is indirectly observed and inferred. Labor is not directly observed, but is inferred by a combination of signs and symptoms exhibited by the pregnant woman.

Another type of concept is the construct, which refers to a property which is neither directly nor indirectly observed. A construct has empirical meaning only when it is defined by more observable terms. Constructs are invented for special scientific purposes. The construct perceived body space was invented to describe a property of a person, namely, the amount of space the person perceives his body to occupy. Perceived body space cannot be directly or indirectly observed, but the person's report of the amount of space he perceives his body to occupy can be noted.

The fourth type of concept, the theoretical term, refers to a complex, global property which, like a construct, is impossible to observe. The theoretical term is, however, more complex and more abstract than the construct, and can be interpreted only through its relationship to other terms within a given theory. For instance, body image cannot be observed, but can be interpreted in a theory through its relationship to the construct perceived body space.

Kaplan's classification schema, while widely cited by theorists, is not particularly helpful in the construction of theories. Distinctions among the four types of concepts are somewhat unclear, resulting in confusion and lack of agreement about the meaning of the various uses of the term concept. Dubin suggested using the more neutral term unit when referring to "the things out of which theories are built." This new term avoids the confusion associated with concept and, as will be clear later, has other advantages.

Four types of units, classified in terms of measurement charac-

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24 Ibid.
teristics, may be used in the construction of theories. The enumerative unit is defined by a property characteristic of a thing in all its conditions. This unit refers to a property that will always be present, regardless of the condition of the thing that is observed or imagined. The enumerative unit can never take a zero value. (A person's sex is an example of an enumerative unit which is an attribute.) When this unit is a variable, the amount of the property present is of interest, as with a person's age.

The associative unit is defined by a property characteristic of a thing in only some of its conditions. This unit has a real-zero or absent value. Associative units may also be either attributes, which are present or absent, or variables, which can take a real-zero value. Associative units that are attributes include: pregnant-not pregnant, married-not married. Variables for this type of unit include number of children, number of years married.

The relational unit refers to a property characteristic of a thing that can be determined only by the relation among properties. It is a property of two or more properties. Relational units may be based on interaction among properties, such as mutual identification, a property of two significant others in interaction. Relational units may also be based on a combination of properties. For example, the designation elderly primigravida is a combination of the properties age and pregnancy. Relational units may involve plural properties and things, as with sibling rivalry, where the plural properties are child-child relationship and parent-child relationship, and the plural things are children and parents.

The statistical unit is defined by a property of a thing that summarizes the distribution of that property in the thing. There are three classes of statistical units: (1) units that summarize a central tendency in the distribution of a property, such as mean strength of identification; (2) units that summarize the dispersion of a property, such as the range of a variable in a population, or a standard deviation; and (3) units that locate things by their relative position in a distribution of a property, as when a person is described as "middle class."

Dubin also identified a fifth type of unit, one that he claimed is too diffuse and complex to be used in theory construction. This is the summative unit, a global unit that stands for an entire complex thing. The summative unit draws together many properties of a thing and gives them one label. Although this unit mans a great deal, much of the meaning is unspecified or ill-defined. Body image is a summa-

25 Dubin, op. cit.
26 ibid.
tive unit. The summative unit may be compared with the summative term in Kaplan's classification of concepts.27

A series of rules for the use of units has been proposed by Dubin.28 The rules help the scientist to build logical theories, avoid the problem of multi-collinearity. Any one of the constituents may be used exclusively in a theory, with the only criterion being logical consistency of the particular properties as they are related. Enumerative units and associative units may be used with restriction together in a theory in any logically consistent way. However, relational units may not be combined in the same theory with enumerative or associative units that are themselves properties of the relational unit. For example, it would be redundant to predict a married couple's strength of identification from a measure of the subject's cathexis, since cathexis is an aspect of identification. In a similar vein, the prediction of elderly primigravida from the age of a pregnant woman would lead to a relationship which is an artifact of the measures. Furthermore, a statistical unit, which is by definition a property of a collective, may not be combined with any other type of unit (enumerative, associative, or relational) that describes a property of members of the same collective. Thus, suppose it is known that, on the average, marital adjustment scores rise three points with every increase of one point in strength of identification for married couples. The knowledge based on the collective married couples cannot be used to predict the marital adjustment scores of a given married couple. That is, predictions cannot be made from a knowledge of two statistical properties of a collective to the values that would be associated with a member of that collective. Dubin noted the clear logic of this rule, explaining, “Even though the value of the property [of] the member has gone into the determination of the property of the collective, we cannot locate from a knowledge of the collective property the value of the member property.”29

The employment of the term unit has distinct advantages over the term concept. First, if followed, the rules associated with units will prevent the construction of logically inconsistent theories. Second, the classification of units ignores the dubious and difficult-to-apply distinction among various types of concepts. And third, the classification of units is based upon established distinctions of measurement theory.

One possible deficit of Dubin's typology of units is that it does not directly consider the extent to which a given unit is observable. However, the notion of empirical indicator may be employed to deal

27 Kaplan, op. cit.
28 Dubin, op. cit.
29 Dubin, op. cit., p. 69.
with the issue. An empirical indicator is an operation or a procedure employed by a scientist to secure measurements of values on a unit. Empirical indicators, then, are the translations of inherently non-observable units into directly observed measurements of the values of units.30

Units are the basic building blocks of theories. However, to be useful in science, units must be precisely and explicitly defined. Units are defined by constitutive and operational definitions. The constitutive definition defines a unit in terms of other related units and thus is a circular definition. Constitutive definitions have theoretical importance for units and permit the establishment of theories containing the units. The operational definition defines a unit in terms of observable data, i.e., the activities necessary to measure the unit or manipulate it. Operational definitions are also called "rules of correspondence" or "rules of interpretation." These definitions link units with the empirical world, providing the units with empirical import.31,32 Essentially, an empirical indicator is the operational definition of a constitutively defined unit.

All units in a theory must have constitutive definitions, and any theory that is to be empirically tested must include some units that are operationally defined. Moreover, units lacking operational definitions must be connected to those that are operationally defined if empirical testing is desired.33

Criteria for the definitions of units have been explicated by Sellitiz and her associates.34 They maintained that definitions, while neither "true" nor "false," should (1) explicitly and precisely assign empirical (operational) and logical (constitutive) meaning to units; and (2) assign meaning to units so that empirical indicators of the units relate to the indicators of other units in ways that are predicted by theory, and so that the units fit into a given theory in a logically consistent manner.

Units are linked together in a theory by verbal or (rarely) mathematical statements called propositions. Propositions are the theoretical links that express the relationships between two or more units in a theory.35 Propositions are essentially laws of interaction that bring meaning to a group of previously unrelated units. Three general

30 Dubin, op. cit.
32 Torgerson, op. cit.
33 Ibid.
34 Sellitz et al., op. cit.
categories encompass all forms of propositions (laws of interaction) needed for theory construction:36,37

1. Categoric laws of interaction. These laws state that values of one unit are associated with values of another unit. Categoric laws are symmetrical (if A, then B and if B, then A) or concurrent (if A, also B).

2. Sequential laws of interaction. These laws always employ the time dimension to order relations among units. They may be asymmetrical (if A, then B; if no A, no conclusion about B), or unidirectional (if A, later B), or a combination of the two (if A, then later B; if no A, no conclusion about B).

3. Determinant laws of interaction. These laws associate determinant values of one unit with determinant values of another unit. Determinant laws set forth specific relations which determine the values of the units and are often expressed as correlations. They may be considered predictive, in that the value of A predicts the average value of B (the exact value of B being predicted only when the correlation is 1.0).

As laws of interaction, propositions are never directly tested. What are tested are the hypotheses based on a given theory. Hypotheses are deduced from propositions, and in contrast to propositions, always contain empirically measurable variables. If empirical testing reveals that the relationship between the variables is as the hypothesis predicts, this is taken as validation of the hypothesis and thus support for the proposition from which it was derived. If, on the other hand, the hypothesis is not supported by empirical testing, the proposition must, along with other factors,38 be called into question.

NURSING THEORIES AND THE ESSENTIAL UNITS OF NURSING

The theories of any one science are identified mainly by the particular units which specify the phenomena of interest to that science. The phenomena of interest to nursing are most clearly specified in the conceptual models of nursing. An analysis of the nursing

36 Dubin, op. cit.
37 Hardy, op. cit.
38 For a discussion of factors to be considered if an hypothesis is not supported, see Florence S. Downs, "Elements of a Research Critique," in F. S. Downs and Margaret A. Newman, eds., A Source Book of Nursing Research (Philadelphia: F. A. Davis, 1973), pp. xli-xlvi. It should be noted that Downs maintains that the same factors should be considered, even if the hypothesis is supported.
models revealed four essential units present in each—person, environment, health, and nursing.39

Since the units person, environment, health, and nursing specify the phenomena of interest to nursing science, it seems reasonable to conclude that those theories dealing with these units are nursing theories. A nursing theory, then, is defined as a set of propositions consisting of defined and interrelated units which presents a systematic view of the person, the environment, health, and nursing by specifying relations among relevant variables.

The definitions of units and the propositions linking the units can be derived from the conceptual models of nursing. It is expected that relevant independent variables will be derived from the various conceptualizations of the unit “nursing.” Dependent variables will be related to the views of “person,” “environment,” and “health” held by a given model.

The work on interaction analysis described by Diers and Schmidt illustrates the selection of variables following this schema.40 Although it was not noted explicitly, the broad conceptual base for this work can be identified as Orlando’s model of nursing.41 In a series of studies investigating the relation between nurse-patient interaction and patient condition, the unit nursing was treated as the independent variable and was operationalized as types of nursing approaches. The unit health was the main dependent variable, operationalized as relief from pain. The unit person was taken into account both in the independent variable (since nursing approaches were based upon different views of the person) and in the dependent variable (since it was the person who had the pain). The unit environment was controlled in the studies through the use of a population of hospitalized persons.

Briefly stated, the proposition tested in these investigations was: “the more of the patient’s experience that is included in the nurse’s interaction with him, the better he will be.”42

Although the central variables of nursing theories should come from the conceptual models of nursing, it must be recognized that a

39 Adapted from Helen Yera and Gertrude Torres, “Today’s Conceptual Framework Within Baccalaureate Nursing Programs,” in Faculty-Curriculum Development, Part III: Conceptual Framework—Its Meaning and Function (New York: National League for Nursing, 1976), pp. 17-25. The authors identified the units as man, society, health, and nursing. The terms “person” and “environment” have been substituted here to avoid the use of the sexist term man and to express more fully the notions inherent in the term society.


42 Diers and Schmidt, op. cit., p. 115.
science, and the theories of that science, do not "arise out of a vac-
uum nor are the knowledges [sic] encompassed by [one] science
necessarily of meaning only to [one group of scientists]." Therefore,
it is permissible, and perhaps desirable, that supplementary
definitions and propositions be taken from the conceptual and
theoretical formulations of other sciences for use in nursing theories.
However, the motivation for borrowing from other sciences should
be the specific elaboration of one or more of the essential units of
nursing. Moreover, any borrowed definition or proposition must be
closely examined to determine if it fits logically into the particular
theory being constructed.

It would seem that the most sophisticated nursing theories will
be those that are sets of interrelated units, definitions, and proposi-
tions which describe, explain, predict, and prescribe nursing activities
related to person-environment interactions within the context of
health. These theories will not only be the most sophisticated, but
also the most distinctive and most readily identifiable as nursing
theories. However, it is maintained here that theories that are descrip-
tions, explanations, or predictions about any one or more of the four
essential units (person, environment, health, nursing) may also be
considered nursing theories, since these units are the phenomena of
interest to nursing.

It may be argued that a theory dealing with only one, two, or
even three of the essential units of nursing is not, in fact, a nursing
theory, especially if the unit nursing is not included. However, it may
also be argued "that nurses have great need for knowledge which
scientists in other fields may not be interested in developing, and,
therefore, nurses must take responsibility for developing this knowl-
edge." Moreover, if nurses need certain knowledge traditionally
associated with other sciences, then that knowledge has direct rele-
vance to nursing science and there seems no reason why it cannot
legitimately be considered a part of nursing theory.

The position taken here in regard to the units included in a
nursing theory requires a modification in our earlier definition of a
nursing theory. It now seems more accurate to define a nursing
theory as "a set of interrelated propositions and definitions which
present a systematic view of one or more of the essential units of
nursing—person, environment, health, nursing—by specifying rela-
tions among relevant variables."

However, it should be noted that nursing theories that fail to
include all four essential units could not logically be considered pre-

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43Martha E. Rogers, An Introduction to the Theoretical Basis of Nursing (Philadelphia:
44Jacox, op. cit., p. 12.
scriptive theories, since this level of theory must encompass all of the phenomena of interest to the science.\textsuperscript{45}

There are advantages in defining nursing theory as it has been in this paper. One advantage is that the units and their definitions, as well as the propositions linking the units, are provided by the conceptual model from which a given theory is derived. Another is that, since the theories are to be derived from generally accepted models of nursing and since they will be concerned with the recognized essential units of nursing science, their significance and relevance to nursing will be clear.

**Empirical Testing and Utilization of Nursing Theories**

The construction of nursing theories is only the first step in the consolidation of a body of nursing knowledge. Theories must be rigorously tested by empirical studies before they can be accepted and then utilized in the real world of nursing practice, clinical research, and education.

A detailed analysis and evaluation of the conceptual models of nursing revealed that each model defines and describes the four essential units of nursing and their interrelationships differently.\textsuperscript{46} These variations will provide the base for derivation of competing theories that can then be tested empirically. As theory testing proceeds, it is anticipated that some theories will be found to be false and will be discarded. Others will stand tests of refutation\textsuperscript{47} and will be accepted as constituting the reality of the phenomena of interest to nursing science. Ultimately, these theories will replace the conceptual models from which they were derived as the paradigms for nursing science.

There are indications that nurse scholars would like to develop a unified conceptual model of nursing.\textsuperscript{48} However, since few of the conceptual models have been utilized to any great extent in clinical practice, research, or education, and since perhaps even fewer have been used as a base for theory development, it seems premature to attempt unification. The limitations imposed on a science by one

\begin{footnotesize}
\begin{itemize}
    \item \textsuperscript{45} Dickoff and James, op. cit.
    \item \textsuperscript{46} An analysis and evaluation of the recognized conceptual models of nursing was conducted in a graduate seminar led by the author at the University of Connecticut School of Nursing during the fall semester, 1976-1977. The contributions of the following students are recognized: Maureen Avery, Esther Haloburdo, Rosemary Hathaway, Barbara Munro, and Mary Ropka. These students, as well as Eleanor Gill, dean of the School of Nursing, contributed to the development of criteria used for the analysis and evaluation.
    \item \textsuperscript{48} Riehl and Roy, op. cit.
\end{itemize}
\end{footnotesize}
model, or paradigm, are far-reaching and may present impediments to the explication of a comprehensive body of knowledge in the formative stages of the science. It therefore seems reasonable to urge nursing to avoid the mistakes of other sciences in the rush toward unification and to avoid subjecting the science to premature "scientific revolutions," which would be disruptive rather than constructive.

There are also indications that nurses are extremely interested in the development of theories directly related to clinical practice. The rush to prescriptive theory should be a concern to an embryonic science like nursing. It is crucial that prescriptive theories be built up from a solid theoretical and empirical base, and this can be done only through a relatively slow process that emphasizes the testing of lower-level (descriptive, explanatory, predictive) theories. Furthermore, much work must be done to develop fully each level of nursing theory.

The most sophisticated theories are those containing mathematically stated propositions. Therefore, efforts should be directed toward achieving the precision of mathematic formulations, even in the lower levels of nursing theories. It is encouraging to find that such endeavors are currently being undertaken.

The essential units of nursing are obviously summative units. Therefore, in the construction and testing of nursing theories, efforts must be made to invent less global and complex units and select ones that represent enumerative, associative, relational, and statistical units. Moreover, care must be taken in the choice of empirical indicators of these units. In the search for units and empirical indicators, the immediate urge to borrow from other sciences must be resisted. Such units and indicators must be closely examined to determine if they fit logically into nursing theories and into the conceptual models of nursing from which the theories were derived. Furthermore, to avoid the conceptual "muddles" of past formulations of so-called nursing theories, of which there are several examples, all elements of theories that might be borrowed

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52 Field, op. cit.
(units, definitions, propositions) must be carefully scrutinized. However, at the same time, new units, definitions, and propositions should not be invented just for the sake of uniqueness to nursing.

The potential utilization of nursing theories in all endeavors of nursing science is vast. The ultimate goal of nursing science is to establish a practice based upon and directed by sound, rigorously tested theories. This goal should be well worth the time and caution needed to develop and fully test nursing theories.

Conceptual Models and Nursing Theories: An Example

This paper has urged the construction of nursing theories from the base provided by the conceptual models of nursing. The following example illustrates such an endeavor.

A descriptive theory was derived by the author from a conceptual model of nursing to provide the rationale for an empirical investigation of one aspect of spouses' behavior during and after pregnancy. The foci of the theory were the essential units, person, environment, and health; the unit nursing was not explicitly included in this theory. Wives and husbands were designated as persons, with each acting as environment for the other. The person-environment interactions were viewed within the context of pregnancy, the operationalization of the unit health in this theory.

The theory for the investigation was derived from the writer's conceptual model of the family as a living, open system. The model represents an extension to the family of Rogers's conceptualization of man. Rogers posits that man and environment are complementary energy fields characterized by wholeness, openness, unidirectionality, pattern and organization, sentience and thought. Alterations in pattern and organization are postulated to be continuous and to reflect the mutual and simultaneous interactions between man and environment.

The family is also an energy field engaged in mutual and simultaneous interactions with the environment. The family is a living, open system, an integral, unified whole characterized by a unique and ever-changing pattern and organization. It is a system of interrelated systems, the family members, and a system of relationships. The family evolves unidirectionally and possesses sentience and thought.

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54 Jecox, op. cit.
56 Rogers, op. cit.
57 Fawcett, op. cit.
The investigation was directly based upon a theory which utilized the units of the conceptual model openess, pattern and organization, and mutual and simultaneous interaction within the family system. It was postulated that since the family is an open system, change in the pattern and organization of one family member would be associated with a similar change in other family members. Furthermore, since change in pattern and organization is effected by mutual and simultaneous interactions, it was postulated that extent of interaction would determine the extent of similarity of change.

One property of the unit person of interest in the theory was body image. Since body image is a summative unit, less complex units were needed. Perceived body space and articulation of body concept were the selected units. Perceived body space, the amount of space a person perceives his body to occupy, is an enumerative unit essentially unique to nursing. Its empirical indicator, the topographic device, was developed within nursing science. Articulation of body concept, an indicator of the extent to which a person experiences his body as separate from the surrounding environment, is also an enumerative unit, and like its empirical indicator, the figure drawing test, was borrowed from psychology. In the theory, both perceived body space and articulation of body concept were designated as empirical indicators of change in pattern and organization.

Another interesting property of the unit person was identification, a relational unit. Identification was defined in this theory as the similarity between two individuals' sets of connotative meanings. The reasoning behind the selection of this unit is as follows. Family members identify with one another. Identification, the process and end product of change in a system's pattern and organization, is effected by interactions between a system and the environment. Since identification is mediated by interactions, and since interactions between systems are mutual and simultaneous, identification was selected as the indicator of mutual and simultaneous interaction between spouses. The unit identification and the empirical indicator

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used in the investigation, a somatic differential, were borrowed from psychology.65

The propositions of the theory were developed from theoretical formulations and empirical evidence found primarily in the literature of nursing, medicine, and psychology. The propositions are:

1. Since pregnancy involves changes in a woman’s body, and since body image changes as one’s body changes,66 it was hypothesized that a woman’s body image would change during pregnancy.

2. Since the amount of space occupied and the relationship between body boundaries and the environment change during pregnancy,67,68,69,70 it was hypothesized that perceived body space and articulation of body concept were two aspects of body image which would change.

3. Since pregnancy involves the whole family,71,72,73 and since husbands experience “sympathetic symptoms” during their wives’ pregnancies,74,75,76 it was hypothesized that a man’s body image would change during his wife’s pregnancy, and that two aspects of body image which would change were perceived body space and articulation of body concept.

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64 Lazowick, op. cit.
4. Since "sympathetic symptoms" experienced by husbands during their wives' pregnancies are an expression of a man's involvement in pregnancy and of his identification with his wife, it was hypothesized that the husband's pattern of change in perceived body space and articulation of body concept would be similar to his wife's pattern of change in the two variables.

5. Since identification is associated with changes in body image, and since a husband may identify with his wife, it was hypothesized that the amount of similarity in spouses' patterns of change in perceived body space and articulation of body concept would be mediated by the strength of their identification.

The findings of the investigation suggested that the empirical indicators employed may not have been the most appropriate ones for the units of the conceptual model. However, there were indications of support for parts of the theory as formulated.

**SUMMARY**

This paper has presented an attempt to answer the questions, "What is theory?" and "What is nursing theory?" A definition of theory was given and the elements of a theory were defined and described. Nursing theory was defined through the identification of the phenomena of interest to nursing—person, environment, health,

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80 Schilder, op. cit.
and nursing. The conceptual models of nursing were identified as the base from which uniquely nursing theories should be derived.

Empirical testing and utilization of nursing theories was discussed and caution against premature leaps to a unified model or theory urged. It was emphasized that rigorous testing must precede the use of nursing theories. And finally, careful examination of theory elements that might be borrowed from other sciences was urged.
FROM HERE-AND-NOW TO THEORY: REFLECTIONS ON "HOW"

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It is important to recognize and respect the crucial influence graduate faculty have on the future of nursing theory, and consequently nursing practice, by virtue of their position to encourage and their efforts to develop theory and future theoreticians. It is likewise important to recognize and respect the necessity of rooting nursing theory development in the clinical setting—"rooting" in the sense both of appreciative nursing practice as the source of nursing phenomena and of nourishing clinicians' and administrators' valuing of theory development as an essential dimension of nursing. If there is any need for nurse educators and nurse clinicians to meet together for an exchange of ideas, it is in the area of theory development.

The question that prompted this paper, "How is nursing theory developed in a clinical setting?", was clear, direct, and simple—or so it seemed at the beginning.

One morning, in gathering thoughts on the subject, I suddenly remembered two previous experiences. Some years ago, during the oral defense of my doctoral dissertation (a phenomenological construction of a concept of empathy), one of the committee members asked, "Does phenomenology lead to theory?" The question was totally unexpected, but before I realized I answered spontaneously, "For me it did." I am certain that I did not grasp the full import of the question at that time (at least not consciously), for I had never recalled this incident during the intervening nine years until thinking about this paper. The second recollection came a moment later. During the past year, a colleague and I had presented a two-day pro-
gram on Humanistic Nursing in which we repeatedly urged practicing nurses to value and describe their lived nursing experience in the interest of developing nursing theory. During one of the discussion periods, a participant fired a string of questions at us, climaxing in what I interpreted as an angry, futile statement: “I don’t see how this will lead to theory.”

Now, as this incident popped out of my memory in association with my oral examination question, I wondered if the nurse was expressing frustration with the methodology rather than anger at our urging description. It dawned on me that my professor and the nurse in the audience were both asking the same question: “How does one move from here-and-now phenomena to a theory?” In my preliminary thinking about this paper, I had focused on possible answers to the original question. Now I was startled into a new awareness of the possibilities of the question itself. It was a call, an invitation to think it through again from another angle, from many angles.

Gradually, my folder of notes and the pressure to begin writing increased. Finally, one day at a scheduled time, in a quiet office, with a firm resolve to make some sense out of my views, to find a logical pattern for the coherent sharing of my experience of developing nursing theory, I began reviewing my notes, focusing now on a particular idea, then relating it to other ideas, then shifting back and forth among ideas. Drifting in my reflections, oscillating between individual notes and the whole body of notes, I suddenly comprehended a whole, a gestalt. The pieces fell into place and I had an outline that fit. Now I could work out the details.

What became apparent was that I had interpreted the “how” of my experience of developing theory in different ways, and my responses reflected three perspectives: (1) Looking Back—the historical aspect of how it happened; (2) Looking At—the procedural aspect of how it is done; and (3) Looking Toward the Future—the developmental aspect of how the theory and process are taking shape. This paper is addressed to those three interrelated “hows.”

You may question why I spent so much space detailing the process above, rather than simply stating the three sections of this paper. I shared those experiences to illustrate my typical manner of moving between experiential and theoretical realms. It is an example of my personal form of an existential phenomenological approach. I find myself going through the same process whether I am writing a paper, preparing a lecture, designing a course, planning research, working out the details of a theoretical position, or reviewing and working through a clinical situation. It is this individual “how” of theorizing that underlies the general process of theory development.

I am certainly not proposing that this is how we all ought to theorize. Such a suggestion would be futile and it would disregard
the unique, individual human theorizing process. Rather, I am trying to emphasize the value, the necessity, of each of us coming to know and examine her own personal styles of theorizing and of helping students look at their own styles.

Consider one more point on this subject. We need not fear that encouragement of variation in theorizing styles will necessarily lead to chaos in nursing theory. For example, a colleague (Dr. Josephine Paterson) and I have been developing a Humanistic Nursing theory in collaboration for the past seventeen years. We have found that we usually approach issues or questions in different ways; we have our own styles of moving between concrete and abstract, of searching for meaning in experience. Despite our different ways or perhaps rather because of our different ways, our dialogues move us both beyond the theory development we could attain alone. As in all genuine dialogue we have not lost the ability to question the other. By different roads we arrived at the same basic view of nursing and the same general existential phenomenological approach for studying and describing it. I believe it is this essential commonality that accounts for the coherence and logical consistency of our theory. We share the theme and enjoy playing the variations. In theory development, as elsewhere, differences can make for harmony as well as chaos.

LOOKING BACK—HOW IT HAPPENED

From the historical perspective, the question of “how” took this form in my mind: “How does nursing theory come to be developed in a clinical setting?” In one of my early attempts to answer, I planned to review my own experience in theory developing and to describe the sequence of events. To my chagrin I did not know where to begin. It was surprising, even somewhat embarrassing, to realize that the origin of a major value and effort in one’s current professional life went unnoticed. Is there something about theory development like history that “takes place behind our backs”? For example, my colleague and I were well into writing these papers before it occurred to either of us that it might help clarify our approach if we included a bibliography of some of our early works. They were not labeled nursing theory then, but in retrospect they seem to be all of a piece. Does one’s involvement in theory development grow through quiet evolution rather than revolution?

The question implied in asking how it happens is, “What motivates a nurse to develop theory?” I cannot recall ever setting the goal for myself that I would develop a theory of nursing. I never fantasied going into the business, hanging up a shingle: “Theories Built While You Wait.” This is not to say that theorizing was not a conscious, de-
liberate effort. But for me it is more a process of searching than of producing and packaging. It is a personal-professional need to find answers that moves me to theorize. Personal in the sense that it is my question for which I need my answer. Professional in that the question is significant in my nursing world.

As a nurse educator I saw my responsibility as helping others learn how to nurse. Each question raised by a student aroused five other questions of my own. As a clinician, every time I was confronted with a decision about the nursing care of a patient, there would be questions behind the immediate clinical practice situation. What should I do? What am I trying to do? What am I really doing? These questions repeatedly brought me to the most basic question: What is the nature of nursing? My search led me to graduate study; first to nursing where I naively looked for experts to answer my question, then to philosophy where I sought methods for studying the nature of things. Now I am still searching for answers through clinical practice, research, and teaching.

The basic question “What is the nature of nursing?” has become, if anything, more real in my lived nursing world, more frequent, and more demanding of my personal response. It would be impossible for me as a feeling, experiencing, intuiting, thinking, valuing, searching human being and nurse to survive in the clinical arena without entering into this questioning dialogue with reality and, further, without sharing my responses, regardless of how tentative and unclear, with other clinical theoreticians. As a result nursing theory develops.

So by looking back at how it happened, one may discover factors that influence the development of nursing theory in a clinical setting. A basic requirement is the nurse’s inquiring attitude. One needs to be equally at home in the practical and theoretical realms and to move easily between the two. Any thinking, practicing nurse does this many times a day. But a shift to a broader perspective is necessary for developing theory. It grows from a habit of looking beyond the immediate, concrete details of a situation to its underlying questions.

To develop nursing theory, nurses first need to ask the proper nursing questions. Here a focus on values helps. The “what should I do?” questions appear every day in clinical settings. As clinicians we have all lived, eternally it seems, with the need to “develop sound clinical judgment” and to “learn to set priorities.” For the sake of quality care it is necessary to develop these skills; but in the interest of theory development, we need to go one step further. The nurse’s actions reflect what was valued in making the clinical judgment. So the critical examination of one’s actual nursing practice for the purpose of uncovering its inherent values raises questions and
offers clues to one's conception of the nature of nursing. This is a major step toward developing nursing practice theory.

A further necessary condition is a sense of intellectual and imaginative freedom and responsibility. In fact, as hallmarks of the theoretician's mode of being, creative freedom and responsibility become driving forces. They are values lived, expressed through the process of theory development. In other words, the nurse must be free from taking things for granted, from stereotyped answers; she must be free to encounter clinical realities in new lights, to let her creative imagination go. At the same time, she must feel a responsibility, a commitment to the search, and a constant awareness of the need, the purpose, or goal of the theorizing.

Looking back, how does it happen, then, that one develops a nursing theory in a clinical setting? It is a creative, purposeful response to satisfy a deeply felt personal-professional need to find meaning in one's clinical nursing world.

LOOKING AT—HOW IT IS DONE

The process of clinical theorizing, as we know it now from our experience, has three interthreaded states—experiencing, reflecting, describing. I say "now" because, as more nurses share not only the substantive results but the "procedural how" of their clinical theorizing, the process itself should be developed and explicated. I have always urged others to try to describe their ways of theorizing. The one force that holds me back in describing it as an ordered process (other than the difficulty of doing so, of course) is a gnawing fear that such a description might give the impression that our approach is fixed and could be taught and used in a cookbook fashion. This is farthest from our intent and hope. The very nature of this existential phenomenological approach implies openness to new possibilities in the process itself. It is in this heuristic spirit that I would like to share my reflections on "how it is done."

Theorizing is a form of dialogue with reality, an attempt to find meaning in the world one lives in. So it is natural that in our existential phenomenological approach the process of theory development begins in experience. To a nurse with an open, inquiring attitude, any phenomenon in the clinical situation can be a call to intellectual dialogue. An observed fact, event, or appearance, whether objective or subjective, may begin the process.

We have an unfortunate tendency (probably nourished by writing curricula vitae) to think of experience in terms of months and years. Here it is the quality of experiencing that is especially
important. Of course, time can never be overlooked, and admittedly, duration is an influential factor in this first stage of the theorizing process. For instance, the phenomenon under question may be a rare, even a once-in-a-lifetime occurrence, or it may be something manifested only over the years. But quality is being emphasized here because the phenomenological method proposed requires a certain kind of experiencing. It has tinges of surprise and wonder. The basic attitude is not "experience period" but rather "experience exclamation point, question mark."

If a theory of nursing practice is to be derived from actual clinical situations, then the fuller the nurse’s experience is, the greater the possibilities and the richer the data bank of phenomena, which are the "stuff" of theory. Such experiencing calls for an existential engagement in nursing. In other words, it requires the fullest experiential participating in the everyday clinical world as well as a thoughtful sensitivity to one's own perceptions of and responses to it. In such a state of openness any phenomenon may trigger the nurse’s habitual searching response. For instance, sometimes a question—a patient’s, a colleague’s, one’s own—may call attention to some phenomenon and provoke thinking. The same is true of answers that are not quite satisfying. Or perhaps the stimulus is an observed occurrence, an isolated instance or a series or pattern of occurrences. It may be something heard, seen, touched, smelled. On the other hand, the beginning of theorizing may be the absence of an expected response experienced by the nurse with surprise, anger, disappointment, relief. These subjective responses may be used as clues to the nature of the phenomenon itself. For instance, why am I surprised? or why did I expect such and such a response? What is puzzling about this? This made me feel discouraged, angry, relieved. But what did the patient feel?

There are different sources of phenomena in clinical situations. A nurse may find some phenomenon in her own immediate experience in the process of nursing. Or it may be described or expressed in the behavior of the patient. Sometimes the phenomenon occurs in a shared situation and the theorist may be fortunate enough to gather views of it from different angles. Let me illustrate. For a long time I have been pursuing the very elusive yet very real phenomenon of "presence." It is intriguing but difficult, and though I sometimes wonder if I will ever get it all together, I think it is worth continued effort because I see "presence" as basic to the whole process of nursing. I am convinced that although much has been written on it in relation to various life situations by existential philosophers, novelists, dramatists, and poets, "presence" has other distinctive qualities and characteristics in the nurse-patient situation. I believe its further elucidation in this regard could add to the science of nursing and of
man. So it is always in the back of my mind, and I am usually alert to the phenomenon especially in clinical situations.

The following incident occurred in a small discussion group with long-term medical patients. The group has been meeting weekly for over a year and a half. The sessions are usually attended by six to twelve patients, one or two registered nurses from the patients' units, and myself. Three of the original patients are still in the group; others have died, have been transferred or discharged; new members join continually. The men are elderly veterans, most with several physically disabling and some terminally pathological conditions. Almost all are wheelchair-bound. Generally, they are coherent and verbal, although some have hearing loss, speech difficulties, or memory impairment.

The purpose of the group is to talk together about whatever the patients want with a view toward making their lives better, more meaningful, more comfortable. Usually the group focuses on current living situations or reminiscences. Most often the latter deal with their armed service experiences. They love to swap stories and relive old interservice rivalries, or to talk about successes in their work experience. It is usually possible to expand these discussions to more general considerations of human behavior and values and to make application in their current situations. They often make practical suggestions for improving the ward milieu and routine. Sometimes we explore affective experiences, e.g., loneliness, boredom, rejection, anger, frustration, waiting, compassion, friendliness. Other times the discussion turns to current events, sports, gardening, hospital events, medical treatments and discoveries, trips, parties, or family visits.

One day we met in our usual room with the wheelchairs in a circle. As our session progressed, the noise of workmen's hammers and drills came closer and closer and grew louder and louder until we had difficulty hearing each other. The noise resounded throughout the unit. The other nurse and I looked at each other hopefully (for there was no stopping it or getting away from it); finally the other nurse said to the group, "Perhaps we should close our meeting early today." I was nodding my agreement, when the patient next to me said, "Let's just push our wheelchairs closer together and we can pretend we're sitting around the campfire and keep on talking." His response stopped me in my tracks. I was surprised, ashamed, and pleased. All the men agreed. We huddled together and continued for our whole hour.

Later as I was recording my notes on the session, I realized that that had been an instance where the patients and I had experienced our presence to each other differently in a shared situation. I recalled my feelings. Why was I surprised? The man who urged continuing the
session was one we often had to coax into the group. But he must really like it! Then why does he want to be coaxed? (I made a mental note to remember this next time.) I had felt myself blush. Why had I been ashamed? I had been more related to the noise than to the persons in the room. Why was I pleased? The group, my work, my presence was valued; I do make a difference.

Now what does this one brief incident reveal about "presence" as a nursing phenomenon? Its occurrence or absence can be experienced. Both nurse and patient are aware of it. It is important to both. It makes one aware of oneself and of the other. It reveals a person to himself and to the other. Through it the nurse and the patient can show respect, closeness, caring—in short, can confirm each other. In nurse-patient situations, the nurse’s "presence" is expected by both (as was evident by the patient’s asking for it and the nurse’s guilt feelings for wanting to withdraw). In realizing that the patient values her presence, the nurse experiences pleasure, pride, purpose. Now one wonders, is "presence" a depreciable intangible in nursing that is more obvious in its absence?

The kind of engagement or full experiencing of the clinical situation in which our phenomenological methodology is rooted is not to be equated only with fully conscious awareness. To expect such a state of constant "intuneness" would be asking the humanly impossible. Fortunately, some experiential knowledge can be gained in clinical situations without one’s full and constant attention.

Let me cite another example from the same patient group. For some months the group consisted mostly of patients who had had one or both legs amputated. One day, as we sat in our circle and one patient was retelling a rather lengthy story, I became aware that I had been looking around the circle, moving my gaze from man to man, counting men and counting legs, totaling so many men and so many legs. As I completed the circle, my eyes rested on my own legs and I became acutely conscious that I had two. I felt different, self-conscious, uncomfortable. I wanted to hide a leg under my chair. This all went through my mind in a brief moment and was gone as I gave fuller attention to the speaker. I recalled it after the session when I was writing my notes, but simply labeled it "compulsiveness," laughed, and forgot it.

Some weeks later, the men were teasing one of the nurses in the group about her being on television. (A class she attended had been videotaped.) I asked if any of them had ever been on television. When they said "no," I asked if they would like the experience and offered to have the group videotaped. They rejected the suggestion immediately saying, "Who would want to look at us?", and quickly moved to another topic. I did not expect this and something in their response (self-consciousness? discomfort? fear?) triggered in my
mind my previous experience of acute consciousness of my two legs. I relived the uncomfortable feeling of being different in appearance. I looked around the circle and saw, really saw, the men, welded to their wheelchairs, hiding their leglessness under afghans and towels, trying to conceal flaccid limbs, tremulous hands, drooling distorted smiles, thick glasses, hearing aids, tubes, plastic bags of urine. It was a shock, painful to look at. It brought back my initial physical-emotional repulsion on first meeting these patients. I had forgotten what it was like before these patients became Mathias and Sarge and Tom and Bob and George and Pat. I understood their resistance to being videotaped; I also had experienced the desire to hide.

Reflecting on this experience later, I wondered how I could have forgotten. Their appearance had not changed. In a sense, I had simply overlooked it. Yet if anyone had asked at that instant, I could have given an accurate description of each patient. So when a nurse is with a patient she sees and does not see his pathology all at once. There is something paradoxical in the phenomenon of nursing “presence.” Is the nurse with the patient in two ways, two realms?

It is not difficult to become aware of a phenomenon in the clinical situation when the occurrence is novel, startling, unusual, or in some way personally significant. Some nurses have reported that, when they are really trying to study and describe a particular phenomenon, they find it everywhere. However, openness in experiencing implies also that one can see common phenomena from different perspectives. It is more difficult to view ordinary events in a new light. But the very fact that an occurrence is common is more reason to be open to the possibilities of its meaning. For if a theory of nursing practice is to be relevant, then it must deal with the usual and ordinary in the nurse’s world.

In his book, Out of Solitude, Nouwen writes about a conversation with an old professor. Speaking of his long life of teaching, the professor said, “I have always been complaining that my work was constantly being interrupted, until I slowly discovered that my interruptions were my work.” Of course, I thought of nursing. What would a study of the nurse’s “interruptions” reveal about the nature, the content and process of nursing practice? What do nurses (clinicians, educators, researchers, administrators) consider interruptions as opposed to work? The story made me wonder also about the process of theorizing. What could we discover about common nursing phenomena if, like Copernicus, we could turn our clinical world view around?

It is easy to see from these examples why we refer to experiencing, reflecting, and describing as interthreaded stages of clinical

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theorizing. In the process as it is lived, these stages (if they can be called that) seem to flow back and forth and together. It is like living an experiential reflective dialogue. One cannot always say when the experiencing ends and the reflecting begins. On the other hand, the exploratory reflecting sometimes evokes an affective reliving of the experience. The flavor lasts and also comes back. The same interplay occurs in the describing stage. One reflects on the experience in terms of words, pictures, symbols in struggling for a conceptualization that conforms most truly to the lived experience. One's thoughts move back and forth between the concept and the recollected real experience as in a dialogue where each calls forth and responds to the other.

Reflection in the process of clinical theorizing is directed toward comprehending, finding meaning in the experience. This involves recalling and reliving the experience; dwelling on the details, the facts and flavors; comparing and contrasting elements; looking for similarities, differences, commonalities, and opposites; perhaps recalling related incidents. There is a quality of imaginative playfulness in the reflecting as one lets his free associations arise and creates metaphors, symbols, and analogies. And throughout these analyzing activities there is an underlying need to understand the meaning of the experience that, like a driving force, constantly moves one's thoughts toward a comprehensive synthesis.

In the third stage the conceptualized phenomenon is described in detail. Its explication includes all the knowledge derived from the reflective analysis and synthesis, as well as the unanswered questions about its nature.

From our experience, Dr. Paterson and I have distinguished two levels of clinical theorizing. One is concerned with specific nursing phenomena. This may be quite extensive. Through it knowledge of selected nursing phenomena expands, growing deeper and broader. For example, I have been studying the phenomenon of nurse-patient relatedness for years, focusing first on "empathy," then on "presence," and recently refining my interest still further to a special kind of nurse-patient relatedness that, for the time being, I am calling "withness." Such phenomenological description we believe is basic to theory development.

The second level of clinical theorizing is concerned with the interrelatedness of nursing phenomena. This requires the discovery of a key for relating the phenomena to each other. In other words, it calls for a shift in perspective from the parts to the whole. Our humanistic nursing practice theory includes both levels of clinical theorizing. Of course, nurses may have different views of what the

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“whole” is, and consequently one could envision level upon level of nursing theory dealing with ever broader and grander systems.

Most likely, different theoreticians search for the integrating key or structure in different ways. I usually find it by reflecting on the phenomena I am trying to order and understand.\(^4\) Rather, I should say it finds me, for after much mulling the idea seems to come unexpectedly “out of the blue” with force and clarity. It comes in the form of an insight, a central intuition. It has the quality of an epiphany, for this single insight lights up the whole, makes everything clear. It is integrative; in light of this insight the pieces fall into place, the details fit into a whole. And it is generative. Like a seminal idea it leads to more and more possibilities and more and more questions.

R. D. Laing’s statement that “theory is the articulated vision of experience”\(^5\) succinctly expresses our position on clinical theorizing. For us experience here refers to the nurse’s existential encounter in the health world with whomever and from whatever position she lives it. Articulated means that the conceptualized experience is both intelligibly expressed in clear, effective words and connected to form a systematic whole. The term vision implies something more than a mere glimpse. It has the connotation of a visionary aim or philosophical perspective in the sense of a particular world view. It also implies discernment of something beyond the concrete, a kind of global apprehension, a view of the whole. And these characteristics apply to both levels of clinical nursing theory.

LOOKING TOWARD THE FUTURE

From the third perspective, looking toward the future, my thoughts on theory development in clinical practice might perhaps more properly be labeled dreams and wishes. The current nursing scene offers cause for optimism. The fact that NLN holds a workshop on the subject itself attests to nursing leaders’ interest in theory development and their recognition of its necessary relation to clinical practice. Similarly, graduate programs in nursing, which are an important source of future theoreticians, show supportive trends, such as emphasis on theory courses, research addressing nursing practice questions, and programs in clinical specialization.

Our own greatest encouragement for developing theory in the

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\(^4\) Peterson and Zdarad, op. cit., pp. 24-25.

clinical situation has come from the responses of practicing nurses themselves. They have found the concepts and methodological approach of humanistic nursing useful in their daily practice. In our courses, they have shared hundreds of examples of implementation. It is through clinicians' ever-expanding use, continued searching, empirical testing, and sharing of described nursing phenomena that nursing theory will evolve.

Practically speaking, there is a major deterrent to developing nursing theory in the clinical situation, namely, the fact that the situation itself is action-oriented. The atmosphere is one of immediacy; the need to act, and often to act quickly, is paramount. Multiple demands are made upon the nurse's time and energy by patients and others in the system. These factors tend to increase the pervasive climate of urgency and to inhibit the attitudes and habits of reflection essential to theorizing. For the promotion of nursing theory development in the clinical situation, what is needed—in addition to practitioners' commitment to the task—is an administrative support system (e.g., time, consultation, recognition of intellectual contributions) that reflects the valuing of nursing theory and its development. For the responsible, budget-conscious administrator, I believe the only force that will raise the priority of theoretical nursing endeavors in the clinical situation will be the resultant improvement in patient care. In the end, nursing theory must be judged in terms of making a difference in the quality of nursing.

As colleagues, nurses can do much to support each other in their intellectual forays into the realms of theory. By being open to each other's questions and responses; by having the courage of their conceptualizations; by being willing to risk the sharing of their unique views, expressed in their unique ways; in short, by working together as a genuine community of scholars as well as a team of doers, nurses can advance the development of nursing theory in clinical situations.

The trend toward specialization in nursing could also lead to further clinical theory development. Narrowing one's clinical field should foster greater depth of knowledge and increase one's perceptive- ness of the phenomena experienced. A more concentrated focus of interest raises other levels of nursing questions and highlights the need for other levels of answers. So it seems logical to expect richer explications of nursing phenomena with clinical specialization. Ideally, if cross-clinical communication could be increased, as nurses in various clinical areas shared their phenomenological studies, broader applications could be recognized and developed through their collaborative efforts.

Our privileged experience of working with nurses in various clinical settings has repeatedly served to increase our appreciation of
the richness of their professional wisdom. We are constantly struggling together with them to find ways of expressing their lived nursing experience. I am impressed with the number of nurses who naturally turn to forms of artistic expression. It is so usual these days to associate theory with science that I would like to submit for consideration this proposition: There are some dimensions of nursing experience that naturally, perhaps necessarily, evoke artistic expression. My point is that if clinical nursing theory is to conform as truly as possible to actual lived nursing reality, then every kind of expression of this lived reality needs to be valued and studied for what it can reveal.

Let me illustrate. Dr. Paterson and I teach a course in Humanistic Nursing for which one requirement is the weekly submitting of a description of some meaningful experience in the student’s nursing world. We receive papers (paragraphs to pages), poems, and drawings. We both respond in writing to each. One nurse (Carole Bouza) submitted the following and gave me permission to share it with you.

I think I want a transfer to the well-baby clinic. The last three weeks have been so depressing. There has been one after another, four very young men, all admitted with diagnoses quite different than their final diagnosis, cancer. Chest colds turning into lung cancer. Appendicitis turning into bowel cancer. When will it stop? Why does it have to be? Sometimes I think I’m going to go back to being a barmaid. I could still serve mankind. I could still listen to people’s problems. I could still help and love in my own way. The hours were better, the money about the same, and no one ever died on me. But then I think if everyone thought like me, we’d be in sad shape today.

I feel so helpless when I’m with a terminal patient. I think mostly because it strips me of my facade. I can’t be flip and can’t hide behind my hardness.

I think most of all it’s my love of life that hurts me the most when I see it being snatched so soon from these young men. I’ve answered my own questions and now I have to deal with them. I guess that’s why I don’t go back to being a barmaid. Just to be there and being a small part of helping these guys gives me a feeling of being and a reason for being.

As I read this paper, I was very moved. It brought an image to my mind that I felt I had to express. And what I imagined took this form:
Reflection on Carole’s Paragraph

Death lifts his scythe
to swipe down the young man
misdressed in hospital gown
displaced in hospital bed.

The cruel cold blade slashes
the hard mask of his nurse
silently standing there
bleeding forth her presence.

This drive and struggle for poetic expression brought me in
touch with the phenomenon of “presence” in another way. Through
vicarious experiencing I shared in its affective dimension and felt
again its beauty, its pain, its healing power.

In recent years there have been more poems by nurses about
nursing interspersed among the technical articles in The American
Journal of Nursing. Like the nurse scientists, the nurse poets, the
nurse artists also share “an articulated vision of experience.” Can
clinical theoreticians afford to ignore their views?

CONCLUSION

Nursing, as every discipline, has its own distinctive encounter
with reality; and in its encounter, each seeks meaning. From this
evolves a science, i.e., both a body of substantive knowledge and a
methodology for discovering new knowledge and verifying it. Each
science, then, bears these twin hallmarks: its particular area of concern
with reality and its particular approach to theorizing about it.

Nurse theoreticians are in an enviable position. The scope of
our search may extend to the limitless horizons of the questions of
human survival—survival, not as an abstract concept, but as the most
basic human reality. As a community of nurses, we have the need
and the potential for developing these methods of theorizing and
thus responsibly shaping the growth of nursing science methodology.
Will our theory support the evolution of nursing as a fully human
response to a human need?