THE TORTUOUS WAY TOWARD NURSING THEORY

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If we imagine Kierkegaard and Nietzsche revealing each to the other his innermost soul and ideals and strivings, without any attempt to “convert” the other, we can see each man growing in the understanding of the meaning and direction of his own existence.  

It is in this spirit that I would like to relive with you efforts, struggles, tears, and joys while burrowing about in the health service situation attempting to locate the ways and means of crystallizing the belief systems, acts, and effects of nurses’ “doing and being” in this chaotic, complex, and conflictual realm.

As nursologists at the Northport, NY, Veterans Administration Hospital since 1971, Loretta Zderad and I have studied nursing practice as it is experienced by nurses, ourselves and others. We deliberately implemented “humanistic nursing” through a three-pronged approach: practice, education, and research. To further this approach on formal and informal bases, we meet and work with both staff and patients individually and in groups.

Humanistic nursing proposes a perspective of nursing as a happening between persons, an approach to nursing as existential presence and awareness, and a method of describing nursing as phenomenology. Our book, *Humanistic Nursing*, we view as offering a practice theory and a metatheory. A metatheory is a systematized body

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of knowledge formulated for the purpose of making something else possible. Humanistic nursing, as a metatheory, strives to reveal comprehensively how nurses have expressed and can express their lived nursing experiences.

R. D. Laing says that "theory is the articulated vision of experience."\(^3\) Wiedenbach views theory as "mentally developed abstract phenomena derived from reality and action influencing."\(^4\) One's own responses, observed, initiate an intellectual process. If meaningful ideas are related and articulated, a theory is born.

In our nursing service setting, Dr. Zderad and I as often as possible describe our nursing experience phenomenologically. In our work with other nurses we have influenced many toward beginning to describe their nursing experiences. In many instances we have made opportunities for these nurses to share these descriptions with other nurses, directly, or (with their permission) through videotapes. Written descriptions, audio- and video-tapes are utilized as often as appropriate to accrue retrievable, enduring phenomenological data, and to serve as remembering tools.

Why should time, effort, energy, and currently extremely tight material resources be invested to cultivate a womb, or field, to yield nursing theories? Nursing theory made explicit allows refinement of direct patient care; it advances practice and furthers nursing as a profession by offering a resource:

- To the practitioner in decision making derived from experience.
- To the administrator in decisions related to appropriate quality-quantity education and experience in nurse staffing.
- To the educator for sharing nursing wisdom and interpreting specific nursing acts.
- To the scholar for distinguishing the empirically testable from that which necessitates a courageous philosophical stance.
- To man for comprehensively choosing the priority the profession of nursing will be granted within the hierarchy of community needs.
- To nurses as a vehicle for self-knowledge, and identity; a secure, yet open and not rigid authority base from which they can relate to the many others in their nursing worlds.

THEORY, BUT HOW?

The father of phenomenology, Edmund Husserl, directed one to study the thing itself, to come to know it. What is the nursing "thing itself"? We say that it is the act of nursing, the intersubjective transactional relation, the dialogue experienced, lived in concert between persons where comfort and nurturance prod mutual human unfolding.

We are convinced that the nursing experience, undescribed and unappreciated because of inadequate conceptualization in theory, presents the nurse in effect as an impotent mute. The need for assertion through attestation of nursing events, their abstract current, enduring, and relevant meanings, often creates free-floating turmoil of unknown origin within the nurse. Only our consciousness-raising age has made it possible for this need for expression to be realized by so many nurses. For responsible, effectual existence the profession requires language to relate authentically the purposes, beliefs, concerns, and events experienced continually in the nursing world.

CONCRETION AND ABSTRACTION
"ALL-AT-ONCE"

In the descriptions of nursing situations that follow, certain values that are important in my approach to nursing theory are evident:

1. Comfort—persons being all they can be in particular life situations.
3. Clinical—aware presence in the health situation, reflected and acted upon.
4. Empathy—imaginative moving towards oneness with another, sharing his being in a situation, resulting in an insightful knowledge of his perspective.
5. All-At-Once—awareness of living many concepts, emotions, desires, values in a particular instance dispels narrow singularity of purpose and complements wisdom.

In the depictions of interactions between nurse and patient and nurse and nurse, I will try to show theory and practice as two sides of one indivisible coin.
A Nurse-Patient Depiction

My humanistic nursing experience with a patient I shall call “Dominic” reveals the relevance of the above interrelated theoretical phenomena to nursing, regardless of the particular pathology.

For four years I have conducted a humanistic nursing psychotherapy group in a VA Psychosocial Clinic in a Veterans of Foreign Wars building about 15 miles from our hospital. I recently experienced the death of one of its members. Dominic, a 54-year-old veteran, a charter member of the group, a volunteer and client at the clinic, first came to group after a recent prostatectomy. This followed a hospital admission for a coronary. He had a long history of out-patient psychiatric treatment. A routine X-ray revealed cancer of the lung.

Till recently, Dominic had lived in Greenwich Village. His own coronary and the coronary and death of a close childhood friend had motivated him to move to his wife’s home fifty miles away from New York City. Though they had been more or less separated for seven years, his wife had always visited him on weekends. Now he repeatedly and dramatically expressed his dislike for living so near his in-laws.

He even spoke of his wife in a deprecating tone. While saying she was the perfect wife, all loving and caring, a fantastic housewife and cook, vice-president of a bank and well-off financially, his voice betrayed other feelings. She was powerful and had forced him out here to live with her in her beautiful home. In a frighteningly quiet voice he described threatening her with choking and facial scarring. She epitomized adequacy for him, while he felt inadequate and impotent, worthless and useless.

On admission to the hospital he was considered for chemotherapy and received cobalt treatments. Needless to say, the humanistic nursing psychotherapy group discussed Dominic’s plight and dying. My nurse group co-leader and I talked about visiting Dominic in the hospital. She got to the hospital door twice for this purpose, but was never able to go in.

I had not been in the medical-surgical situation with a dying patient recently. Since nurses discuss dying situations with me frequently, I decided to visit Dominic weekly. I learned much. Because Dominic knew me so well from our group, he beamed with unabashed pleasure when I arrived at his bedside. I told him of my intention of visiting him weekly. He accepted this as his due and immediately complained about his wife, the medical and nursing staff, and his roommate patients. He indirectly expressed his fear of dying and his wish to live.

In the therapy group, Dominic and I had had a close and trust-
ing relationship. He was able to discuss his sexual impotence, masturbation, inability to function generally, his intense anger, caring, and love. He had left the clinic after each visit because he had a life going on “out there.” He had worn street clothes; he was up and about. Now, all of a sudden he was in pajamas, in bed. I had been told he was dying of lung cancer. Our usual relation was shaken and chaotic.

We had confronted many issues together, but I felt nothing—just a kind of indifference and numbness—as Dominic expressed his miseries, fears, and anger. I pride myself on my empathic ability. But I felt terribly inadequate; I did not believe I could not feel with him what he was experiencing. Intellectually I understood his words; his expressions were full of pain. My feelings of inadequacy, helplessness, and inability to control myself were strong. I mulled reflectively about this. Suddenly a light dawned: I was experiencing what Dominic was expressing. At this time I was feeling his, and not my, shock, inadequacy, helplessness, and inability to control his cancer, his destiny.

This realization allowed us to talk about his feelings; now our relationship was as strong or stronger than ever. But I learned something important. Families, friends, and patients need to know that solid past relations are rocked roughly for a time when a person’s status is changed to “dying” or “seriously ill.” Otherwise, feelings can be misinterpreted and there is added and unnecessary human suffering.

Staff informed me that the wife did not want Dominic told of his cancer. I tried to share with each of them that it was not a matter of telling him: he already knew. It was a matter of being with him in his fearful knowing. But his wife could not accept his dying.

As the weeks went by, my visits to Dominic’s bedside continued. After greeting me and saying what he needed to, he would often fall asleep. At first I thought, “It doesn’t matter whether I come or not.” Then I noticed that when I moved his eyes flew open. I reevaluated his sleeping during my visit and discussed it with him. He felt safe when I sat with him. He was exhausted, staying awake, watching himself to be sure he did not die. When I was there, I watched him, and he could sleep. I no longer made any move to leave before my time with him was up. I told him of this intention, so that he could relax more deeply.

This is another notion that could profitably be shared with visitors. Often their feelings of helplessness, “being able to do nothing,” keep them from continued visiting and make them angry with themselves. And often this anger is projected onto the patient, staff, or others available. Alleviating aloneness is a most precious gift. To give this gift of time and presence, a person has to value the out-
comes of relating; a person has to love a lot.

I last saw Dominic on a Friday. He went home for the weekend in an ambulance, returned on Sunday, and died on Tuesday. Anticipating this weekend after three months in the hospital, he remembered the weekends when his wife used to visit him in New York City. I asked about his anticipation during those seven years, now long ago. He lit up; his very black eyes twinkled and sparkled with love, warmth, and tears. He chuckled as he recalled the efforts he had made to get tickets to the best shows. He had bought her favorite foods and wines and fussed around the apartment till she arrived. I said, "It sounds like you loved her a lot." He replied, "It's strange, after all we've been through, all of our fighting, all the things my sisters said. Now, now I know. I've always loved her most of all." I simply said, "Tell her." We squeezed each other's hands, and as we looked at each other, tears came to our eyes. As I left, he called "Goodbye, sweetheart." Catching himself, he looked shocked and embarrassed. I responded, "In many ways, you are my sweetheart."

Later, I received a beautiful letter from his wife. On their last weekend together, he had told her he really loved her.

Before Dominic died, he and I, because of our relationship, experienced the comfort of human adequacy; we both grew through nurturance; I was aware of experiencing the clinical process, the existential presence in-the-situation followed by reflection; for empathy I deliberately turned to Dominic, and throughout this experience I lived many emotions, desires, and values, all-at-once and intermittently. In this experience I believe I lived my theory of nursing.

Some Reflections on the Nature of Being a Nurse and a Patient

The profession of nursing evolved, continues, and will survive because everyone has the potential, and knows he has the potential, of becoming a patient. However, the term nurse may cease to exist as a label for a group of health professionals. Powerful enemies, within and outside the profession, could bring this about. The unique way of relating that which is nursing, however, will continue because human beings' needs will call forth this response from their fellows. For the term nurse to be considered obsolescent, or for us to lose this label, would be regrettable.

To be a patient is to worry, hurt, and suffer to a degree beyond one's own ability to heal or bear alone. At any time each human being has the potential of being a patient; some human beings are and will be nurses. Perhaps if we meet today's timely professional responsibility, theory building, those who stand totem-style on our should-
ers tomorrow will have more rugged and more abundant survival characteristics.

When a patient, I worry, hurt, and suffer, question my health, my survival. When my life is at risk, this is a most meaningful event in my life. I am a being in a body; through my body my being is touched and affected. Because of this body it is necessary to lean, to depend. I am very aware of and alert to those other beings who touch and affect me, who support me. How they touch and affect me and allow me to lean on them is important to me. I come to know something of them, and they call forth a response in me. They influence my world and my perception of it. On the other hand, in accordance with my state, I may experience others as more or less powerful, more or less benevolent, than they actually are. But because of their influence on my existence, I will always interpret these others in some way.

As a nurse, I am a presence with others whose health and survival are an issue; my existence is confirmed because of the difference I make. Through my patients I become. Frequently, I hurt, suffer, worry, and wonder with them. For instance, an intensive care coordinator recently walked with me through her unit, focusing on each patient en route. She briefly depicted each of their situations for me: their pasts and their expected futures as they affected their here-and-nows. It was as if this nurse lived eight persons' nightmares with them, all at once. Thus nurses, hopefully including myself, learn and become through relations with patients and each other.

Others, hurting and suffering, can call forth different responses or behaviors from me. Deliberately and awarely, I may turn to them, as I said, and be present to them, move into their realm and rhythm of existence. Or I may attack or flee, either physically or spiritually; I may exclude as best I can their pain, fear, anger, physical condition, appearance, caring. The many pressures of my nursing world allow ample justification for ignoring and avoiding aching, distorted, disintegrating, tortured persons. There are innumerable "matters of consequence" (as labeled by St. Exupéry's Little Prince) to consume me; there are paper-work pressures, effectiveness in technical medical skills, and functions to perform.

If we value the patients being nursed and the nurses who nurse, we must attest to the wonders of the human dimension expressed in and through nursing experiences. Many people are unfamiliar with the intimacies and pressures of these situations, though they want their fellow human beings (and someday themselves) to be cared for in health crises. These people must be made aware of the real values and meaning of nursing and nurses. I have expressed some of my feelings on these subjects in the following poem:
To live, really live, and have your living go unnoticed,
to have the other never recognize the depth of your concern,
the appropriate reward or appreciation never granted—
humans, nurses, need more.
Other men, can they become aware?

Nurse-to-Nurse Interactions

In my nursing practice in clinical areas I have frequent opportunities for interaction with other nursing staff. As a clinician and educator I deliberately spend much time with other nurses. I believe that in experiencing and valuing others and being with them, they in turn will give more value to their own abilities and presence with those they nurse.

One afternoon, after wondering about this presentation, I had three meaningful dialogues with nurses in medical-surgical areas. I believe that conceptualizing nurses' concrete clinical experiences will help us construct abstract theories of nursing. To illustrate this, I would like at this point to relate those three experiences and then, by elaborating on them, to show their relevance to nursing theory.

In one unit a young nurse had just experienced overwhelming rudeness from an older person of a different sex, profession, and culture. Broodingly, a middle-aged nurse colleague associated this verbal assault with a sexual assault she had personally experienced in a clinical situation many years ago.

On another unit, a nurse was holding her lower back. When I verbalized this observation, she acknowledged the pain. She had a residual back weakness since being struck years ago by a confused, drug-addicted patient. Her present discomfort had been activated by moving a helpless, confused person.

On still another unit, a nurse spoke to me about her own life-threatening physical condition and its meaning to her. She had struggled with decisions about her life and work, considering the possible imminence of death.

In the first encounter, the older nurse associated a verbal attack on a young colleague with a personally experienced physical assault of many years ago. This past traumatic event, though usually suppressed, had not been erased, and witnessing this current verbal attack
had activated the memory. The unresolved feelings of the old event were relived. Such an experience in youth can color and possibly even distort one's future experiences. On the other hand, if the nurse had worked through her feelings related to the event, what might she have learned?

Despite the superficial resemblance of two experiences, to equate verbal and physical attack is a gross distortion. Yet the experience of a blatant, unmistakable attack is likely to cause one to recognize other attacks, though less obvious, as threatening. However, this nurse had talked the would-be attacker down, pointing out the consequences of such an assault.

This event revealed a great deal about this particular nurse's ability to survive. She was not immobilized, nor did she wage an aggressive, physical counterattack. Rather, she emphasized her verbal skills, survived, and won.

For several years she has survived in the emotionally loaded, constant crisis health care situation—an area where crucial life-death, interdependent-interdisciplinary decisions and actions are almost a necessary constant and are often experienced conflictually by each involved participant. This is a realm where, despite caretakers' obvious uncertainty, time and change demand rapid decisions. Again, this nurse has survived in this difficult arena.

Like many of her colleagues, this nurse tries to appear one of the "imagined always strong." In some nurses, fright, depression, colitis, and other symptoms may reveal inner struggles for continued personal and/or professional survival. In a way, such a nurse is asking for help; and yet her background, including her nursing background, has not prepared her to accept and use available help. In my presence this particular nurse is very overprotective of her image of competence and strength. I feel I have been placed by her into a group she has categorized as "authority," to whom she must reveal only carefully censored behavior.

There are many indications in this incident about the human qualities necessary to survival in many health-crisis situations. It makes one realize the magnitude of the responsibility of deciding in non-emergency time who shall work where. Very serious thought must be given to the kinds of clinical support needed by and acceptable to patients and the nurses' preparation to give that support in light of the "pressure cooker" climate of nurses' eight-hour-a-day, five-day-a-week worlds.

Then there are the nurses who have spoken to me about their right to work when financially they do not have to. These nurses may have gone on a social route for a time, doing what they always dreamed of—bridge, golf, tennis, and beach. These activities did fulfill a part of them, but eventually boredom set in. Then a feeling of
superficial interhuman relations overwhelmed them. They felt lonely and wanted the experience of “aliveness of being” remembered from their nursing experiences. In Power and Innocence, Rollo May observes that, though we declare our hatred and disdain for war, yet wars have persisted throughout man’s history. Many of us nurses talk about the desperation of our nursing worlds, and yet we stay in them and survive. Occasionally, I hear pride expressed when I hear about this desperation. A question, similar to Rollo May’s question about war situations, comes to my mind about these nursing situations. What are the benefits of these crisis-type situations that cause nurses to stay in them? Do some nurses survive because of the desperation of their situations? What do these nurses experience in them? Do they need desperation to really experience their existing? Do such situations increase our awareness of our aliveness and our importance?

Reflection raises many deep questions and considerations. These questions need the attention of the nursing leadership. When units are staffed, when nurses are assigned, or when nurses ask for reassignment—what is deemed important, what is valued? Is it considered that staffing, assignment, and reassignment mean something to the real world of the nurse and therefore influence the quality of nursing?

Gabriel Marcel says that each human being is his own “live project.” Do we allow each nurse the right to be her own live project? Do we deny this, resent this, and feel inadequate at the suggestion that we do not know best for all concerned? Do we accept the fact that man is a contradictory being? Or do we project onto others our nonacceptance of our own human contradictoriness and overreact when those others change their minds? How do we feel about each nurse being responsible for the consequences of her acts, or her failure to act?

Theoretically, and depending on the climate of the nursing situation, nurses, who are of necessity deeply involved, periodically (and sometimes regularly) need nursing, comforting, nurturance, clinical relating, and empathy. A long time ago at a national nursing meeting, one of our leaders reported almost gleefully on a study (done by members of another discipline) that purported to show how “inadequate and inept” nurses really are. One of nursing’s truly wise, but usually quiet, thinkers replied. Softly, yet with an intensity that reflected my own feelings, she asked, “When are nurses going to nurse nurses?”

The second confrontation was with the nurse whose lower back pain had begun that morning when, with her foot, she had protectively shoved a stool out of the path of a confused patient with a partially paralyzed leg. The resulting back pain stimulated this nurse
to remember an incident which had taken place a number of years ago, when she had risked herself to protect a colleague who was being physically threatened by an out-of-control patient. In this old situation, the patient had pushed her roughly, which had caused the sensation of a spring unwinding in her lower left back. She had narrated all the above and much more rapidly and in an unpunctuated manner. The form, quality, and intensity of expression revealed, more than her words possibly could, the condition of her being. She was not experiencing acknowledgment from the bureaucracy, which did not seem to value her efforts, caring, and investment. Since the community sets up cultural symbols which indicate, "We value and respect the presence of your doing and being in our health care system," what happens to nurses and consequently nursing when they fail to receive comforting, nurturing, clinical relating, empathy?

This particular nurse is representative; throughout her 19-year professional career she has given much to patients and health colleagues. I happened upon her when her physical discomfort had triggered her human suffering and floodlighted multiple abuses and ever-deepening scars. How much bounce of spirit, considering the constant onslaught of threats to human beingness, can one realistically hope for?

I was aware that this nurse had withdrawn from “alcoholic” and “psych” patient situations. Now I understood better that what she experienced in a current situation seemed to her similar to the incident of long ago. I felt less blaming, less like shooting a righteous lecture her way; I felt more like her, and easier about being with her. Our relating moved beyond the walls of our histories and our beings were opened to each other. Perhaps now I will be able to offer her my presence in her fear, anger, and disappointment.

My encounter with this nurse reaffirmed my knowledge and awareness that, when a person relates in detail an old traumatic event, one should be alert for an experience that has occurred and that has aroused old, residual responses. The old wound has been irritated, opened. Today’s event is viewed and filtered through the veil of yesterday; the differences are simply but unwittingly ignored.

By truly listening to others and living the past events through with them, their hurt, fear, and anger will dissipate, and the long-established, solid, non-pliable mass will thin out, soften, become porous, and allow reinterpretation. Lived events, facts, and specifics are not erased. However, revisited and reconsidered, a new perspective may be possible. Time, maturation, recategorization, restructuring can change old shadowing, inappropriate flavoring, and persons’ appetites and expectations. Latent potentials can thus be freed for actualization.
It is possible that, through empathic relating in the clinical situation, we can come to understand rather than blame nurses for their attitudes towards "alcoholics" and "psych" patients. They, in turn, may be able to open themselves to these patients in a nonjudgmental and understanding way. Humans in their suffering often need others to establish external controls; I question whether they can ever use others who establish external blame. A person's own internal blame system is usually more than adequate, frequently monumental. Part of human suffering is the inability to trust others with one's internal system; maybe because one's system is too fragile, too unacceptable even to oneself, or maybe because this system has been badly abused.

In the third encounter, the nurse had a life-crippling physical condition. Though not currently painful or activity-inhibiting, her symptoms kept her aware of her condition. I was aware of this nurse's diagnosis, but in prior contacts with me she had limited our dialogue to her nurse-patient situations, which were often nursing situations involving health workers' responses to critically ill patients. In these discussions, my focus, purpose, and responses had a deliberately dual dimension.

On this day her anger—really her manner of expressing acute fear—was directed at administrators' expectations of staff, especially as regards rotation of tours of duty. Since this nurse is bright, her criticism was clever and had real style. If I had been an administrator, I might have unwittingly and defensively turned her off or responded with reciprocal anger. Not being or feeling responsible for unit staffing policies, I was able to observe her high-pitched, clipped voice, her darting eye, and her jerky, aggressive body movements. These said, "I'm so upset; everything in my world seems bad and wrong." So I listened, commented, and questioned. I wanted to keep communications open in order to understand better. Then this nurse's manner changed.

She confided to me that she was awaiting the results of a recent test to determine the current state of her health. She was to contact her doctor, who was difficult to reach. Later she said, "I keep forgetting to call him." (How very, very human, when one fears what the other will say.) I asked this nurse to give me some background diagnostic data so that I could better understand what she was experiencing. I thought that by expressing herself she might clarify her situation for herself and be better able to make decisions.

After being divorced for several years, this nurse had recently remarried. Her symptoms became evident after this. Initially she adjusted her life-style, thinking this might be causing her symptoms. But her symptoms continued. Several medical specialists and diagnostic tests later, her incurable, crippling condition was conclusively diagnosed.
She pondered aloud how long she would be able to function and how she should use her time. Ruefully she described a past where things had happened to, had been imposed on her. She had lived a lonely childhood. Impulsively, she married at 17 and immediately became pregnant. She said with forceful anger, "And I remained pregnant till my fourth child was born." While her husband worked at two jobs, she kept house and brought up the children. Her husband, prior to the fourth child's birth, left her suddenly. Her small physical presence seemed to fill the room with the weight of her burden.

Hoping to encourage her, I asked, "Do you share your concerns with your current husband?" She responded, "He's very reserved, very involved in his work world, except for a long close relationship with his partner." With a pained facial expression, she added, "I don't know how to say this; I am suspicious about what goes on between them. They talk quietly together, so much." Her suspicions were considered, but still not accepted as certainty. Her diagnosis was proffered as a possible reason for his needing a confidant. She wondered, "Should I stay married; should I have remarried?" She spoke wistfully about other ways of life. Significantly, visiting her first husband's hometown in South America headed her list. Despite the fact that many years had intervened between marriages, I wondered if this nurse had ever been helped to grieve the loss of her first husband. Rather, it seems these unresolved feelings towards yesterday's actualities were distorting her responses toward today.

I asked, "Can you talk with your grown children, your son or daughters, about your condition, your concerns." She said, "Well, not really; none of them live with me." Elaborately she described her suspicions about each child's activities. Considering how rigidly and narrowly she views significant others, it is easy to guess that her internal private self-judgment is quite painful. Projection appears to be a strong mechanism in this nurse's response to her world.

Abruptly this nurse asked, "If you pass a telephone with an out-of-town directory, could you look up my doctor's number?" She had forgotten his telephone number and had not brought it with her, even though the results of this last test should indicate the rate of progress of her disease over the last two years. Two specialists had indicated that this rate of progress would indicate prognosis and the length of her life.

I viewed this nurse as immobilized, blocked mentally from acting by fear and anger. My past education, experience, and nonadministrative position allowed me to understand and accept the inappropriate fierceness of her expression of anxiety at rotating tours of duty. How difficult it often is for usually independent persons who have had intense, lonely life struggles to reach out in an easy, direct
way for help and understanding. So many nurses and others have had to be independent and pride themselves on that independence. Often they experience themselves as "the bad child, the inadequate one," if they are forced to reach out to others. Their means of asking, then, often begs for rejection: it is an unaware yet deliberate defeating of one's own purpose. Because of the obscurity of the request for assistance, the person approached may go away never having recognized the plea. Listening carefully in a human dialogue, not to the literal words only, often reveals the person's real message. Attention to such professional clinical listening and responding builds one's empathic capacity to understand. The result is the basis for choosing our response in accordance with our values as nurses.

Why have I related these particular here-and-now experiences of my nursing world? One, they exemplify the effects of the past and future on other persons' here-and-nows. Two, they typify many of my past transactional relations with both nurses and others. Three, I value these experiences. Four, these situations have the potential for the actualization of humanness. Five, through reflection on these situations my nursing values become apparent, available for conceptualization, abstraction, and theory building.

TOWARDS FURTHER ABSTRACTION

A nurse striving for increased conscious awareness of the meaning of her existential experiences gains in distinguishing the here-and-now from what it calls forth from yesterday and what it touches in her imagined future. This ability to distinguish allows an appropriate and relevant human response.

For instance, if a patient revealed to me an old experience of sexual assault prior to a complete physical examination, before or after surgery, or prenatally, I would consider the recalling of this event as meaningful to the patient only within the context of the here-and-now situation; I would not consider it as an indicator of how a nurse might react when a patient in a constant crisis "dumped" his feelings of inadequacy and uncertainty on her. When, where, and to whom something is expressed relates to a person's experiencing of the here-and-now. The meaning we attribute to the content of the message must be based for reality's sake on these factors. In the abstract: a nurse interprets and acts on a unique person's message viewed amidst his or her particular situation in the world.

In the example where the nurse's old back injury was aggravated in the here-and-now, she did not need a lecture. Health education and body mechanics are her areas of expertise. Furthermore, educational information on the needs of the acting-out, ag-
gressive, confused psychiatric patient offered at that time would neither have opened her mind, soothed her soul, nor cured her back. Her anger provoked by and directed at out-of-control, psychiatrically labeled individuals was more related to her unresolved needs to be omnipotent. And to her authorities' lack of omnipotence. The answer would be to alleviate the psychiatric patient's misery and therefore this nurse's suffering at feeling helpless. We must confront our own feelings of helplessness if we are to see beyond them. This nurse, like other professionals I have encountered, associates her latent anger with "psychiatric" patients, "alcoholic" patients, patients helplessly out of control, and patients projecting their anger at not being healthy. These types of patients can arouse unresolved childhood omnipotence needs. Often the intensity of expression of these needs leaves one wondering if the "answers" are not in well-encapsulated memories somewhere in these nurses' pasts, created by relevant family situations that may have been much more devastating than the suffering of patients in current situations.

Each nurse is her history and of necessity this affects her inner responses to her nursing world. Awareness of the meaning of her personal history enables her to be in charge of it, rather than for it to be in charge of her.

In my nursing world, existentially aware in my here-and-now, I might offer this nurse the soothing, healing balm of understanding, recognition, and acceptance of her suffering conveyed through presence and few words. This is very difficult; it requires both intellect and self-discipline to confirm and let the other be—both his expressed and unexpressed selves—when he experiences and interprets the world in a manner different from our own. The meetings between myself and these other nurses could well have been between myself (as a nurse) and a patient. Patients frequently tell nurses events aroused from their past by similar events in their current worlds, e.g., a past hospitalization, a previous surgery, another accident, recalled embarrassments, a visit from a significant other. Such described past events allow a nurse to understand better what a patient is experiencing in his here-and-now.

What is expressed now to a significant other is relevant to now. There is a testing and safeguarding in its being revealed through a past experience; questions hang in the air. "Will you assume? Will you judge? Will you be available to me in my uniqueness?" Deliberately empathic listening makes it possible to hear and, through imagination, to live in another's world—in their time, space, and perspective—long enough to understand that other person. Struggling together allows the distinguishing of his today from his yesterday. Sharing your view without imposing it requires an appreciation of the need for an expertly and individually sculpted key. Attempting to
control how the other experiences today often provokes his installing additional locks, or doors, or entirely walling off the entry to his point of view from your possible contamination.

Hearing the quality, the feelings and pattern of a past event, rather than only the explicit message of the words, might better allow a nurse to experience being with, accepting and offering herself, alleviating aloneness. In turn, the other will possibly strive to be more in accord with his unique possibility in this time and situation.

The third example demonstrated how a person experienced and expressed the anger and fear aroused by her impending loss, separation, and death. Initially through discussing “rotating tours of duty,” this nurse had revealed the condition of her spirit. A patient might attempt a similar expression of anger or fear by criticizing his nurses, doctors, medication, or dietary regime.

When such communications are initiated frequently, a patient, though unaware, is deliberately and prudently testing. “Will you, can you listen to me, to the real me?” The nurse who passes the test, who does not defend grandly or break into a fury of activity, is the nurse who conveys that she is trying to understand better how he is experiencing his world. To such a nurse the patient can give his gift. Together, in an I-Thou relation, they can acknowledge their existence and the Heaven-Hell of each. The patient can share his real message: anger at the unknown, his condition, his fate. Together, aloneness is alleviated; in communion his reality, his existence, his condition is confirmed. Through being with, truly with, the patient, it is impossible for a nurse not to recognize and actualize her own and nursing’s potential human value.

After offering presence to the person who in experiencing is suffering fear, anger, and inadequacy, we too live these feelings. Transcendence of self then becomes imperative. A nurse must step back, look inward, and learn to distinguish the self from the other. She must acknowledge these feelings as having been aroused by the other person’s experience, not in or by her own life experience. Such taking on and later sorting out of self and other is necessary: (1) for a true understanding of the other, (2) for the other to experience a sense of being important, and (3) to survive the ongoing bombardments of others’ feelings.

Prior to stepping back, each of us, in accordance with his or her uniqueness, must experience the feelings of the other. We may initially experience an urgency to do, a desire to ignore, or a panic compelling us to run. Awareness of the prereflective, lived experience can be our clue—our inner self telling us it is time to introspect, to reflect, to sort out self and other. After this process, recognition that we have already nursed the other is apparent. Simplistically, one can say that the depth of feelings we have experienced equates roughly with the
depth of human relief the other experiences. This is an aspect of the mystery of interhuman relating, a result of the human's capacity to hear, to care, and to become.

A CULMINATION FOR FURTHER EXPLORATION

This presentation has aimed at presenting a word picture of the way I envision my nursing world and the relation between theory and practice.

Why? The six reasons theory furthers the practice and profession of nursing by offering a resource were stated earlier in this presentation.

What? Nursing theory is made of phenomena abstracted from multiply varied, specific and concrete nursing situations and related to one another to make the meaning of practice explicit and comprehensible. Nursing theory could do with quality nursing descriptions what a statistic does with quantity nursing samples. It can bring many under the umbrella of a meaningful few.

How? Through describing nursing—or the act of nursing as it is experienced by nurses in relation with other human beings—phenomenologically. In the author's Humanistic Nursing courses involving 102 registered nurses, most have selected a phenomenon they viewed as essential to nursing. Forty wrote clinical papers which focused on their selected phenomenon. Phenomena which these practicing nurses selected as essential to nursing are:

- acceptance
- authenticity
- awareness
- becoming
- caring
- change
- choice
- commitment
- confirmation
- confrontation
- dedication
- dying and death
- food—its meaning
- freedom
- frustration
- give-and-take
- laughing-crying
- loneliness
- openness
- patience
- readiness
- response
- responsibility
- self-recognition
- sustaining
- touching
- trust
- understanding
- waiting

This presentation has been a glimpse of how my co-workers and I are making beginning attempts to describe man's becoming in nursing situations, nurses' self-actualization, and our visions of nursing theory and nursing science.
THE "HOW" OF THEORY DEVELOPMENT IN NURSING

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I have tried my best to be wise. I declared, "I will be wise," but it didn't work.

Wisdom is far away, and very difficult to find.

I searched everywhere, determined to find wisdom and the reason for things, and to prove to myself the wickedness of folly, and that foolishness is madness.

Ecclesiastes 7:23-25 (paraphrase by Kenneth Taylor, The Living Bible)

It seems that people have been searching for "the reason for things" for centuries, so we in nursing are not unique. We are finding that "wisdom is far away, and very difficult to find"; however, it is not impossible. I would like to explore the method of finding this wisdom, or the "how" of theory development in nursing.

This "how" includes more than method and process, for there are two general requirements one actually needs to develop theory in nursing. The first is to identify one's philosophy of science; this provides for the structure of the theory to be developed and gives one the rules and standards for the way to develop theory. The second requirement is to identify one's philosophy of nursing. This furnishes one with the guidelines for the content of the theory; it supplies the criteria for selecting and analyzing the problems. These two requirements are not always consciously identified, but it is very helpful if they are.
THEORY STRUCTURE

In order to put theory development into its total perspective, I will present some aspects of theory structure from my philosophy of science. First, I will briefly describe the levels, components, and scope of theory. Then I will give the method and process of theory development and show how all of these are related. Finally, I will give an example in relation to a specific nursing theory.

Theory Levels

Theory consists of the abstract world as well as the real world. It is not one or the other, but both. As a matter of fact, the real and the abstract represent levels of theory. The abstract level is the general or the conceptual level of knowledge, while the real-world level is the level of particulars, of empirical knowledge—the practice world. For example, the idea of self-concept is an abstract or general notion, but the measurement of one individual’s self-concept is a particular bit of information at the real-world level.

In nursing there has been difficulty bridging the gap between the real and abstract levels, since nursing has been oriented primarily to the real world or the practice level.

Theory Scope

While the level of a theory is dependent on the degree of abstraction, the scope of a theory is determined by its breadth or extent. There are three different scopes of theory. The first and narrowest is referred to as the “phenomena,” “micro,” or “factor” scope. Some of the work dealing with decubitus ulcers and energy expenditure for nursing tasks would represent theories of this scope.

Of a broader range would be the theories referred to as “set of phenomena,” “middle-range,” or “situation/factor” scope. This

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4 Millman, loc. cit.
6 Dickoff et al., loc. cit.
range of theory lies between the minor working theories and the all-inclusive efforts. One such as Maslow's theory⁷ and the various family theories would fall into this range.

The third and broadest range is that of "general-general,"⁸ "macro,"⁹ or "situation"¹⁰ scope. Martha Rogers's theory would be one of such scope.¹¹

Ideally, a theory should be developed and eventually built in all three scopes. For example, adaptation could be classified at the very broadest range, and stress, coping, and crisis could be grouped at the middle range, with the effect of sudden infant death syndrome on a family at the narrowest range.

There is a relationship between scope and level, with the two broader ranges being at the abstract level and the narrowest scope being at the empirical level.

As a point of interest here, conceptual frameworks, like ones used in curriculum planning, are of a much broader scope than these three and would consist of any number of theories from all of the scopes, rather than just a single theory.

Theory Components

A theory not only has levels and scopes, but also consists of two basic components: units and statements of relation. While these are often confused in theory models, the units consist of facts (or phenomena) and concepts. The statements of relations consist of premises and propositions. The names given these components vary considerably from author to author. For instance, the term construct may be used in lieu of "concept," or the term law instead of "proposition." The concepts are related by the propositions and are based on the facts which are related by the premises.

The theory components are also closely related to levels, with concepts and propositions at the abstract level, and facts and premises at the empirical level. An example of a "concept" could be noncompliance; the related proposition might be: noncompliance is related to inadequate knowledge. At the empirical level, a "fact" could be the omission of a medication, with a possible premise that the number of medication omissions is related to the level of knowledge about that medication.

⁸ Millman, loc. cit.
⁹ Etzioni, loc. cit.
¹⁰ Dickoff et al., loc. cit.
These characteristics of level, scope, and components are basic to the description of the method and process of theory development.

METHOD OF THEORY DEVELOPMENT

The methods of theory development most often cited are induction, deduction, and hypothetico-deduction.\textsuperscript{13,15,16} Inductive thinking moves from the particular (or empirical) level to the general (or abstract) level. In the narrowest sense, induction is merely an enumerative process which can result in false conclusions if no negative cases are observed. If theory building were done by such a mechanical procedure, then we should have a cure for cancer. Glaser and Strauss focus on induction in their work in grounded theory.\textsuperscript{15} Although I do not know how she developed her theory, it would seem to me that Ida Orlando used induction primarily.\textsuperscript{16}

Deductive thinking, on the other hand, moves from the general to the particular by inference. Deduction plays the part of eliminating unsuitable hypotheses without the problem of testing them. It leaves only the surviving hypotheses to be confirmed or rejected by investigation. It would appear that Martha Rogers used the deductive process for her theory.\textsuperscript{17}

The hypothetico-deductive method combines inference and observation, deduction and induction. By this method the inferences (or propositions) are tested through empirical hypotheses.

All methods are acceptable and may be used in combination; they merely describe the direction of movement for thinking between the levels of theory. The steps in research depict this movement back and forth between levels of theory: the theory model, the theoretical definitions, and the conclusion are all steps of the research process on the abstract level, while the hypothesis, the operational definitions, and the findings are on the empirical level. As the research proceeds, there is movement back and forth, using both the inductive and the deductive methods.

\textsuperscript{17} Rogers, op. cit.
PROCESS OF THEORY DEVELOPMENT

The theory development process consists of four steps, which are: to describe, to explain, to predict, and to prescribe (or to control).

To describe is to list and define facts or concepts. For instance, to describe "A," "B," and "C," or to describe concepts such as stress, coping, and crisis.

To predict is to establish the sequence of relations between facts or concepts. What are the sequences of relations between "A," "B," and "C"? Either coping or crisis can follow stress; crisis may also follow coping and coping may follow crisis.

To prescribe is to control events so that the preferred outcome occurs—either "A," "B," or "C." In this case, either coping or crisis can occur. Since coping is the preferred outcome, events are controlled so that coping occurs rather than crisis.

These steps can be carried out at either the empirical or the abstract level and are not all necessary in order to have a theory. For example, it is possible to predict without having a theory, as is the case for treating hiccoughs by prescribing the ingestion of granulated sugar without knowing how the sugar accomplishes this.

Nevertheless, the goal is to develop theories that include all of the steps at both levels. One problem involved in developing a predictive theory is that one must have measurable values of the facts or concepts in order to predict. Even when there are measurable values, events are considered in degrees or in probability rather than as true or false and are therefore predictions for groups of people rather than for an individual instance.

THEORY STRUCTURE PARADIGM AND CRITERIA

The diagram on page 72 is a summary of the preceding information; it is a paradigm for theory structure. It may be used as a basis for determining criteria related to the structure of a theory. For example, a criterion for levels of theory would be that the empirical and the abstract be related. This would not be true if you have only an empirical-level theory, but the empirical theory could be a stage of development toward the abstract-level theory.

Criteria for method would be that the method be valid and logical. For scope, the criteria would be that the boundaries be clear, that there be breadth and general applicability. The components should be defined operationally and theoretically, logically related, flexible, reliable, and adaptable to the theory model. The research process should test the validity of the theory and have quantitatively
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<thead>
<tr>
<th>Level and Method</th>
<th>Scope</th>
<th>Components</th>
<th>Research Steps</th>
<th>Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract</td>
<td>General-general Macro</td>
<td>Concepts/ propositions</td>
<td>Model</td>
<td>Describe</td>
</tr>
<tr>
<td></td>
<td>Macro Situation</td>
<td></td>
<td>Theoretical definitions</td>
<td>Explain</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Conclusions</td>
<td>Predict</td>
</tr>
<tr>
<td>Induction</td>
<td>Set of phenomena</td>
<td></td>
<td>Hypothesis</td>
<td>Prescribe</td>
</tr>
<tr>
<td>Deduction</td>
<td>Middle-range Factor/situation</td>
<td></td>
<td>Operational definitions</td>
<td></td>
</tr>
<tr>
<td>Hypothetico-</td>
<td></td>
<td></td>
<td>Findings</td>
<td></td>
</tr>
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<td>deduction</td>
<td></td>
<td></td>
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A PARADIGM FOR THEORY STRUCTURE
diverse hypotheses. The theory development process should be conducted in a logical, valid manner, and the theory should include all of the steps of the process.

The Paradigm and a Nursing Theory

Now look at this paradigm in relation to nursing. Start with a nursing problem on the empirical level; for instance, the case of the woman who still could not look at her radical mastectomy scar some weeks after her surgery. Next, move up to a theory or theoretical model. You could use stress theory since the traumatic experience of the mastectomy was certainly a stress situation. Or you could use a theory of grief or crisis or coping or adaptation, since her reaction involves such problems. Or you could use stimulus-response or behavior modification because the behavior she is presenting is not desirable and you need some method to help her change. Or you could use self-concept theory since her problem is related to her self-image. You might even select a conflict theory or a change theory, although they are oriented more to groups than to individuals.

Perhaps this seems absurd, but the point is that the same problem can fit a number of theories; thus, it is important to select the theory compatible with your philosophy of nursing. In fact, you can flounder at this point unless you have a clear nursing frame of reference. Research studies done without a nursing-theory focus may end up being just a set of unrelated studies.

Now look at the problem using Orem's theory. She states that "nursing has as its special concern man's need for self-care action and the provision and management of it on a continuous basis in order to sustain life and health, recover from disease or injury, and cope with their effects." How could this woman with the mastectomy care for herself if she cannot even look at herself? Her problem of self-care is related to her self-concept.

Therefore, the abstract-level components of this theory would be the concepts of self-care conduct and self-concept, and the proposition that self-care conduct is related to self-concept. The theoretical definitions would be: (1) self-care conduct "refers to actions based on culturally or scientifically derived practices freely performed by individuals (or their agents), directed to themselves or to conditions or objects in their environments in the interests of their own life, health, or well-being"; and (2) self-concept is an individual's perception of himself/herself.

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The empirical components would be the fact of self-care conduct following a mastectomy and the individual self-concept; the premise would be that self-care conduct following a mastectomy is related to self-concept. Operationally, self-care conduct is defined by the score obtained on a tool measuring postoperative self-care practices, and self-concept would be the score obtained on a tool measuring self-concept. The hypothesis would be that there is a correlation between postoperative mastectomy self-care conduct and self-concept. This theory would fit into the middle range with testing at the level of phenomena.

If the findings should show a positive correlation, then the conclusion would be in support of the proposition that self-care conduct is related to self-concept.

**COMMENTS ON THEORY DEVELOPMENT IN NURSING**

I have stressed method and process in the “how” of theory development in nursing, but I do not believe that the use of these is a primary problem. Nursing is moving from actions based on facts, or limited units of knowledge (such as nursing procedures), to actions based on theories or broad units of knowledge with wide applicability (such as the developmental theories). We are a practice discipline, but we must not be exclusively practice-oriented.

Therefore, we in nursing need to accept the importance of theory to practice; we need to teach principles that enhance practice, rather than procedures that hamper it; we need to support those who have the creative ability to develop theory; we need to be more productive in conducting high quality nursing research regardless of the support available; and last, but most important, we need to know what nursing is, to have our own philosophy of nursing clearly in mind, but also to have a conceptual framework that accepts nursing theories of a different focus, even though we may not agree with them.
EVALUATING NURSING THEORY

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In recent years, the discipline of nursing has invested considerable time and effort in developing paradigms, theories, models, and conceptual frameworks to direct nursing practice and to establish the boundaries of its knowledge. Nursing conferences, journals, articles, and graduate curricula reflect this interest and concern. Nurses are now asking significant questions, such as: What is nursing theory? What theory can nurses use? What is a theory as opposed to a conceptual framework? Although some of us may at times be dissatisfied and impatient at the speed with which these questions are being answered, perhaps we can gain a better understanding of theory development by looking at the total process objectively.

The confusion and lack of consensus about "what theory is" and "what nursing theory is" may be typical of the early stages of scientific development in any discipline. Thomas Kuhn, in his significant book The Structure of Scientific Revolutions,1 presents a fascinating thesis on the development of scientific knowledge; some of his points may shed considerable light on nursing's concern with theory. Kuhn has pointed out that the early stage of scientific development, the pre-paradigm stage, is characterized by divergent schools of thought which, although addressing the same range of phenomena, usually describe and interpret these phenomena in different ways. It seems to me that nursing is now in this pre-paradigm stage.

Kuhn challenges the commonly held belief that knowledge advances in a cumulative manner and he questions the belief that science has achieved its present status through slow and steady increments of knowledge. He proposes that science advances through revolution. In his view, a prevailing paradigm with its associated theories, concepts, and research methods is overthrown by another paradigm with its own theories, concepts, and methods. When this revolution occurs, the new paradigm is embraced by the majority of scientists in that discipline. The new paradigm accounts more fully for what had been anomalous data and in general seems more plausible than its predecessor.

Kuhn has identified several types of paradigms. The general type (metaparadigm) refers to a total world view or gestalt. The prevailing paradigm (1) is accepted by most of the members of a discipline, (2) serves as a way of organizing perceptions, (3) defines what entities are of interest, (4) tells the scientist where to look to find these entities, (5) tells him what to expect, and (6) reveals how to study them.

What do paradigms have to do with evaluating nursing theory? When there is a prevailing paradigm—a world view accepted by the majority of the scientists in that field—the normal work of science is purposeful, orderly, and raises fewer unanswerable questions. Anomalies in data are ignored. If nursing had a prevailing paradigm, the evaluation of its knowledge might be an easier task. At this time, I do not believe that nursing has a prevailing paradigm. Rather, several pre-paradigm schools of thought exist.

When a dominant or prevailing paradigm does not exist, a discipline may be in a situation of crisis with competing paradigms, or it may be in a pre-paradigm stage where much energy goes into defending differing ill-defined perspectives and justifying one’s concepts. If a discipline is in a pre-paradigm stage, there is little agreement among its scientists as to what entities are of particular concern, where to locate these entities, or how to study them. It seems to me this is where nursing is today, with much of its energy going into justifying the correctness of one of the several embryonic paradigms. As a result, research is often poorly focused and unsystematic; confusion exists as to what exactly nursing should be studying.

I have introduced Kuhn’s ideas of paradigms and scientific revolution to suggest that the development and evaluation of knowledge relevant to nursing may proceed at a very slow pace, not because nurse-scientists lack the necessary ability or tools, but because time is being devoted primarily to justifying one of the pre-paradigms. Furthermore, without a prevailing paradigm to provide a focus for the work of nurse-scientists, knowledge develops slowly and it is not clear just how this knowledge should be evaluated.
If Kuhn's conception of science is correct and if nursing is indeed in the pre-paradigm stage, as I suggest, then nursing's concern with conceptual frameworks, models, theory construction, and research methods is all part of an evolutionary process that other disciplines have either passed through or have yet to face. Although this period of theory development in a discipline is characterized by ambiguity and uncertainty, nurse-scientists can, nevertheless, contribute constructively to the development of the knowledge base of nursing by being well-informed and actively participating in both theory construction and research. The perseverance of nurse-scientists in developing knowledge that may solve very specific nursing care problems is vital.

Nurse-scientists who realize that the pre-paradigm stage of science is characterized by confusion, frustration, the defense of theory and research, as well as by power struggles among factions within the discipline, may be able to raise themselves from the verbal battleground and use their efforts and skills in developing sound nursing knowledge. This working group of nurse-scientists may well make significant contributions to the development of a predominant paradigm in nursing. This paradigm, with its prevailing *gestalt*, will make it possible for nurses to define their own "turf" and subject matter. While working on knowledge for practice, nurse-scientists must at present, I believe, tolerate loosely constructed theoretical notions. This pre-paradigm stage of nursing science is not only difficult for those developing theory and research, but also for those who attempt to evaluate nursing knowledge.

Before I address the question of theory evaluation, the term *theory* must be defined. In common usage, the meaning of "theory" ranges from a hunch or a speculative explanation to a plan and a body of established knowledge. Kaplan elaborates on the process of theorizing. He suggests that theory formation might well be the most important and distinctive characteristic of human beings. He does not imply that it is a process removed from experience, but rather that it is the symbolic dimension of experience as opposed to brute fact.²

In science, the term *theory* refers to a set of verified, interrelated concepts and theoretical statements. In his discussion of man's ability to develop scientific theory, Kaplan says:

In the reconstructed logic, ... theory will appear as the device for interpreting, criticizing, and unifying established laws, modifying them to fit data unanticipated in their formulation, and guiding the enterprise of discovering new and more powerful generalizations. To engage in theo-

rizing means not just to learn by experience but to take thought about what is there to be learned.³

I have drawn upon Kaplan’s work for two reasons. First, to identify what theorizing is, and second, to point out the vital part that experience plays in theorizing. The latter is something which nurses will do well to remember.

Since a theory is a validated body of knowledge about some aspect of reality, it is only reasonable that nurses should now concern themselves with identifying aspects of reality they wish to focus on, attempt to identify relevant theory, and evaluate the soundness of the knowledge they develop or draw upon. The scientist, in developing theory, looks for lawful relationships, patterns, or regularities in the empirical world. These lawful relationships between concepts, sets of facts, or variables are carefully studied in order to identify conditions which modify or alter the original relationship.

Few “theories” in nursing or in disciplines relevant to nursing are sufficiently well developed to permit specification of both the lawful relationships and the conditions under which these relationships are modified. Perhaps behavioral modification might be an example of a theory used by nurses that specifies lawful relationships and conditions altering them. For example, the relationship between specified behavior and reinforcement is a lawful relationship. Furthermore, the relationship between exhibited behavior and reward alters according to the type of reinforcement schedule employed.

As noted earlier, Kaplan has addressed the interrelatedness of theory and experience. In the health professions, scientists and practicing nurses frequently characterize each other as being out of touch. The nurse-scientist is typified as a thinker and as being unconcerned with the practice setting, while the practitioner is characterized as being a provider of nursing care and is sometimes referred to as a technician. It is from the practice setting that the nurse-scientist should get ideas to work on, and it is for the nurse in the clinical setting that the work is being done. If the nurse-scientist is to be the major developer of theoretical knowledge, then the practitioner must be in a position to provide the nurse-scientists with research-worthy problems and, at the same time, be able to evaluate the knowledge generated for its soundness and applicability. A similar symbiosis has been found highly successful in other fields. For instance, the theoretical physicist develops ideas and the engineer makes use of those ideas for the practical benefit of mankind.

³ ibid., p. 295.
NURSING THEORY

Nursing has a legal mandate from society to use its specialized body of knowledge and skills for the betterment of mankind. The mandate implies that the body of knowledge will be in a continuous state of growth to provide the basis for nursing skills necessary to meet the changing health goals of society. Furthermore, nursing has a mandate to regulate the practice of nursing, to control the qualifications of its practitioners, and to develop the measurement of knowledge.

Clearly, the majority of nurses are "doers" or practitioners. Nursing must also include persons who are scientists dedicated to the explanation of knowledge. Scientists are committed to finding things out, to obtaining an understanding and an explanation of phenomena in their world. The practice of nursing and the scientific discipline of nursing, as pointed out earlier, are not antithetical. Nurse practitioners need nurse-scientists in order to carry out society's mandate, and nurse-scientists need nurse practitioners to identify problems and questions arising in nursing practice. It is important that theoretical knowledge be empirically sound, that theory be internally consistent, and that theory be useful and encompass significant concepts and conditions which can be modified in the clinical setting.

These criteria are not the usual major criteria used by scientists to evaluate theory, but are important to persons applying knowledge in the clinical setting.4 Since nursing draws upon psycho-socio-biological knowledge, it is free to draw upon the knowledge developed in these disciplines; it also has an obligation to alter the theories it draws upon appropriately so they fit the problems and needs associated with nursing care. I believe that there is no reason for nurses to spend years of diligent work duplicating knowledge that already exists in other disciplines. However, when knowledge from another discipline is considered, such knowledge must first be empirically validated to determine if the theoretical generalizations are applicable to conditions found in the clinical setting. For example, generalizations from cognitive-dissonance theory should be assessed to see if they can be used by nurses; it is conceivable and, in fact, likely that modifications will need to be made in this theory before nurses can utilize it appropriately.

Consider the number of man-hours which have been expended in developing theoretical frameworks on role and on social exchange. If nurses wish to make use of these two sets of knowledge, they will need to determine how, when, and where the concepts and empirical generalizations are applicable. It is likely that nurses will identify

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conditions that are unique to nursing practice and that alter the generalizations identified by social scientists. Nurses may also need to add to the theoretical terms that the original theory encompassed.

THEORY DEVELOPMENT

If nursing is in the pre-paradigm stage, consideration must be given to the level of theory development and the type of theories or paradigms which exist. Given a set of criteria for evaluating theory, the evaluator must make a decision as to which body of knowledge can be evaluated or treated as theory. A body of knowledge which is in the pre-paradigm stage cannot be evaluated as a theory, nor can formulations which are "grand theories" or philosophies about nursing. These formulations can provide neither solid nor practical foundations for nursing practice.

A theory which is in the early stage of development is characterized by discursive presentation and descriptive accounts or anecdotal reports to illustrate and support its claims. The theoretical terms are usually vague and may be close to everyday language. In general, the terms are not specifically defined. Paradigms at this stage of development are very readable and provide a perspective rather than a set of interrelated theoretical statements. This type of formulation generally lacks empirical support; the empirical illustrations are not tests of the theoretical perspective.

Another type of formulation found in the pre-paradigm stage is the "grand theory" or "general orientation." Merton has addressed the problems of these global perspectives which are aimed at explaining the totality of behavior. In addressing the problem of grand theories, Merton makes a plea for scientists to move into the study of partial theories. Grand theories tend to use vague terminology, seldom clearly define their terms, leave the relationships between terms unclear, and provide formulations which cannot be tested. Examples of grand theory or pre-paradigm formulations might be Parsons' theory of social systems, formulations by Martha Rogers and by Orem, crisis theory, and some of the stress formulations. These all present unique ways of looking at reality; however, with vague and ill-defined terms and questionable linkages between their concepts, they are impossible to test empirically. Testability of a theory is one of the most important conditions a formulation must

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80
meet. "Testability" refers here to the possibility of refuting claims made by the theory.

It seems that scientists have been successful in working on what might be called circumscribed theories. The task of adequately testing grand theories was sufficiently overwhelming that scientists were forced to turn to circumscribed theories. These theories may become paradigms; the move from grand formulations to circumscribed theory may move a discipline from the pre-paradigm stage to a stage where multiple paradigms exist.

The circumscribed theories focus on selective aspects of behavior such as communication, social exchange, role behavior, and self-consistency. With time, these formulations lead to explication of theoretical terms and testable hypotheses. Carefully designed studies can be used to test hypotheses deduced from such theory. The cumulative research and resulting theory are sound. There is still much work required on these paradigms; of the various existing paradigms one may eventually predominate or perhaps several will combine into a new paradigm which will address a larger part of reality.

Nurses work with complex problems in a very complicated system. It is likely that the circumscribed theories on which scientists are working seem irrelevant and unimportant when compared to the major day-to-day problems the nurse confronts. Yet nurses must know that very complex problems cannot be solved quickly. The number of man-hours this nation has spent trying to determine what cancer is and how it develops are an example of the time involved in solving an important, complicated problem. Complicated problems are usually broken down into smaller and more manageable parts; this certainly has been the approach used in studying cancer. Nurses should not be discouraged by the fact that relatively little solid nursing knowledge is presently available. The scientific process for developing knowledge is slow, but it is the most dependable process we have.

Theory development, the outcome of the scientific process, is the major goal of the scientist. The norms that guide scientific activities seem to be universal; they are not specific to a discipline or country. These norms speak to the need for public discourse on knowledge, the need for establishing the validity of scientific work, the need for critical assessment of both theory and research, and the need for empirical, objective work which can be replicated by others. It is in a milieu influenced by these norms that knowledge is generated.

Scientists have a variety of criteria for assessing knowledge. Scientists look at their theories for explanatory and predictive

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power, for parsimony, generality, scope, and abstractness. Although nurse-scientists are likely to use these general criteria in theory development, there is a subset of criteria that is pertinent for nurses who plan to develop or use a particular theory in clinical practice. The nurse might ask the following questions of the selected theory: Is it internally consistent or logically adequate? How sound is the empirical support for the theory? Does the theory present concepts and conditions which the nurse can actually modify? Is the theory capable of being used in bringing about major, favorable changes?

The remainder of this paper will address these questions and relevant criteria which, I believe, are most important for evaluating theory in applied disciplines.

**CRITERIA FOR EVALUATING NURSING THEORY**

Since a theory is a set of interrelated concepts and theoretical statements, the theory’s structure can be examined for its internal consistency or logic. Here one examines the syntax of the theory rather than its substantive meaning. If the theory is inconsistent or illogical, then empirical testing which stems from the theory may not be a test of the theory itself but of unrelated or only loosely related hypotheses.

One method for examining the internal consistency of a theory involves identifying all of the the major theoretical terms. These may include constructs, concepts, operational definitions, or references. Once the terms have been identified, a symbol can be used to represent each term. Use of symbols serves to decrease the evaluator’s bias and to lessen the likelihood that substantive meaning will be attributed to the theory without adequate proof. The next step is to identify the relationships or linkages between the theoretical terms. The linkages are usually expressed in terms of direction, type of the relationship (positive or negative), and form of the relationship. Symbols are used to signify the linkages; if the theory does not specify a linkage, then this will become obvious as the structure of the theory is diagrammed. To illustrate this process, consider the statement “High role conflict experienced by a person results in less communication with coworkers” and the statement “Frequent communications with coworkers is associated with job satisfaction.” Let $RC = \text{role conflict, } C = \text{communication, } S = \text{satisfaction, } +$ a positive linkage, $-$ a negative linkage, and $?$ an unspecified linkage. The structure of these two statements would be as follows:
Diagramming these statements clearly shows that there are no contradictions in the specified linkages and that there is no link specified between role conflict and satisfaction. This type of diagramming makes it possible to identify gaps, contradictions, and overlap. Operational definitions can also be diagrammed and will clearly show if the hypothesis to be tested logically flows from the theory.

EMPIRICAL VALIDITY

Empirical validity is perhaps the single most important criterion for practitioners to use in evaluating a theory. Many theories are proposed but only a few are testable. Unfortunately, it is too easy to select a theory which seems plausible or fits our own belief system and then use it in teaching students and in working with patients. Popular theories which have questionable empirical support are psychoanalytic theory, crisis intervention theory, and Erickson's theory of development crises. There are many other theoretical perspectives that could be listed here, but the point of identifying a few common ones is to stress the importance of determining the empirical support for all theoretical perspectives used in the practice area.

Assessing the empirical support for a theory is a rigorous but exciting puzzle-solving activity. It requires going to the literature and identifying studies that address the theory of concern. Care must be taken that case studies, anecdotal accounts, or descriptions of processes which are presented in a discursive account of the theory are not taken as empirical tests for the theory. Such empirical accounts are generally presented to give the reader the feeling that the theory is plausible and congruent with life events. This type of empirical support does not constitute an empirical test of the theory, but may be used to assess the theory's scope.

The assessment of empirical support for a theory requires several independent but closely related steps. Assume that you are planning to go to a major theoretical work and attempt to identify the key theoretical terms and the linkages between them. This process is identical to the processes used in determining the internal consis-
tency of the theory. When you have diagrammed the theory and identified proposed predictions and hypotheses, it is then necessary to examine the empirical support that actually exists. This challenging process takes one to the relevant journals which report research in detail.

In assessing the research on the theory of therapeutic communication, for example, the terms, as in any other theory, should be clearly defined to identify any changes from the common meaning of concepts. For instance, in literature of the 1950s, the concept of negative feedback may have been redefined to mean any communication which alters (increases or decreases) the communication of the other person.

After the pertinent studies have been reviewed, they may be classified on the basis of the strength of the research methodology. Studies which give only detailed descriptions of a concept like nonverbal cues should not be discarded; they may not say much about the effect of nonverbal cues, but they may be valuable in redefining concepts and in addressing the scope of generality of the theory. Once the studies have been categorized on the basis of the soundness of their methodologies, each study should be read critically. In this reading, the reader assesses the empirical support each study gives to the hypotheses being tested and thus indirectly to the theory itself. Don't forget that the researcher usually has a vested interest in his study and may have inadvertently misinterpreted data or introduced biases which alter the interpretation of the findings. During the critical review of the empirical support for a theory, the hypotheses and their empirical referents may be diagrammed, as may the empirical relationship found between the concepts. The congruence between the theoretical predictions and the empirical outcomes can then be readily assessed in a relatively objective manner.

In examining the theory and its empirical support, it is necessary to determine that the hypotheses are clearly deduced from the theory. If they are not, the research is not testing that theory. In examining the theoretical terms and their corresponding operational definitions, one's concern is with the empirical validity of the research. If the operational definition of a theoretical term does not validly reflect the meaning of the theoretical term, then again the research is not really addressing the theory. A theory may be logically sound, the hypotheses may follow from the theory and may be stated in a form that can be rejected; but if the operational definitions do not reflect the meaning of the theoretical concepts, then the empirical data derived from the research have limited bearing on the theory purportedly tested.

To complete the assessment of the empirical support for a theory, all of the relevant studies must be evaluated as a whole. Some of the studies may support part of the theory, there may be minimal support for most of the theoretical claims, or there may be strong, consistent support for the theory. This assessment should result in a decision as to whether the empirical support for the theory is sufficiently adequate to warrant application or use of the theory. The absolute necessity for determining the empirical adequacy of a theory cannot be overemphasized. If nurses are taught theories which have little or no empirical support, then the nursing care interventions based on such "theory" may have deleterious effects on clients who believe in the nurse's skill, expertise, and competence.

In addressing the issue of using empirically sound theory, one should make special note of the tendency to base nursing actions on tradition, intuition, and conceptual frameworks which seem sound but have not been empirically tested. These sources of knowledge may be creative and give the nurse a sense of security in her action. However, knowledge based on tradition, intuition, and untested conceptual frameworks remains in the realm of myth and nonscientific knowledge. For example, even if a crisis-intervention conceptual framework makes intuitive sense to a nurse, using it as a basis of action when it has not been empirically tested is a serious error in judgment.

I believe that the process of evaluating the empirical validity of a theory should be shared with students, since they, as practicing nurses, should carry out this same type of activity for the remainder of their nursing careers. Although the incidence of nurses basing their activities on questionable knowledge bases has not yet become an important issue, the ethical and moral implications warrant serious thought. Furthermore, there is a need for a recognized, established body of scientific knowledge if nursing is going to retain its reputation as a profession.

USEFULNESS AND SIGNIFICANCE

Since nursing is an applied profession, it follows that relevant theories are those which nurses can use in the clinical setting. After a nurse has identified a theory as having internal consistency and strong empirical support, is she able to use the theory? This question is directed at the ability of the practitioner to exert control over the major variables and conditions specified by the theory. To use a theory purposefully to bring about some desired outcome, the nurse must be able to alter the variables which are part of the theory. If a disease such as multiple sclerosis is found to be caused by a virus which is dormant in a person for thirty years, there is little the nurse can do to prevent the disease in the already affected person.
on the other hand, if the nurse is aware of the association between smoking and both lung cancer and heart disease, she is in a position to decrease the occurrence and severity of both these diseases. This theoretical knowledge is useful. The nurse is in a position to provide patients with information which they can use to improve the quality of their life. Also, the professional may become active in informing the public of the dangers of smoking. The inhalation of carcinogens from cigarettes is an activity which the nurse is able to influence for the improved health of her clients.

Related to the usefulness of a theory is its significance. Given two theories which are internally consistent, have strong empirical support, and encompass variables that the nurse is able to modify, what else should influence the choice of which theory to use? Assuming that these two theories are both focused on the same nursing problem, presumably the nurse would implement action based on the theory which will bring about the strongest, most favorable outcome. For example, psychoanalytic theory and behavioral modification theory both address the problem of obesity; it would seem that of the two theories behavioral modification would bring about more major and enduring changes in eating habits. Although one theory addresses the childhood origins of obesity and the other the environmental factors influencing overeating, both theories can be used to assist patients to lose weight. In this example, no comparison is being made of the internal consistency or empirical support of the two theories. The example is used to illustrate the efficacy of one theory over another in achieving desired behavioral outcomes.

Nursing, as a health profession and scientific discipline, has come a long way, but it still has a long way to go. With confidence and competence, nursing as a discipline needs to struggle through the pre-paradigm stage of scientific development. Nurses in this evolving discipline will continue to be faced with challenges and risks. It is my belief that a core of nurse-scientists will emerge who can develop knowledge that reflects sensitivity to problems in the clinical area and that their clinical counterparts will be capable of evaluating and using this knowledge.