Middle Range Theory for Nursing

Third Edition

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Middle Range Theory for Nursing
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Middle Range Theory for Nursing

Third Edition

Mary Jane Smith, PhD, RN
Patricia R. Liehr, PhD, RN
Editors

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Foreword

This third edition of *Middle Range Theory for Nursing* by Mary Jane Smith and Patricia R. Liehr deepens our understandings of the importance of theory development to the scientific enterprise in nursing. Particularly noteworthy is the extent to which the editors and chapter contributors articulate the relevance of the theoretical content for both research and professional nursing practice.

Smith and Liehr were pioneers in nursing knowledge development with the publication of the first edition of this middle range theory book. In that first edition, eight middle range theories for nursing were presented. In this latest edition of the book, 12 theories are included, and each of the chapters exploring these theories includes updated information about the further explication of the theory and its relevance to practice and research. Thus faculty and graduate students will have access to the most recent developments in disciplinary knowledge. The demand for information about middle range theories has substantially increased since the publication of the first edition of this book, and Smith and Liehr have remained in the forefront in expanding the boundaries of knowledge development, sustaining their focus on middle range theories.

Two new theories have been included in this edition, the theory of transitions and the theory of self-reliance—evidence that the discipline has moved forward in the development of theoretical knowledge. It is important to include these new ideas so that, through systematic evaluation, other nurse scholars can assist the theory authors in the refinement of knowledge.

The most significant new content included in this edition is the model of concept building developed by Smith and Liehr. This process of concept building can serve as a complementary process to concept
analysis. Yet an important distinguishing factor is the origin of the concept building process in a practice story. Through this rigorous 10-step process, scholars are led from the identification of an important clinical phenomenon to the development and expansion of their conceptual understandings. This process holds great potential for future theoretical and scientific development of the discipline.

It is significant that Smith and Liehr continue to refocus attention on the theory lens of nursing knowledge development, an undertaking that is particularly significant at a time when the focus has drifted to empirical and practical knowledge. As with prior editions, there are key dimensions of the work that make it especially useful to new students of nursing theory, at the graduate and undergraduate levels. Smith and Liehr present their ideas succinctly, and raise important discussions about the nature of theoretical thinking within the discipline. The structured format that is used across all of the chapters that are focused on specific theories provides the reader with a consistent level of explanation and analysis, and is especially useful for those trying to understand the similarities and differences in the theories. This structure facilitates assessment of knowledge development content components, and provides a detailed model for evaluation of the internal and external validity of the theories. And, importantly, each of the chapters includes delineation of the relevance of the theory in research and professional practice.

This third edition is an important contribution to nursing science literature. Smith and Liehr provide depth to our understandings of middle range theory and set the stage for further theory development within the discipline. Nurses in practice, as well as students of nursing at all educational levels, will benefit greatly from this scholarly work. This contribution extends our understandings and presents new opportunities for expanding the science of nursing through research and theory.

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The interest in middle range theory continues to grow, as demonstrated by the increased number of published theories and the desire among nursing faculty and researchers to use theories at the mid-range level to guide practice and research. This book is based on the premise that students come to know and understand a theory as the meaning of concepts are made clear, and as they experience the way a theory informs practice and research in the everyday world of nursing. Over the years, we continue to hear from students and faculty telling us that the book is user friendly and truly reflects what they need as a reference to move middle range theory to the forefront of research and practice.

Middle range theory can be defined as a set of related ideas that are focused on a limited dimension of the reality of nursing. These theories are composed of concepts and suggested relationships among the concepts that can be depicted in a model. Middle range theories are developed and grow at the intersection of practice and research to provide guidance for everyday practice and scholarly research rooted in the discipline of nursing. We use the ladder of abstraction to articulate the logic of middle range theory as related to a philosophical perspective and practice/research approaches congruent with theory conceptualization.

The middle range theories chosen for presentation in this book cover a broad spectrum—from theories that were proposed decades ago and have been used extensively, to theories that are newly developed and just coming into use. Some of the theories were originated by the primary nurse–author who wrote the chapter, and some were originally created by persons outside of nursing. After much thought and discussion with colleagues and students, we have come to the conclusion that theories for nursing are those that apply to the unique perspective of
the discipline, regardless of origin, as long as they are used by nurse scholars to guide practice or research and are consistent with one of the paradigms presented by Newman, Sime, and Corcoran-Perry (1991). These paradigms, which are recognized philosophical perspectives unique to the discipline, present an ontological grounding for the middle range theories in this book. By connecting each theory with a paradigmatic perspective, we offer a view of the middle range theory’s place within the larger scope of nursing science. This view was included to create a context for considering theories other than those developed by nurses, which have been used to guide nursing practice and research.

We have structured this book in three sections. The first section includes three chapters that present a meta-perspective on middle range theory, whereby setting the stage for the next sections. The first chapter in this section, “Disciplinary Perspectives Linked to Middle Range Theories,” elaborates on the structure of the discipline of nursing as a present and historical context for the development and use of middle range theories. The second chapter, “Understanding Middle Range Theory by Moving Up and Down the Ladder of Abstraction,” offers a clear and formal way of presenting the theories. The ladders were created by the editors and represent the editors’ view of the philosophical grounding of the theory rather than the chapter authors’ view. We have found that a ladder of abstraction can provide a starting place to guide students’ thinking when they are trying to make sense of a theory. In addition, moving ideas up and down the ladder of abstraction generates scholarly dialogue. The third chapter in this section is titled “Evaluation of Middle Range Theories for the Discipline of Nursing.” Students have told us that understanding the way in which theory is evaluated helps further understanding of the theory. So, we have included this chapter in the first section of the book. Certainly, evaluation of theory is a critical skill required for those who strive to move a theory onward in their own work. A unique feature of the evaluation process described in this chapter is that it is based on post-modern assumptions in which context is appreciated as an essential dimension, creating an always-tentative theory critique.

In the second section of this book, 12 middle range theories are included. Ten of these were presented in the second edition: uncertainty, meaning, self-transcendence, symptom management, unpleasant symptoms, self-efficacy, story, cultural marginality, caregiving dynamics, and moral reckoning. Two new theories are included in this third edition: transitions and self-reliance. The theory of transitions addresses the importance of change in the lives of persons confronting significant health situations. The theory of self-reliance
is based on Cherokee core values that have potential for promoting health and well-being across cultures.

Each chapter describing a middle range theory follows a standard format. This includes purpose of the theory and how it was developed, concepts of the theory, relationships among the concepts expressed as a model, use of the theory in nursing research, use of the theory in nursing practice, and conclusion. We believe that this standard format facilitates a complete understanding of the theory and enables a comparison of the theories presented in this book.

The third section contains five chapters that frame a systematic approach for concept development and provides exemplars that highlight the approach. The first chapter in this section, “Concept Building for Research,” is one that was first introduced in the second edition. It has been further developed to refine a 10-phase process guiding conceptualization of ideas for research. The process presented in this chapter can be used by faculty who teach courses on concept development and by students who are working to establish their ideas for research. The third section includes two new chapters, written by students, demonstrating use of the concept development process. The chapters, titled “Yearning for Sleep While Enduring Distress” and “Reconceptualizing Normal,” provide exemplars that follow the 10-phase process while reflecting unique ways of implementation that bring each phase to life for the students. Finally, in the last two chapters of this section, scholars who wrote about their concept development process in the second edition while they were students, present ideas that they have now taken to research proposal development. These chapters focus on research proposals for studying yearning to be recognized and catastrophic cultural immersion. These students, like many others with whom we have engaged, contributed to our understanding of how to develop structures for research through concept building. Although this structure-developing effort shares some of the processes of concept development, it is distinguished by its foundation in nursing practice stories and the systematic inclusion of inductive and deductive processes that culminate in a newly created model to be used in research.

The reader will notice when reading this book, and comparing the theory descriptions of one edition of this book with the next, that some theories have had ongoing development and use while others have received less attention and use during the past 5 years. The vibrancy of theory is dependent on its use by scholars who critique and apply it, testing its relevancy to real-world practice and research. Proliferation of middle range theory without ongoing critique, application, and development is a concern that requires ongoing attention.
As noted in the second edition of this book, there are beginning clusters of middle range theories around important ideas for the discipline, such as symptoms (theories of unpleasant symptoms and symptom management) and moving through difficult times (theories of meaning, self-transcendence, and transitions). It would be useful to evaluate theory clusters, noting the common ground of guidance emerging from the body of scholarly work documented in the theory cluster. An advantage of this effort would be that the thinking of unique nurse scholars would come together. One might expect that essential dimensions of the discipline could be made explicit by distilling and synthesizing messages from a theory cluster. Although the analysis of theory clusters is not undertaken in this book, the information about middle range theory provided here creates a foundation for considering theory-cluster analysis.

At the end of this book, readers will find a table of middle range theories published from 1988 to 2012 in which the year, full citation, and name of the theory are given. This table is useful as a starting place for scholars who want to find additional middle range theories in the literature.

In conclusion, this third edition presents an organization of chapters by meta-theory, middle range theories for nursing, and concept development through a theoretical lens. The added chapters on transitions and self-reliance contribute to the breadth and depth of the array of middle range theories in this third edition. Chapters elaborating the concept building process contribute exemplars to engage the developing scholar in a meaningful way. As with the previous edition, we have edited and written with the intention of clarifying the contribution of middle range theory. We believe that this clarification serves established and beginning nurse scholars seeking a theoretical foundation for practice and research.

Mary Jane Smith, PhD, RN
Patricia R. Liehr, PhD, RN

REFERENCE

An endeavor such as this book is always the work of many. We are grateful to our students who have prodded us with thought-provoking questions, our colleagues who have challenged our thinking and writing, our contributors who gave willingly of their time and effort, our publisher who believed that we had something to offer, and our families who have provided a base of love and support that makes anything possible.
Middle Range Theory for Nursing
Section One

Setting the Stage for Middle Range Theories

This section describes meta-perspectives that create a context for the middle range theories in this book. In the first chapter, a connection is made between middle range theory and the unique focus of the discipline of nursing, the structure of the discipline, and grand theories in nursing. In the second chapter, middle range theory is described according to philosophical, theoretical, and empirical levels of abstraction along with ladders depicting the assumptions, concepts, and practice/research applications. The editors have created the ladders of abstraction, thereby interpreting each theorist’s perspectives and enabling the reader with a means for visualizing, comparing, and contrasting each middle range theory when related to the others. In Chapter 3, a framework for evaluating the substantive foundations, structural integrity, and functional adequacy of middle range theory is provided, emphasizing thoughtful consideration with empathy, curiosity, honesty, and responsibility.
Each discipline has a unique focus for knowledge development that directs inquiry and distinguishes it from other fields of study. The knowledge that constitutes the discipline has organization. Understanding this organization or the structure of the discipline is important for those engaged in learning the theories of the discipline and for those developing knowledge expanding the discipline. Perhaps this need is more acute in nursing because the evolution of the professional practice based on tradition and knowledge from other fields preceded the emergence of substantive knowledge of the discipline. Nursing knowledge is the inclusive total of the philosophies, theories, research, and practice wisdom of the discipline. As a professional discipline this knowledge is important for guiding practice. Theory-guided, evidence-based practice is the hallmark of any professional discipline. The purpose of this chapter is to elaborate the structure of the discipline of nursing as a context for understanding and developing middle range theories.

The disciplinary focus of nursing has been debated for decades, but now there seems to be some general agreement. In 1978, Donaldson and Crowley stated that a discipline offers “a unique perspective, a distinct way of viewing … phenomena, which ultimately defines the limits and nature of its inquiry” (p. 113). They specified three recurrent themes that delimit the discipline of nursing:

1. Concern with principles and laws that govern the life processes, well-being, and optimum functioning of human beings, sick or well;
2. Concern with the patterning of human behavior in interaction with the environment in critical life situations; and
3. Concern with the processes by which positive changes in health status are affected (p. 113).

Nursing is a professional discipline (Donaldson & Crowley, 1978). Professional disciplines such as nursing, psychology, and education are different from academic disciplines such as biology, anthropology, and economics in that they have a professional practice associated with them. According to the authors, professional disciplines include the same knowledge, descriptive theories, and basic and applied research common to academic disciplines. In addition, prescriptive theories and clinical research are included. So the differences between academic and professional disciplines are the additional knowledge required for professional disciplines. This is important, because many refer to nursing as a practice discipline. This seems to imply that the knowledge is about the practice alone and not about the substantive phenomena of concern to the discipline.

Failure to recognize the existence of the discipline as a body of knowledge that is separate from the activities of practitioners has contributed to the fact that nursing has been viewed as a vocation rather than a profession. In turn, this has led to confusion about whether a discipline of nursing exists. (Conway, 1985, p. 73)

Although we have made significant progress in building the knowledge base of nursing, this confusion about the substantive knowledge base of nursing lingers with nurses, other professions, and in the public sphere.

Fawcett’s (1984) explication of the nursing metaparadigm was another model for delineating the focus of nursing. According to Fawcett, the discipline of nursing is the study of the interrelationships among human beings, environment, health, and nursing. Although the metaparadigm is widely accepted, the inclusion of nursing as a major concept of the nursing discipline is tautological (Conway, 1985). Others have defined nursing as the study of the life process of unitary human beings (Rogers, 1970), caring (Boykin & Schoenhofer, 2001; Leininger, 1978; Watson, 1985), human–universe–health interrelationships (Parse, 1981), and “the health or wholeness of human beings as they interact with their environment” (Donaldson & Crowley, 1978, p. 113). Newman, Sime, and Corcoran-Perry (1991) created a parsimonious definition of the focus of nursing that synthesizes the unitary
nature of human beings with caring: “Nursing is the study of caring in the human health experience” (p. 3).

My definition uses similar concepts but shifts the direct object in the sentence: “Nursing is the study of human health and healing through caring” (Smith, 1994, p. 50). This definition can be stated even more parsimoniously: Nursing is the study of healing through caring. Healing comes from the same etymological origin as “health,” haelen, meaning whole (Quinn, 1990, p. 553). Healing captures the dynamic meaning that health often lacks; healing implies a process of changing and evolving. Caring is the path to healing. In its deepest meaning, it encompasses one’s connectedness to all, that is, a person–environment relatedness. Nursing knowledge focuses on the wholeness of human life and experience and the processes that support relationship, integration, and transformation. This is the focus of knowledge development in the discipline of nursing.

Defining nursing as a professional discipline does not negate or demean the practice of nursing. Knowledge generated from and applied in practice is contained within this description. The focus of practice comes from the definition of the discipline. Nursing has been defined as both science and art, with science encompassing the theories and research related to the phenomena of concern (disciplinary focus) and art as the creative application of that knowledge. Newman (1990) and others, perhaps influenced by critical/postmodern scholars, have used the term praxis to connote the unity of theory–research–practice lived in the patient–nurse encounter. Praxis breaks down the boundaries between theory and practice, researcher and practitioner, art and science. Praxis recognizes that the practitioner’s values, philosophy, and theoretical perspective are embodied in the practice. Chinn refers to it as “thoughtful reflection and action that occur in synchrony, in the direction of transforming the world” (2013, p. 10). Praxis reflects the embodied knowing that comes from the integration of values and actions and blurs the distinctions among the roles of practitioner, researcher, and theoretician.

Middle range theories are part of the structure of the discipline. They address the substantive knowledge of the discipline by explicating and expanding on specific phenomena that are related to the caring–healing process. For example, the theory of self-transcendence explains how aging or vulnerability propels humans beyond self-boundaries to focus intrapersonally on life’s meaning; interpersonally on connections with others and the environment; temporally to integrate past, present, and future; and transpersonally to connect with dimensions beyond the physical reality. Self-transcendence is related
to well-being or healing, one of the identified foci of the discipline of nursing. This theory has been examined in research and used to guide nursing practice. With the expansion of middle range theories, nursing is enriched.

Several nursing scholars have organized knowledge of the discipline into paradigms (Fawcett, 1995; Newman et al., 1991; Parse, 1987). The concept of paradigm originated in Kuhn’s (1970) treatise on the development of knowledge within scientific fields. He asserted that the sciences evolve rather predictably from a preparadigm state to one in which there are competing paradigms around which the activity of science is conducted. The activity of science to which he is referring is the inquiry that examines the emerging questions and hypotheses surfacing from scientific theories and new findings. Paradigms are schools of shared assumptions, values, and views about the phenomena addressed in particular sciences. It is common for mature disciplines to house multiple paradigms. If one paradigm becomes dominant and if discoveries within it challenge the logic of other paradigms, a scientific revolution may occur.

Parse (1987) described nursing with two paradigms: the totality and simultaneity. For her, the theories in the totality paradigm assert the view that humans are bio-psycho-social-spiritual beings responding or adapting to the environment, and health is a fluctuating point on a continuum. The simultaneity paradigm portends a unitary perspective. Unitary refers to the distinctive conceptualization of Rogers (1970, 1992) that humans are essentially whole and cannot be known by conceptually reducing them to parts. Also, the term unitary refers to the lack of separation between human and environment. Health is subjectively defined by the person (group or community) and reflects the process of evolving toward greater complexity and human becoming. Parse locates only two nursing conceptual systems/theories: the Science of Unitary Human Beings (Rogers, 1970, 1992) and the Theory of Human Becoming (Parse, 1981, 1987) in the simultaneity paradigm. For Parse, all nursing knowledge is related to the extant grand theories or conceptual models in the discipline. While she agrees that theories expand through research and conceptual development, she disagrees with the inclusion of middle range theories within the disciplinary structure if they are not grounded in the more abstract theoretical structure of an existing nursing grand theory or conceptual model.

Newman et al. (1991) identified three paradigms. These paradigms are conceptualized as evolving because the more complex paradigms encompass and extend the knowledge in a previous paradigm. The three paradigms are particulate–deterministic, interactive–integrative, and unitary–transformative. From the perspective of the theories
within the particulate–deterministic paradigm, human health and caring are understood through their component parts or activities; there is an underlying order and there are predictable antecedents and consequences, and knowledge development progresses to uncover these causal relationships. Reduction and causal inferences are characteristics of this paradigm. The interactive–integrative paradigm acknowledges contextual, subjective, and multidimensional relationships among the phenomena central to the discipline. The interrelationships among parts and the probabilistic nature of change are assumptions that guide the way phenomena are conceptualized and studied. The third paradigm is the unitary–transformative. Here, the person–environment unity is a patterned, self-organizing field within larger patterned self-organizing fields. Change is characterized by fluctuating rhythms of organization disorganization, toward more complex organization. Subjective experience is primary and reflects a pattern of the whole (Newman et al., 1991, p. 4).

Fawcett (1995, 2000) joined the paradigm dialogue with her version of three paradigms. She named them as reaction, reciprocal interaction, and simultaneous action. This model was synthesized from the analysis of views of mechanism versus organism, persistence versus change, and the Parse and Newman and colleagues’ nursing paradigm structure. In the reaction worldview, humans are the sum of the biological, psychological, sociological, and spiritual parts of their nature. Reactions are causal and stability is valued; change is a mechanism for survival. In the reciprocal interaction worldview, the parts are seen within the context of the whole, and human–environment relationships are reciprocal; change is probabilistic based on a number of factors. In the simultaneous action worldview, human beings are characterized by pattern and are in a mutual rhythmic open process with the environment. Change is continuous, unpredictable, and moves toward greater complexity and organization (Fawcett, 2000, pp. 11–12).

Each middle range theory has its foundations in one paradigmatic perspective. The philosophies guiding the abstract views of human beings, human–environment interaction, and health and caring are reflected in each of the paradigms. This influences the meaning of the middle range theory, and for this reason, it is important that the theory has a philosophical link to the paradigm clearly identified.

Figure 1.1 illustrates the structure of the discipline of nursing. This is adapted from an earlier version (Smith, 1994). The figure depicts the structure as clusters of inquiry and praxis surrounding a philosophic paradigmatic nexus. The levels of theory within the discipline based on the breadth and depth of focus and level of abstraction are represented. Theory comes from the Greek word, theoria, meaning “to see.”
A theory provides a particular way of seeing phenomena of concern to the discipline. Theories are patterns of ideas that provide a way of viewing a phenomenon in an organized way. Walker and Avant (2010) describe these levels of theory as metatheory, grand theory, middle range theory, and practice theory.

The figure depicts five levels of abstraction. The top oval includes the nursing metaparadigm and focus of the discipline of nursing. This is the knowledge beyond or at a more abstract level than theory per se. Grand theories are at the next level of the figure and include the abstract conceptual systems and theories that focus on the central phenomena of the discipline, such as persons as adaptive systems, self-care deficits, unitary human beings, or human becoming. These grand theories are frameworks consisting of concepts and relational statements that explicate abstract phenomena. In the figure, the grand theories cluster under the paradigms. Middle range theories are more circumscribed, elaborating more concrete concepts and relationships such as uncertainty, self-efficacy, meaning, and the other middle range theories addressed throughout this text. The number of middle range theories is growing. Middle range theory can be specifically derived from a grand theory or can be related directly to a paradigm. At the bottom level of the figure are the research and practice traditions related to the grand and middle
range theories. Walker and Avant (2010) refer to this most specific level of theory as practice theory. Practice theories specify guidelines for nursing practice; in fact, the authors state that the word “theory” may be dropped to think of this level as “nursing practices” (p. 12) or what can be considered practice traditions. Both grand theories and middle range theories have practice traditions associated with them.

A practice tradition contains the activities, protocols, guidance, and practice wisdom that emerge from these theories. Models such as the LIGHT model (Andersen & Smereck, 1989) or the attendant nurse caring model (Watson & Foster, 2003) are examples. Smith and Liehr (2008) refer to these as micro-range theories, those that closely reflect practice events or are more readily operational and accessible to application in the nursing practice environment. Research traditions are the associated methods, procedures, and empirical indicators that guide inquiry related to the theory.

Some differentiate between grand theories and conceptual models. Fawcett (2000) differentiates them by how they address the metaparadigm concepts as she has defined them. Those that address the metaparadigm of human beings, environment, health, and nursing are labeled conceptual models, whereas those that do not are considered grand theories. Using her criteria, Human Caring Theory (Watson, 1985, 2008) and Health as Expanding Consciousness (Newman, 1986, 1994) are considered grand theories. Walker and Avant (1995) include conceptual models under the classification of grand theories, and it seems more logical to define conceptual models by scope and level of abstraction instead of their explicit metaparadigm focus. In this chapter, the grand theories will be referred to as theories rather than conceptual frameworks.

The grand theories developed as nursing’s distinctive focus became more clearly specified in the 1970s and 1980s. Earlier nurse scholars contributed to theoretical thinking without formalizing their ideas into theories. Nightingale’s (1860/1969) assertions in *Notes on Nursing* about caring for those who are ill through attention to the environment are often labeled theoretical. Several grand theories share the same paradigmatic perspective. For example, the theories of Person as Adaptive System (Roy, 1989, 2009), Behavioral Systems (Johnson, 1980), and the Neuman (1989, 1995) Systems Theory share common views of the phenomena central to nursing that might locate them within the interactive–integrative paradigm. Others, such as the Science of Unitary Human Beings (Rogers, 1970, 1992), Health as Expanding Consciousness (Newman, 1986, 1994), and Human Becoming (Parse, 1998), cluster in the unitary–transformative paradigm.
There may be an explicit relationship between some grand theories and middle range theories. For example, Reed’s (1991) middle range theory of self-transcendence and Barrett’s (1989) theory of power are directly linked to Rogers’s Science of Unitary Human Beings. Other middle range theories may not have such direct links to grand theories. In these instances, the philosophical assumptions underpinning the middle range theory may be located at the level of the paradigm rather than at the level of the grand theory. Nevertheless, this linkage is important to establish the theory’s validity as a nursing theory. Theoretical work is located in the discipline of nursing when it addresses the focus of the discipline and shares the philosophical assumptions of the nursing paradigms or the grand theories.

Some grand theories in nursing have developed research and/or practice traditions. Laudan (1977) asserts that sciences develop research traditions or schools of thought such as “Darwinism” or “quantum theory,” in addition, Laudan’s view includes the “legitimate methods of inquiry” open to the researcher from a given theoretical system (p. 79). Research traditions include appropriate designs, methods, instruments, research questions, and issues that are at the frontiers of knowledge development. The traditions reflect logical and consistent linkages between ontology, epistemology, and methodology. Ontology refers to the philosophical foundations of a given theory and is the essence or foundational meaning of the theory. Epistemology is about how one comes to know the theory and incorporates ways of understanding and studying the theory. Methodology is a systematic approach for knowledge generation and includes the processes of gathering, analyzing, synthesizing, and interpreting information. The correspondence among ontology (meaning), epistemology (coming to know), and methodology (approach to study) gives breadth and depth to the theory.

Examples of the connection between ontology, epistemology, and methodology are evident in several grand theories. For instance, the research-as-praxis method was developed by Newman (1990) for the study of phenomena from the Health as Expanding Consciousness perspective, and a research method was developed from the theory of Human Becoming (Parse, 1998). Tools have been developed to measure theoretical constructs such as self-care agency (Denyes, 1982) or functional status within an adaptive systems perspective (Tulman et al., 1991), and debates on the appropriate epistemology and methodology in a unitary ontology (Cowling, 2007; Smith & Reeder, 1998) characterize the research traditions of some extant theories. These examples reflect the necessary relationship between theory, knowledge development, and research methods.
Practice traditions are the principles and processes that guide the use of a theory in practice. The practice tradition might include a classification or labeling system for nursing diagnoses, or it might explicitly eschew this type of labeling. It might include the processes of living the theory in practice such as Barrett’s (1998) deliberative mutual patterning, or the developing practice traditions around Watson’s theory such as ritualizing hand washing and creating quiet time on nursing units (Watson & Foster, 2003). Practice traditions are the ways that nurses live the theory and make it explicit and visible in their practice.

Middle range theories have direct linkages to research and practice. They may be developed inductively through qualitative research and practice observations, or deductively through logical analysis and synthesis. They may evolve through retroductive processes of rhythmic induction–deduction. As scholarly work extends middle range theories, research and practice traditions continue to develop. For example, scholars advancing uncertainty theory will continue to test hypotheses derived from the theory with different populations. Nurses in practice can take middle range theories and develop practice guidelines based on them. Oncology nurses whose worldviews are situated in the interactive–integrative paradigm may develop protocols to care for patients receiving chemotherapy using the theory of unpleasant symptoms. The use of this protocol in practice will feed back to the middle range theory, extending the evidence for practice and contributing to ongoing theory development. The use of middle range theories to structure research and practice builds the substance, organization, and integration of the discipline.

The growth of the discipline of nursing is dependent on the systematic and continuing application of nursing knowledge in practice and development of new knowledge. Few grand theories have been added to the discipline since the 1980s. Some suggest that there is no longer a need to differentiate knowledge and establish disciplinary boundaries because interdisciplinary teams will conduct research around common problems, eliminating the urge to establish disciplinary boundaries. Even the National Institutes of Health rewards interdisciplinary research enterprises. This emphasis can enrich perspectives through interdisciplinary collaboration, but it is critical to approach interdisciplinary collaboration with a clear view of nursing knowledge to enable meaningful weaving of disciplinary perspectives.

Nursing remains on the margin of the professional disciplines and is in danger of being consumed or ignored if sufficient attention is not given to the uniqueness of nursing’s field of inquiry and practice. There are hopeful indicators that nursing knowledge is growing. The blossoming of middle range theories signifies a growth of knowledge.
development in nursing. Middle range theories offer valuable organizing frameworks for phenomena being researched by interdisciplinary teams. These theories are useful to nurses and persons from other disciplines in framing phenomena of shared concern. Hospitals seeking Magnet status are now required to articulate some nursing theoretic perspective that guides nursing practice in the facility. The quality of the practice environment is important for the quality of care and the retention of nurses. Theory-guided practice elevates the work of nurses leading to fulfillment, satisfaction, and a professional model of practice.

The role of the doctor of nursing practice has the potential to enrich the current level of advanced practice by moving it toward true nursing practice guided by nursing theory. The movement toward translational research and enhanced absorption of research findings into the front lines of care will demand practice models that bring coherence and sense to research findings. Isolated, rapid cycling of findings can result in confusion and chaos if not sensibly synthesized into a model of care that is guided not only by evidence but also by a guiding compass of values and a framework that synthesizes research into a meaningful whole. This is the role of theory. With this continuing shift to theory-guided practice and research, productive scientist–practitioner partnerships will emerge committed to the application of knowledge to change care and to improve quality of life for patients, families, and communities.

REFERENCES


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