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Language and Nursing Research: The Evolution

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Discussing or talking is the way in which we articulate significantly the intelligibility of Being-in-the-world. The way in which discourse gets expressed is Language.
—M. Heidegger, Being and Time

So the main function of a language symbol is not to stand for or represent an object to which it corresponds. Rather, it initiates a total movement of memory, imagery, ideas, feelings, and reflexes, which serves to order attention to and direct action in a new mode that is not possible without the use of such symbols.
—D. Bohm, On Creativity

Being in the world holds many challenges for those nurse researchers who embark on the path of discovery through qualitative research designs or methods. One of these challenges has to do with the limits and power of language. Our world is narrated and organized through language. The use of language is one way in which we communicate meaning. We also experience moments when we cannot find the language to express a feeling, an emotion, or a response. So our language at once allows expression and also constrains expression. In the very way that we narrate with language, the particulars of our context, personal, social, and cultural agendas are set. So too in our research language: Values, beliefs, and aims are communicated from which varying meanings of being in the world will evolve.

For many years, nurse researchers and theorists have engaged in a lively and enlightening dialogue of various paradigms, the two most common being the logical positivist or empirical-analytic paradigm and the contrasting one, phenomenology. This dialogue was prompted by many nurse researchers who initiated what was to become an "interpretive turn" in nursing research (Munhall, 1989). These nurse theorists and researchers began to raise these questions:

> Was nursing a natural science, like that of chemistry and biology, and therefore based on similar linguistic assumptions?
> Was nursing a human science based on differing linguistic assumptions?
> Was nursing research ready for a poststructuralist perspective? (Dzurec, 1989)

The purpose of this chapter is to illustrate the words and perspectives that gave rise to these discussions and the evolution of nursing research. You will most likely see that much of the same language is relevant in today's historical context. Nursing language is both concealing and revealing of the stances and perspective that we pose to nursing as we interact with the phenomenon of concern. For some nurse researchers, this discussion will be historical because they have chosen one paradigm over another for various reasons. For other nurse researchers, it will also be historical because they see a postmodern perspective of multiple research paradigms as not only acceptable but essential.

At this point in time, many nurse researchers are encouraging moving beyond what they see as an unruly dualism between what in the early 1980s was structured as a debate. The debate was centered on two different research paradigms, the quantitative and the qualitative. These two research paradigms were often compared and contrasted, elucidating their different philosophical underpinnings. However, it remains extremely important to students studying qualitative research at the outset to become familiar with some of the fundamental and basic assumptions, beliefs, and outcomes of these two paradigms. Using the concreteness of placing paradigms in stark relief to one another should be of assistance to our beginning understanding of various worldviews.

In this chapter, we will see, in the form of contrasting systems of language, competing articulations in other fields as well as our own that are characteristic of various philosophical orientations. This particular focus on philosophical analysis is further elucidated in Chapters 3, 4, and 5.

Research in nursing is at the center of this linguistic exploration. Methods of doing research are still divided into two purportedly ideological (and thus far considered conflicting) schools of thought with two distinct language systems. These schools of thought have been categorized as the qualitative and quantitative approaches to research.

By quantitative methods of research we mean the traditional scientific methods as presented in most of the contemporary nursing research textbooks. These methods are characterized by deductive reasoning, objectivity, quasi-experiments, statistical techniques, and control. On the other hand, qualitative methods are characterized as employing inductive reasoning, subjectivity, discovery, description, and process orienting (Reichardt & Cook, 1979). The outcome, depending on the method, can be derived from description, interpretation, and analysis (Ashworth, 1997).

This chapter explores a qualitative-quantitative dichotomy and perhaps will appear culpable of unnecessary polarization. This is done for a pedagogical advantage of clearly revealing the possible differences between these two research traditions. I hope to resolve this polarization as the third chapter of this book begins. In that chapter a cyclical continuum is suggested that finds its origins in qualitative research and its validation in quantitative research. Advocating a cyclical continuum is congruent with calls to move beyond the debate, and thus enter post-positivism and reconciliation (Clark, 1998).

The present chapter begins with a discussion of the living aspect of language and then progresses to a contextual analysis of nursing research. The purpose is to ferret out the meanings of our linguistic expressions, their origins, and subsequent propulsions. This motion of transition from nursing's earliest identification with medicine represents a broad worldview transition or paradigmatic shift. Nursing research and the quest for nursing theory development are discussed from the perspective of language development and language usage as we seek out the pattern and process to articulate our meaning and experience.

Language and Lived Experience

Long before children speak actual words, they have learned effectively to express their physical, mental, and emotional states of being. Very early in our childhood we learn that laughing, crying, pouting, and looking quizzical stimulate a response from those who are "significant others." We are indeed beginning to learn the power of expressive language (Wells, 1985).

Eventually, we begin to develop a vocabulary and, interestingly, by the time we are 2 years of age or so, we have learned to treasure the word "no." Individuation, assertiveness, posturing, and a continuing desire for power in our environment render this one of the most important words in any language. People have written entire books on how, when, and where to say "no" effectively (Coventry & Garrod, 2005).

Nursing as a profession, concomitantly with women as a social force, is still very much involved in those processes of individuation, assertiveness, posturing,

and claiming power in our environment. Like the significance of the word no, our language and the use of specific sets of words simultaneously reveal and conceal who we are, both to ourselves and to the world at large.

Thus, in our quest for individuation and, we might add, our autonomy (auto-**no**-my), we are in the process of developing a language system that defines our particular role with our clients. This focus on autonomy correlates well with the point of the revelatory and concealing power of language and the exemplary word no. Nursing has claimed the power to say no through the Greek word autonomous (*autos*–"self" and *nomos*–law or rule), meaning self-ruling. Whenever the Greek suffix *nomos* appears in an English word associated with a human quality, it addresses the rule of right or privilege that has been attributed to the prefix. Using autonomy as an example, "I have a right to be self-determined."

The living of autonomy expresses the position of a profession and, in nursing, has called attention to our transition from the physician's handmaiden (just look at that word!) to an independent self-ruling practitioner. This posturing of ourselves is consistently illustrated in our transition from the primary usage of medical language to our concerted efforts to develop a nursing language, taxonomy, nomenclature, and nursing diagnostic system.[1]

The moment-to-moment language that we choose defines the posture or stance that we assume in the space that we believe is ours in the healthcare _____ (fill in the blank from the choices below):

1. system
2. arena
3. delivery system
4. field

For example, in the preceding multiple-choice option, we find it most interesting to study such words in their starkness for their literal or metaphorical meaning. Is health care "delivered"? Is there a "system" of health care? The word *arena*, which is frequently used with health care, is a word that is often associated with a circus or sports. (The temptation is too great to resist pointing out how that word, with its noted association, may be the most apt description of the present so-called healthcare system.) The word *sports* is also associated with the word *field*, where many games are played, with winners and losers. So, of these words, which one or two or perhaps one not mentioned would characterize, for you, the reader, the state of health care today?

Each profession creates its own language, and nursing is no different. The language of nursing reveals how nurses view the phenomena of their experiences. The symbols that we choose as expressions expose our assertions, propositions, assumptions, beliefs, values, and priorities either implicitly or explicitly. The significance of such expressions manifests in our emergence:

Our expressions bring us into existence. The *noumenal*, or "thing in itself," depends on the phenomenal for its expression.

DeVries (1983) succinctly and humorously illustrated the noumenal emerging from felt obscurity into shared, understood experience in the following passage:

> In the beginning was the word. Once terms like identity doubts and midlife crisis become current, the reported cases of them increase by leaps and bounds, affecting people unaware there is anything wrong with them until they have got a load of the coinages. You too may have an acquaintance or even a relative with a block about paper hanging or dog grooming, a high flown form of stagnation trickled down from writers and artists. Once my poor dear mother confided to me in a hollow whisper, "I have an identity crisis." I say, "How do you mean?" and she says, "I no longer understand your father." Now we have burnout, and having heard tell of it on television or read about it in a magazine, your plumber doubts he can any longer hack it as a pipefitter, while a glossary adopted by his wife has turned him overnight into . . . a male chauvinist pig, something she would never have suspected before. (p. 4)

Satire in the preceding quotation is a useful adjunct to disclosing how concepts develop. Concepts such as "midlife crisis" have a sturdy sound to them. Such concepts seem to have existed like trusted monikers for more years than people can remember. However, midlife crisis was not coined until 1965 (Jaques, 1965). Long before 1965, Carl Jung and others had intimated a maturation crisis as occurring between ages 40 and 60, but Jaques gave it the name. Certainly the "thing itself" (the noumenon) existed before 1965. It was felt; yet we needed the description and language of shared experience to connect us within the world and provide a way of perceiving the phenomenon.

Writers of fiction provided glimpses of the noumenon called midlife crisis years prior to 1965. For example, Willa Cather (1873–1947), an American novelist, described the noumenon of midlife crisis on several occasions. In Book 1 ("The Family") of her novel, *The Professor's House*, Cather (2001) described an existential release from the claustrophobia of the family's home that creative writing provided the character of the professor. We see further examples below of how "something existed", an experience not yet named, has come into our common parlance by creating expressions of the experience through language.

1. Codependency (late 1970s, Beatty, 1989)
2. Deficit spending or "budgetary deficit" (Keynes, 1936)
3. Post-Traumatic Shock Syndrome (PTSS)

4. Premenstrual syndrome (serious study of PMS followed Brozan, 1982)
5. Attention Deficit Disorder (ADD)

Moreover, the proliferation of support groups for various conditions of life as well as the many 12-step programs speak to our need for shared language to connect us with one another within the world. The Internet has provided many ways of using language, ranging from informational purposes to allowing language to connect one human being to another once again. Blogs (Web logs) help form virtual communities. We now can find groups of people who believe and speak the same language, spending hours a day and "unqualitatively" most of the time substantiating their common beliefs.

An emerging field of graduate study today is Narrative Medicine, where people through their own personal experience gives voice to their experience through language that is made available to others. This assists those who identify with the experience so as not to feel alone or isolated in that experience or to assist others in understanding the trials and challenges of that experience. The qualitative method of Narrative Inquiry as illustrated in Chapters 16 and 17 demonstrates these purposes through research.

Language as Points of Contact

The various forms of language that we use, as with all disciplines, bring human experience into emergence. We need to recognize and articulate our points of contact in this pluralistic world, and we need referents to nursing phenomena in language to hold a recognized place in that world. Qualitative research is poised with its emphasis on language and meaning to assist us in understanding the meaning of our various places in experience.

For example, the word *undeveloped*, describing Third World countries, was judged to be a pejorative adjective and was discontinued. The word *emerging* was used instead to describe these countries and to express optimism. Our emergence, like that of children and emerging countries, will depend on our ability to express ourselves clearly within the context of this pluralistic world. Let us look at the lived experience of nursing through a contextual analysis of our language development.

The Context of Nursing Research

Stolorow and Atwood (2002) argue that there can be no meaning without context, and they question the myth of the isolated mind. Allen (1995) encourages us to recognize the social, political, and historical location in the role of nursing research. The historical context in which individuals live places them in a world specific to that time and place, of contingencies that

must be recognized and acknowledged if research or discourse is to be meaningful (Rorty, 1991). So it appears appropriate, especially in a text on qualitative research that readily acknowledges and embodies its search within the context of "things," that we begin this exploration of language in nursing research by attending to the context in which it has occurred and is continuing to evolve.

Context is defined as "that which leads up to and follows and often specifies the meaning of a particular expression" and "the circumstances in which a particular event occurs" (*American Heritage Dictionary*, 1992). I believe that within this definition of context the following three antecedents and their evolutionary-concurrent factors should be acknowledged:

1. Research in nursing evolved predominantly when nursing education became a part of higher education and was seeking its own body of knowledge, different from that of medicine.
2. Nursing's first researchers were being prepared in fields other than nursing and have brought to nursing the various paradigms from those fields.
3. Derivation and/or deduction for nursing research was (is) being drawn from disciplines other than nursing. Each factor will be explored from the perspective of its contributions to our nursing research language.

Transition in Worldviews of Nursing

During the 1950s, as an outgrowth of the development and acceptance of new theoretical approaches to understanding physical and human phenomena emerging from other fields (approaches such as systems perspectives, quantum physics, adaptation, and ecological views), nurse scholars began questioning the prevalent acceptance and alignment of the medical model as the basis for nursing practice. Nursing was also entering the university setting at that time. These two historical events converged, and the need for our own distinct body of knowledge, a benchmark of a profession and the research imperative of the university, spurred a revolution in nursing.

These two factors, the acknowledgment of a major scientific revolution in other disciplines as well as our own, and the desire to attain a level of professionalism at which we would base practice on a distinct body of nursing knowledge, led to a perceptual shift in the way that we spoke about nursing phenomena and simultaneously led to the scientific investigation of nursing phenomena.[2] It seemed, though, that the way in which we spoke about nursing and the way in which we investigated nursing phenomena often reflected assumptions, propositions, beliefs, and priorities of two different worldviews, the first reflecting one worldview and the other reflecting a different

worldview. We will see shortly that this is a characteristic of paradigmatic shift within a discipline.

The spoken language in nursing began to change, reflecting this perceptual shift from the medical, atomistic, causal model to a distinct nursing, holistic, interactive model. This represented a paradigmatic innovation for nursing. The way in which phenomena were viewed in nursing was changing in a way that was considered by some to be irrevocably conflictual in its basic premises and assumptions with the medical model.

This shift, which was well recognized in the discipline of physics, began to permeate the language of other fields as well as nursing. The change is representative of a transition from a mechanistic to an organismic perspective, from the reliance on objectivity to intersubjectivity, and from the received view to a nonreceived view (Watson, 1981). Today, Watson, Dossey, & Dossey (1999) urge us farther "away from the reaction worldview, past the reciprocal and into the transformative-simultaneous" and urge nurses to create nursing's own postmodern paradigm. Many of the qualitative methods of research, before the language of postmodernism became commonplace, have as underpinnings many of the values and beliefs of postmodernism.

Illumination of the differences between and among these worldviews and/or paradigms can be demonstrated in the scrutiny of the respective language systems. It seems appropriate, though, to be clear at this point as to what a worldview or paradigm is. Patton (1978), in terms consistent with those of Kuhn (1970), defines a paradigm as follows: "A worldview, a general perspective, a way of breaking down the complexity of the real world. As such, paradigms are deeply embedded in the socialization of adherents and practitioners: paradigms tell them what is important, legitimate and reasonable" (p. 203).

If we accept the premise that things come into being through language, the language paradigm of a discipline will tell the practitioner what is important, legitimate, and reasonable. Kuhn (1970) suggests that a paradigm is a discipline's specific method of solving a puzzle, of viewing human experience, and of structuring reality. It is a worldview, a way of viewing phenomena in the world.

Laudan (1977), in a similar vein, uses the phrase "research tradition" to communicate the same theme: "A research tradition . . . is a set of assumptions about the basic kinds of entities in the world, assumptions about how these entities interact, assumptions about the proper methods to use for constructing and testing theories about these entities" (p. 97). Morgan (1983) calls our attention to the significance of these assumptions. He states: "Assumptions make messes researchable, often at the cost of great simplification, and in a way that is highly problematic" (p. 377).

This reference about assumptions becomes more powerful when, as Morgan suggests, researchers choose their *own* assumptions on which to base their studies. One could then say that this latitude enables the means for achieving what the researcher values. In the paradigms introduced in this chapter are assumptions about the world, believed in some way to be true, though they are actually the "taken-for-granted" views of human scientists. In a fundamental sense, then, researchers choose the values, "truths," and perspectives on which they base their research endeavors.

Another way of expressing this shift was the idea that nursing was a human science. Nursing seems to be philosophically expressed through language to be compatible with the ideas and concepts of a human science. German philosopher–historian Wilhelm Dilthey (1926; as translated in Atwood & Stolorow, 1993) held these critical assumptions about a human science:

> "The supreme category of the human sciences is meaning" (p. 2).
> "The natural sciences investigate objects from the outside whereas the human sciences rely on a perspective from the inside" (p. 2).
> "The central emphasis in the natural sciences is upon causal explanation: The task of inquiry in the human sciences is interpretation and understanding" (p. 2).

Our transition in worldviews then seems to have moved from a narrowly defined type of science to a much broader connection of what constitutes science. However, in that broader view, there remain two very distinct sciences: natural science and human science. Some would even question the idea of a human science, if using the strict parochial rules of science. However, as the human sciences have evolved, there is little doubt that they have legitimated their place as a science, one with a different philosophy from the philosophy of natural science.

The Language of Worldviews

What follows are expressions belonging to different ways of viewing phenomena (worldviews). The language reveals different assumptions, beliefs, and values concerning human and physical reality. In essence, the paradigm or research tradition is a philosophy: It conceptualizes fundamental beliefs. For this reason, the research paradigm as a puzzle-solving method should be congruent with the discipline's larger paradigm, that is, the paradigm of nursing or nursing's philosophy.

Although this idea of congruency is not held as essential by all researchers, the most sophisticated or reasonable response to any either-or discussion would be to choose a dialectic approach (Moccia, 1988; Morgan, 1983). This

approach, as Morgan (1983) states, "also accepts the diversity of assumption and knowledge claims as an inevitable future of research and attempts to use the competing perspectives as a means of constructing new modes of understanding" (p. 379). A postmodern perspective would transcend the either-or stalemate as an unnecessary obstacle to understanding and would beg the question with an emphasis on plurality of perspectives, which would be context dependent.

To assist students in understanding the different language systems of various fields, the tables included in this chapter present language in stark relief. They are purposely presented to demonstrate the different meaning systems and are more for explicitness than for the subtleties that, of course, also can be discussed. Each of the five tables (Tables 2–1 through Table 2–5) of paradigmatic-type language presents two contrasting belief systems. The language of the systems in the left-hand columns is often the same language or, if not literally the same, it is at least consistent in syntax and meaning, reflecting the underlying continuity of beliefs, values, and assumptions. The same continuity in language will be observed in the systems presented in the right-hand columns of the tables. The observations are important when we take into account that the paradigm preserves and perpetuates the disciplinary matrix of a field (Kuhn, 1970).

A major premise that this text suggests is that the language expressed in the left-hand columns and found within the paradigms of the mechanistic, the realists, the received view, behaviorism, and the medical model is consistent with the scientific method or quantitative research. In contrast, the language expressed in the right-hand columns reflects the paradigms of the organismic, the idealists, the nonreceived view, humanism, and many nursing models and is consistent with qualitative research methods.

We know well that there are more cultures than the two described by Snow (1959, 1993) in *The Two Cultures and the Scientific Revolution*. Today, there are hundreds, and there are disciplines and subdisciplines of those disciplines. Often, the subdisciplines of a discipline speak in foreign tongues to one another. For this reason, it is important to understand the overall fundamental differences so that we may intelligently see what Kirby (1983) calls "the points of contact in a plural world." Illustrating the plurality of worldviews, he optimistically states that "there could be an underlying unity . . . and thus a single earth-centered perspective from which all problems may be viewed" (p. 25). Three decades later, which is just a blip on the time screen, we have yet to come to this perspective. The following tables and the language should illustrate the fundamental differences. Perhaps the reader can surmise possible points of contact and propose an alliance where all sorts of evidence will contribute to the richness of our comprehension and our ability to make sense of the world around us.

Paradigms in Psychology

It has been said that all contemporary psychological systems are derivative of either the mechanistic or the organismic paradigms (Looft, 1973; see **Table 2–1**). Many philosophers and psychologists argue that the assumptions of each are unbridgeable. Either humans are reactive organisms, as Skinner (1953) would have them, or individuals are active and thinking organisms, as Piaget (1970) would predicate. One lays before us a thesis; the other, an antithesis.

The reader is asked to contemplate the differences in meaning as expressed in the descriptive language of the mechanistic and the organismic paradigms of psychology (see Table 2–1).

Are the perspectives unbridgeable? With these paradigms, as well as the ones that follow, discussion about the bridgeability of these perspectives should prove lively and fruitful.

Paradigms in Philosophy

Filstead (1979, p. 34) states that at the core of the distinction between the quantitative and qualitative methods of research lies the classical argument in philosophy between the schools of realism and idealism and their subsequent derivatives (**Table 2–2**). The Baconian reality of "seeing is believing" led to believing in the "real" as the only reality about which one could be positive. Hence, those who ascribed to that belief system were called "positivist." When reality could be held static, observations made, and experiments performed, science was done and the truth revealed. Those philosophers who questioned this positivist logic and method of science when it was applied to the understanding of human beings became known as "idealists" (Kneller, 1964). Today, the same questions asked by the idealists have been amplified by postmodernists. Science is no longer absolute or the final truth. Science is

TABLE 2–1 Paradigms in Psychology

Mechanistic	Organismic
Human being reacts and responds to the environment	Human being acts on and creates the meaning of an experience
Predictable response sets from human beings can be determined	Understanding comes from individual human perspective—variable responses
Empirical reality	Social construction of reality
One reality—same rules	Dynamic reality—different responses
Human beings can be controlled	Human beings are self-determined
Behavior—should be prescribed	Behavior—many possibilities acceptable and desirable

TABLE 2–2 Paradigms in Philosophy

Realism	Idealism
Static conception of world	Evolving conception of world
Seeing is believing	Truth as interpretation
Logical positivism	Dynamic, chaotic world
Social world as given	Social world as created
Independent physical reality	Reality is mentally perceived—sense perception
"At face value"	Approximate representational fit
Semantic truth-condition	Semantic relativism
Judgment-independent	Contingencies matter

an ever-changing body of ideas, and we have daily shifts about beliefs. The whole concept of universality and generalizability is put into question. We have come to see that "being in the world" may be more aptly stated as "beings-in-the-worlds." There are multiple worlds, multiple realities, and multiple perspectives (Anderson, 1995).

Although the idealists acknowledged the existence of a physical reality, they argued that the mind was the creator and source of knowledge. In addition to the language expressed in Table 2–2 from the idealist school, the following short Zen parable is indicative of idealists' ideas and the place of human perception (*Zen Buddhism*, 1959):

> One windy day two monks were arguing about the flapping banner. The first said, "I say the banner is moving, not the wind." The second said, "I say the wind is moving, not the banner." A third monk passed by and said, "The wind is not moving. The banner is not moving. Your minds are moving." (p. 52)

Although briefly presented, inherent here is the great debate between the objective and subjective means of knowing. We are about to see now how research methods as worldviews are an inherent outgrowth of a philosophical worldview that precedes it and establishes its epistemological ways of coming to know about the world.

Subsequent Paradigms in Epistemology

Flowing from the paradigms of philosophy should be congruent paradigms or research traditions for the way in which each school of thought establishes how it comes to know about its particular account of the world. Epistemology is the branch of philosophy that concerns itself with the nature of knowledge. Each school of philosophy will have an epistemology. In other words,

each belief system will have a congruent belief system about coming to know about the world and the nature of knowledge.

For our purposes, the realist philosophy is connected with the epistemological paradigm of the received view, and the idealist is connected with the nonreceived view (**Table 2–3**). I must acknowledge at this point or perhaps call attention to this very simplified version of what is most complex to philosophers. We are examining the gist of language differences, yet I strongly recommend further study in this area for those who are interested in greater in-depth knowledge. (Chapters 3 and 4 provide a further base to this aspect of the discussion.)

The expressions of the received view are those of the positivists and/or realists (Suppe, 1977; Watson, 1981). They are consistent with the scientific method[3] and are representative of expressions found most often in our present nursing research texts. The nonreceived view of coming to know about nursing phenomena is emerging, and those expressions are found in the language of qualitative epistemology as well as most nursing philosophies.

Paradigms in Education

The mechanistic and organismic paradigms are reflected in the field of education as behaviorism and humanism (**Table 2–4**). Learning theories emerging from these two paradigms are distinctively different because they are reflective of differing beliefs, values, and assumptions about the world and the nature of human beings. You may find it interesting here to reflect on which paradigm is more prevalent in nursing education and discuss the relative merits of each and, again, the bridgeability or points of contact (Munhall, 1992).

TABLE 2–3 Paradigms in Epistemology

Received View	Nonreceived View
Logical positivism	Uncertainty
Materialism	Mental perception
Reductionism	Holism
Laws—quantification	Patterns—qualification
Predictions	Interpretations
Objectivity	Subjectivity
Neutrality	Human values
Operationalization	Context integration
Knowing something	Understanding meaning
Determinism, immutable	Variability, interpretations most possible

TABLE 2–4 Paradigms in Education

Behaviorism	Humanism
Homogeneous group	Heterogeneous group
Human reactiveness	Human activeness
Human malleability	Self-determination
Human passiveness	Unique interpretation of reality
Objectivity	Subjectivity
Shaping concrete behavior	Changes in consciousness
Measurable outcomes	Hoped-for outcomes—variable and many non-measurable
Preparation for specific roles	Preparation for world at large
Behavior must disclose state(s) of mind	Behaviors and state(s) of mind may vary
Can be conditioned to react	Reactions chosen by individuals
Experience reduced to measurement	Experience resists uniform measurement

Paradigms in the Health Professions

Table 2–5 seems to reflect nursing's congruity with the preceding paradigms of the organismic, the idealists, the nonreceived view, and humanism. In contrast, the language of medicine seems to be congruent with the mechanistic, the realists, the received view, and behaviorism. It seems important to note, then, that our language system is congruent with some paradigms and not logically consistent with other paradigms. This is particularly relevant when we acknowledge that each paradigm should have a compatible research paradigm or method. The relevance is demonstrated in the philosophical paradigms of the realistic and idealistic and in the concomitant epistemological paradigms of the received view and nonreceived view, respectively. The languages of the medical model and most nursing models are readily distinguishable as to their perspectives, worldviews, tradition, or paradigms.

It is important to return here to our first consideration: "Research in nursing evolved predominantly when nursing was in transition between broad philosophic worldviews." The language presented in Table 2–5 as the language of medicine was for a long time that of nursing. When the worldview for nursing began changing, as reflected in proposed nursing models, the activity of nursing research concomitantly was under way. Ironically, the research activities that occurred in a parallel fashion often were not congruent with the premises of the nursing model. However, this incongruity is quite understandable when we review the second consideration in our language development: Researchers in nursing were being prepared in fields other than nursing.

TABLE 2–5 Paradigms in Health Professions

Medicine	Nursing
Reductionism—treating the part; treating the symptom	Holism—care for the whole person, whether "sick" or well, person as integrated whole: more than sum of parts
Reactive human being—reacts as prescribed	Active human being—transformative and chooses action
Physical symptomatology	Integrated human being
Linear causality—cause and effect	Multiple interaction—self, others, environment, cosmos
Closed system	Open system
Steady state	Dynamic
Objective	Subjective
Manipulation	Self-determination
Control	Choice
Paternalism	Advocacy
Standardized protocols	Divergent trajectories

Early Preparation of Nurse Researchers

It is so commonplace today that our nurse scholars and researchers have doctorate degrees in nursing that we need to reflect on the influence of the earlier doctoral preparation of nurses. Before the opening of specific nursing doctoral programs in the United States, nurse faculty and others sought this degree in other disciplines that seemed to relate to nursing. On completing these degrees, many of those doctorally prepared nurses began to think of developing nursing's own degree, a doctoral degree in nursing. Because our doctoral education evolved in this way, we will proceed to examine its influence rather than discuss the merits and limitations of such evolution.

The outcome was the development of a community of nurse researchers who were educated in the better-established disciplines and who subsequently developed a commitment to that discipline's research method (Chinn, 1983; Corbin, 1999). Although this development offered nursing a wide array of methods from which to choose, it soon appeared evident that the scientific method, with its own language, was adopted to such an extent that, Watson (1981) reported, "The scientific method is considered the one and only process for scientific discovery, experimental quantitative research methodology and design" (p. 414). Swanson and Chenitz (1982) state: "While nursing exists almost exclusively in the empirical social world, the profession uses the laboratory method of the basic sciences in its research design" (p. 241).

Norris (1982) attributes this supremacy of the scientific method in part to nursing's "desperate attempt" to become a legitimate science by embracing the experimental research model as the way to proceed. Indeed, science and scientific cannot be considered neutral words (if there are such words). In today's world, they are extensively value laden as expressing truth, goodness, worthwhileness, and legitimacy. Kaplan (1964) emphasizes this legitimacy point: "There are behavioral scientists who in their desperate search for scientific status give the impression that they don't much care what they do if only they do it right: substance gives way to form" (p. 406).

However, as Norris (1982) points out in a discussion of nursing's leap to experimental research, many nurse researchers are hampered by the lack of concept clarification, theory development, and descriptive methods of research, all of which are linked to qualitative research methods. Norris (1982) observes that, during the period from 1958 to 1975, nursing scholars made a concerted effort to develop a body of nursing knowledge without the necessary training in the methods of concept clarification, which are prerequisite to experimental research. This "scientific" influence continues to exercise its exclusivity, as is evidenced in the following scenario (Tinkle & Beaton, 1983):

> It was her first dissertation committee meeting. The topic of discussion was the proposed research methodology. Two of the committee members (well-known for their "hard" research) began to dialogue about the "softness" of the approach in the proposal before them—the lack of control, the lack of quantitative measurement, and the lack of manipulation of variables. Before long, the committee was in accord about the relatively low scientific merit of this type of research methodology as opposed to an experimental approach. The student found herself agreeing to shift her methodology to one involving experimental manipulation. (p. 27)

What makes this anecdote relevant almost 3 decades later is that, in some colleges of nursing, this belief system has become even more prominent. The status and sometimes the requirement to attain National Institute of Nursing Research (NINR) or National Institutes of Health funding to advance, obtain a position, and even earn tenure demonstrate how fundamental to the research enterprise this commitment to "hard" science is.

Downs (1982) observed in response to a similar theme: "This distorted value system rode in on the coattails of the idea that scientific method was equivalent to experimental research" (p. 4). Bronowski (1965), with a broader conception of science, surpasses this narrow view of the scientific method and enlarges the aperture. Science, he says, is: "Nothing else than the search to discover unity in the world variety of nature or . . . in the variety of our experiences. Poetry, painting, the arts are the same search" (p. vi).

In a cogent argument for a poststructural perspective, Dzurec (1989) comments on the tenacity of logical positivist methodology in nursing:

> The period beginning in the 1960s and stretching to today is perhaps the first in which the power relations in nursing and in human sciences in general have allowed the recognition of logical positivism as a single philosophy of science rather than as science itself. (p. 74)

However, we do know that our worldview has opened to allow for other methods of research. Coming to know and coming to discover rather than verify have become acknowledged as essential to the base of nursing knowledge.

Watson (1981) attributes this increased acknowledgment to the same processes of scientific development that have taken place in other sciences. She states that our commonality with other fields lies in the process of first adopting the received-view idea and then undergoing processes of rejection of that particular paradigm. We would not advocate the abandonment of all the characteristics of the received view or the scientific method, but two important points need to be made about the early preparation of nurse researchers (and, to a large extent, the present preparation of nurse researchers). These points are still discussed today and will lead us into the next contextual consideration (Ashworth, 1997; Clark, 1998; Watson, Dossey, & Dossey, 1999). They are as follows:

1. Nurse researchers predominantly use the scientific method of inquiry and that language system.
2. The scientific method is used in nursing research prior to the description and understanding of the phenomenon within the nurse–patient context. In other words, we take leaps to a step without the necessary conditions for that step. Often we take those leaps within the context of deduction and derivation from theories from other disciplines and from nursing theories representing a totality paradigm (whose assumptions are congruent with those of natural science research).

A third possible point here is that some of nursing research is research done by nurses but is not research in nursing. An example of this is nurses participating in medical research studies.

Deduction and Derivation from Theories: From Then to Now

In this section I attempt to provide for you our origins in nursing research and theory development. Some educated in nursing research say they were spoonfed these first pioneers. It is always critical to know the origins and history of your field, lest someone bring up old information as a new discovery!

Walker and Avant (2004/1983) define theory derivation as "the process of using analogy to obtain explanations or predictions in another field" (p. 163). These authors distinguish between theory derivation and borrowing theory (p. 163), but, for our purpose here, we are speaking about a process in which the description and explanation of phenomena for the development of nursing theory evolved from a discipline or field of knowledge other than nursing. Therefore, the language originates from a world other than the nurse–patient world. Nursing researchers identifying similarities from other fields believe a specific theory to be appropriate to a nursing or patient situation and proceed to generate deductions and/or hypotheses from that theory. This theory derivation is asserted to be useful when there are no available data or when the phenomenon is poorly understood (Walker & Avant, 2004/1983). Thus, we had almost 25 years of nursing research based on theoretical frameworks that did not originate within a nursing or patient context.

One point that should be considered is that many borrowed and derived theories in nursing are based first on the natural and behavioral sciences and, with that, a mechanistic paradigm. Subsequently, the hypothesis deduced from such theories originated from how physical matter behaves, how people respond to forced-choice questions, and, probably all too often, how college students respond to questionnaires and various experiments.

It is amazing to realize with a simple perusal of psychology texts that one experiment after another, leading to the development of theory, has been performed on college students. In these many instances, theories evolved from a very specific age sample and then were generalized to the population at large. The very specific sample has been for researchers of human behavior a real convenience sample, that is, their 19-year-old sophomore students.

Another potential problem with theory derivation and language development from other fields is the male bias inherent in many of our developmental theories (Belenky, Clinchy, Goldberg, & Taub, 1997/1986; Chinn, 1985; Gilligan, 1978). Pinch (1981) proposes that we should critically examine theories of development generated by Freud, Piaget, Erickson, and Kohlberg to recognize how we have accepted worldviews as developed and evolved from a male perspective. When we apply a hypothesis derived from such theory to individuals who may be ill—whether the derivation is from a male perspective, a college student's perspective, a well person's perspective, and so on—we will always have problems of authenticity, validity, and, most important, contextual meaning.

In our history of knowledge development, Dickoff and James (1968) propose a schema of four levels of theory: factor-isolating theories, factor-relating theories, situation-relating theories, and situation-producing theories. This schema dominated the development of nursing theory. We now need to evaluate how

well we have proceeded with each of the four levels of theory. Often, when borrowing or deriving from theories from other fields, we proceed directly to situation-producing theories, sacrificing meaning and true significance to expedience. As far back as 1968, Dickoff and James cited this lack of attention to the beginning levels of theory development as being detrimental to the development of nursing theory. Wald and Leonard (1964) suggest that nurses develop their own concepts for nursing theory from inductive analysis of nursing experience rather than from deductive analysis from others' experiences. Perusal of many of the nursing research articles published today still indicates dependence on deducting hypotheses from unrelated contexts or unrelated populations.

Diers (1979), in a context correlative to the work of Dickoff and James, provides us with another classification of levels of theory (**Table 2–6**).

TABLE 2–6 Levels of Inquiry and Study Design

Level of Inquiry	Kind of Question	Study Design	Kind of Answer (Theory)	Study Design
1	What is this?	Factor-searching	Factor-isolating (naming)	Exploratory Formulative Descriptive Situational
2	What's happening here?	Relation-searching	Factor-relating (situation-depicting, situation-describing)	Exploratory Descriptive
3	What will happen if . . .?	Association-searching	Situation-relating (predictive)	Correlational Survey design Nonexperimental Natural experiment Experimental Explanatory Predictive
4	How can I make . . . happen?	Prescription-testing	Situation-producing (prescriptive)	

Source: From *Research in Nursing Practice* (p. 54), by D. Diers, 1979, Philadelphia: Lippincott.

Indeed, all the qualitative methods of research presented herein seem essential to the beginning steps of theory development. In the first and second levels of inquiry, the questions "What is this?" and "What's happening here?" are answered within our own nurse–patient context. With qualitative research methods, theory is not derived, borrowed, or modified from other fields but rather springs from observation of and participation in an actual phenomenon. Norris (1982) believes that the phenomena with which nurses have the social prerogative and mandate to manage concern human health, illness, and comfort. Newman (1983, 1999) identifies additional patient–nursing phenomena, such as reciprocities, patterns, configurations, rhythms, and composition, and emphasizes context dependency, recognizing the simultaneity of our human-environmental processes.

The Social Policy Statement of the American Nurses Association (1995) specifies that the phenomena of concern to nurses are human responses to actual or potential health problems. All are phenomena researchable through qualitative methods and in the end may well stimulate the development of knowledge grounded in the experience of the patient, in complex interactions, and situated in an individual life-world. In the last edition, I had voiced hope that these discussions and debates of a socially constructed dichotomy would be a historical curiosity. Although some literature speaks to moving beyond this debate (Clark, 1998), Watson, Dossey, and Dossey (1999) offers a strikingly contemporary worldview for nursing in which the old traditions largely dominate. What might influence the dominance of one paradigm over another or one theory over another is the importance placed today on interdisciplinary, multidisciplinary, or intradisciplinary theory and development. With the example of intradisciplinary theory, especially in nursing, we can actually come to see the benefit of combining or bringing together various theories, where there are philosophical consistencies or where one theory may be applicable to a particular experience and another theory better able to explain another area of experience.

Here is a place for human understanding in that nurse theorists who have devoted their life careers to development of their own theories are reluctant to let any part go or combine with another theorist. This is often unspoken, but for the sake of knowing, we need to be aware of this dynamic.

Intradisciplinary and interdisciplinary theory development and research could also come about with the six or so different specialty areas of nursing working together, which is so very complementary to the concepts of holism and the situated context.

Multidisciplinary theory development and research are also compatible with the ideas and tenets of qualitative research. Working with other human science disciplines enriches our understanding and broadens the possibilities by incorporating the many facets of being human. A suggestion, though, if you are to embark on multidisciplinary work, is to think of the following two

considerations. First, is your project multidisciplinary because a granting agency is calling for that? If so, are you committed to a multidisciplinary approach beyond that requirement? Second, it is very helpful to work with an established or experienced researcher who has done multidisciplinary research previously. This can also be said for mixed-method research, which is discussed in Chapter 24 and Chapter 25.

A Transition: Nursing Worldviews, Nursing Researchers, and Theory Development

One of the purposes of this chapter is to explore nursing's coinages (language), its situatedness in this world, and how we choose to express ourselves. The foregoing discussion is an attempt to place in context our present posture in nursing research and to suggest the origin and evolution of how we have come to express ourselves and the language that we use to bring nursing phenomena into being. I suggest that this and other texts on qualitative research methods are a natural outgrowth of this context. It is contemporary, evolutionary, and congruent with changing worldviews. Expanding research horizons, acquiring new languages, and bringing phenomena into view constitute a reconstructing process.

Transitions in worldviews or paradigms are a gradual process wherein beliefs, values, and practices of the old and the new overlap (Kuhn, 1970). This continues to be a time when there is often conflict, incongruity, and confusion. However, these times are good times for self-reflection, self-consciousness, and clarification. Thesis, antithesis, and paradigmatic shifting are all parts of scientific revolutions or, in Laudan's (1977) terminology, the evolution of research traditions. They are the history and essence of science.

Returning now to the three identified factors that seem to influence the context of nursing research most, let us consider them from the perspective of Kuhn's language in an application to nursing research. Kuhn (1970) observes:

> During the transition period [of worldviews] there will be a large but never complete overlap between the problems that can be solved by the old and by the new paradigm. But there will also be a decisive difference in the modes of solution. When the transition is complete, the profession will have changed its view of the field, its methods and goals. (p. 84)

Perhaps for very good reasons we have not reached this stage, with the two main paradigms still being taught simultaneously: the totality paradigm and the simultaneity paradigm. Each of these paradigms indicates a method of research. The former yields best to the scientific method and the latter to qualitative methods of research. Today in our schools or colleges of nursing the

research curricula often reflect the supremacy of the totality or scientific method, or the supremacy of the simultaneity or qualitative methods (very rare) or a combination of the two paradigms with a subtle or not so subtle preference for the scientific method. As in Chapter 1, I mention this so that you as a student understand the context of where qualitative research is placed in our present time. However, you are studying in a time when qualitative research is scientifically accepted, respected and sought after by journals and research conferences. The recognition of what qualitative research has to offer is being recognized more and more in all our scholarly venues. Once again though and as stated in Chapter 1, we must be rigorous in the use of our methods, grounding them congruently with the philosophical underpinnings of the methods and emphasizing significance.

Returning to Chapter 1 and before Chapter 3, teaching both paradigms is from my perspective a valid one. What is not valid is to ask a research question and then attempt to answer it prematurely with the wrong method or just to answer any research question or aim with the wrong method. As we discussed in Chapter 1, some research question and aims require a qualitative approach, while others a quantitative approach. In the scheme of things most knowledge in nursing would best be obtained with a preliminary understanding of the phenomenon or phenomena under study with a qualitative research study and then if necessary followed by a quantitative study. When this is not done we have the results as discussed above with borrowed theory. We find quantitative research derived from theories that do not originate in the patient/nursing world and the fit can be disastrously poor. On the other hand qualitative research does not require theory, such research is atheoretical and can be the origin of theories based in patient/nursing experience.

While Chapter 3 entertains epistemology in nursing and qualitative and quantitative methods of knowing, the task before us next in this chapter is a discussion of the linguistic transition in nursing away from language of the medical model. So whether the method we choose is qualitative or quantitative we still must concern ourselves with the development of our own language. As this chapter opened, we must concern ourselves with bringing nursing and our patient's authentic experience into existence, into being, into theory through language and this you will find within the exemplar chapters of this book and all the previous editions. This is important to understand, we are in the business of bringing the unknown, without language to describe it, into our everyday practice through newly discovered language and phrases. The earlier illustrations in this chapter demonstrate how phenomenon enters our nomenclature and we all have a way of understanding something we had not prior. This is very critical. *If* an entity is not given a name, a "something" to direct our attention to we will simply not even look for it! How significant is that?

Nursing Worldviews

Nursing has attempted to abandon the language of the medical model and, concomitantly, to reject the mechanistic paradigm expressed by that language. To a lesser extent, medicine itself appears to be in transition from its own medical model to one that seems more aligned with some of the beliefs that we have most recently been espousing. There is within that field an emerging language that focuses on holism, psychosomatic phenomena, and the influence of environmental factors.

Even though nursing has attempted to develop nursing language, it often continues to retain the philosophical foundations of the medical model for research and to express its significance and importance in the symbols and practices that traditionally belong to medicine. Perhaps readers will consider some of these nonverbal symbolic forms of language that nursing continues to use and even seeks to acquire from the perspective of paradigmatic transition (Roberts, 1973).

In view of Kuhn's (1970) suggestion that when "the transition is complete, the profession will have changed . . . its methods" (p. 84), let me repeat a question I asked a while back (Munhall, 1982): "Could it be that when nursing abandoned the medical model and the language of that discipline, it retained the research paradigm that perpetuated what nursing was seeking to dissociate from?" (p. 68). Today I would ask the question, not so much regarding an abandonment of the medical model but the hard scientific research model, vis-à-vis logical positivism/scientific method. Is that what we are invested in because of the academic scientific community giving primacy to the natural sciences and not to the human sciences or arts? Is it even more ingrained because research grant money has become a way to attain faculty positions and tenure and research grant money still favors the scientific method?

Because transitions are gradual and because of the aforementioned contextual variables, I am inclined to view this question as characteristic of a trajectory of transition in worldviews. Things do not change at once; Kuhn's (1970) words were: "When the transition is complete, the profession will have changed . . . its methods" (p. 84). Our transition is far from complete. However, many nurse researchers and scholars are catalyzing the progress and process of this transition. Many of them are in every edition of this book!

Nurse Researchers and Scholars

Many of our nurse researchers and scholars, many of whom were socialized in the scientific method, are emerging strongly from that orientation (often meaning experimental research) and are contributing now to the logical shift in research paradigms that would be congruent with the shift in the larger

philosophical worldview and new perspective of viewing phenomena. What seems to have occurred is that questions and problems of the profession with its new and unique nursing perspective, that is, holism versus reductionism and/or simultaneity versus totality, cannot be answered or solved by the old methods, at least not at first.

Laudan (1977) reassures us with the following observation: "But there are times when two or more research traditions, far from mutually undermining one another, can be amalgamated, producing a synthesis which is progressive with respect to both the former research traditions" (p. 103).

We seem to have divided ourselves into two different schools of how to think about what we study. Certainly we have moved from what Norris (1982) identifies as "the occasional nurse who used the podium or the literature to support a descriptive route to knowledge [as] a 'voice crying in the wilderness'" (p. 6). Our progress now includes regular publication of the merits of qualitative research, the need for qualitative methods, research programs highlighting qualitative research, and general recognition of the advantages of a broadened repertoire of research methods.

When we first debated the various methods, it was as though we were seeking a place for each method for a specific purpose. As previously noted today, we see conferences, journals, and particular programs specializing in either quantitative or qualitative methods. It is an interesting evolution, and we need to be cognizant of the need to hear one another's voices, regardless of the orientation.

Hardly hidden in the agendas of various schools or organizations is a strong bias toward one orientation as previously alluded to, and unfortunately there may even appear to be suspicion toward or disrespect for the other. Such suspicion or disrespect is counterproductive, and just as tolerance for individual differences is part of our nursing philosophy and ethos, the same must extend to differences in research orientations. These differences need to enrich us and assist us in ultimately meeting the needs of our patients.

At this point it might be helpful to analyze not only the syntactical parallelism but also the contextual congruence of our larger philosophical paradigm with our most prevalent research method. The language that we use to express the philosophical paradigm and the research method demonstrates the emergence of a new worldview and the residue of the old.

The expressions in **Table 2–7** are provided to demonstrate the transitional nature of our worldviews and research paradigms. Table 2–7 illustrates the expressions of competing paradigms and Kuhn's overlap as we examine the contextual parallelism for logical syntax. This contrast has stimulated for many nurse researchers the proliferation of competing views, debates about methods, and discontent over the effect of nursing research on practice. Kuhn (1970) believes such debates are symptomatic of a "transition from normal to extraordinary research," but, as just mentioned, we should beware of splintering. The

TABLE 2–7 Expressions in Nursing Philosophy and Research Paradigms, and Contextual Parallelism

Expressions of Contemporary Nursing Philosophy	
Humanism	Uniqueness
Individualism	Relativism
Self-determination	Autonomy
Active organism	Advocacy
Open system	Organismic
Holism	Situated context
Life-worlds	Simultaneity
Multiple realities	Multiplicity
Self-interpretive	

Expressions of the Scientific Method	
Reductionism	Theory for the average
Objectivity–positivism	Categorization
Delimited problems	Prediction
Reality reduced to the measurable	Control
Human and environmental passivity	Mechanistic
Manipulation	Totality

Conceptual Parallelism	
Nursing Philosophy	*Nursing Research Based on the Scientific Method*
Individualism	Commonalities
Uniqueness	Generalizations
Relativism	Categorization
Open system	Closed system
Holism	Reductionism
Individual interpretations	Statistical analysis
Active organism	Reactive organism
Organismic	Mechanistic
Self-determination	Control
Simultaneous interaction	Totality
Situated context	Acontextual
Multiple realities	Objective reality
Subjective perceptions	Objectivity

wholeness and the interaction that we propose in nursing models should be reflected in our own community of nurse researchers.

For the sake of conceptual clarity, the various paradigms have been presented in a dichotomized way. However, the practice is used more for its illustrative purposes. The goal here is to build bridges rather than erect walls. The bridge may well represent a transcendence of the two competing worldviews with the emergence of a research paradigm that either utilizes the two views or goes beyond them.

Theory Development

The transition from one paradigm to another paradigm or to the inclusion of another paradigm will be reflected, as has been suggested, in our language and expressions. We previously mentioned the borrowed theoretical frameworks that are used so prevalently in nursing research. We borrow freely from physics, biology, physiology, psychology, and sociology. We seem, as was mentioned, to also have two different nursing paradigms: the totality and the simultaneity. These practices often lead to fuzzy language. For example, in doing interdisciplinary research it is important that the situated context be similar to each discipline. The situated context of our patients' worlds is, in some instances, so very dramatic. The individuals are very vulnerable and there are family threats among contingencies that we must be extremely cautious in choosing what disciplines we do research with in these kinds of matters. On the other hand, if we are researching how to assist people to have a better quality of life then doing research with colleagues from public health, psychology, nutrition, among other fields makes perfect sense. The advantage of interdisciplinary research is that we do not have to reinvent the wheel, so to speak!

Paterson (1978) compiled a list of nursing phenomena (**Table 2–8**) selected by practicing nurses as being essential to nursing. I ask you to compare these expressions with the expressions found in many of our contemporary research titles. It bears repeating that we must recognize just how pioneering Paterson (1978) and Zderad (Paterson & Zderad, 1976) were. To pay tribute to them, their jointly written book, *Humanistic Nursing*, was reissued in 1988 as being contemporary and relevant for the present after its first publication in 1976. Read, think about, and respond to these words in Table 2–8 as perhaps the quintessence of nursing. Could any of us argue that they do not constitute nursing phenomena?[4] Would we not want them to? Are these not the words that express caring in experience? To those who wonder why there is not adequate description of such experiences in nursing literature, I believe the answer lies in the arguments for qualitative research. Qualitative researchers eagerly await the extraordinary research that Kuhn promises as the outcome of scientific revolutions. I believe the quality of patient care and outcomes depend on it.

TABLE 2–8 The Quintessence of Nursing

Acceptance	Give and Take
Authenticity	Laughing–crying
Awareness	Loneliness
Becoming	Openness
Caring	Patience
Charge	Readiness
Choice	Response
Commitment	Responsibility
Confirmation	Self-recognition
Confrontation	Sustaining
Dedication	Touching
Dying and death	Trust
Meaning	Understanding
Freedom	Waiting
Frustration	

Source: Reprinted with permission from "The Tortuous Way Toward Nursing Theory," in *Theory Development: What, Why and How?* (p. 65), by J. Paterson, New York: National League for Nursing, 1978, 1988.

Language and Comprehensibility

> *The existential-ontological foundation of languages is discourse or talk.*
>
> (Heidegger, 1962, p. 203)

> *Discourse is existentially language, because that entity whose disclosedness it articulates according to significations, has, as its kind of being, being-the-world and being which has been thrown and submitted to the world.*
>
> (Heidegger, 1962, p. 204)

> *For in conversation, as in research, we meet ourselves. Both are forms of social interaction in which our choice of words and actions return to confront us in terms of the kind of discourse or knowledge we help to generate.*
>
> (Morgan, 1983, p. 406)

And where does a nurse researcher thrown into and submitted to the world learn to speak? In the pedagogical world of research, a new language is learned. We noted earlier that this language is sometimes chosen freely,

sometimes encouraged in one or another direction, and sometimes "raised" to such high levels of abstraction that it becomes incomprehensible. From a qualitative perspective, language and the ability to express oneself to others is the only way in which we can bring experience into a form that creates in discourse a conversational relation (van Manen, 1990, 1997).

Before this chapter ends, it seems essential to mention an obvious inherent component of language: listening. Discourse and conversing include keeping silent and hearing. The openness that is required for new ideas to penetrate into a belief system requires silence and hearing. Additionally, when considering language, many people silence themselves, they do not give voice to their experience, and what may be meaningful in the "said" may even be more meaningful in the "unsaid."

The language of human science or phenomenology may at first sound strange to people who are steeped in a natural-science language (see **Table 2–9**). Paterson and Zderad's (1976) first attempts to introduce this language into nursing were often met with firm preconceptions and assumptions about being in the world that were dramatically different.

TABLE 2–9 Expressions* of Qualitative Research Methods

Subjective experience	Closeness to the data
Intuition	Process orientation
Variability	Dynamic reality
Communication	Open system
Individual perceptions	Time and space considerations
Shared language	Patterns
Interrelatedness	Polyvocality
Situated context	Configurations
Lived experience	Context dependence
Holism	Complementarity
Naturalism	Human development
Nonmanipulated observation	Life-worlds
Self-interpretation	Contingencies
Multiple perspectives	Multiple realities
Intersubjectivity	Narratives/stories
Existential meaning	Emergence/Convergence

* All these terms will be explained within the text.

As I suggest in Chapter 1, one key idea is to lay groundwork in many curricula to assist students in the language of understanding the meaning of both being human in our different perspectives and understanding those differences in nursing and nursing research. The symbols, signs, and words that we use have inherent meaning. They are signifiers of who we are, what we are, and what is meaningful to us.

Summary

The intent of this chapter can be summarized by borrowing Paterson's (1978) words: "For responsible, effective existence the professional requires language to relate authentically the purposes, beliefs, concerns, and events experienced continually to the nursing world" (p. 51). A mystery exists in those phenomena listed by practicing nurses, but each seems to be a "thing in itself," something waiting for description to bring it into our everyday awareness and to give it significance. It is as though we need to assert these events as belonging to nursing, to articulate our authentic experience with patients, and to claim what we and our patients believe to be essential to health and to our quality of existence. We then assign language to what is uniquely the abstract and the concrete, the enduring and the relevant meanings of shared human experience between patient and nurse. It is indeed a privilege and a calling to assist a patient in finding meaning in experience.

Qualitative research methods have much to offer as a research paradigm that is congruent with nursing's larger worldview, paradigm, or model. These methods offer ways to approach individuals in experiences, to encourage them to give voice to their experiencing, and to care enough to search for meaning within the experience. I refer again to Table 2–9 as an illustration of the language of the qualitative research methods and leave you to draw your own conclusions.

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Endnotes

[1] There is considerable ambivalence within the profession about the usage of the term nursing diagnosis and developing taxonomies. Many view these systems as reductionistic, acontextual, and a continued imitation of medicine. In addition, a long history of debate over whether to identify the recipient of nursing care as "patient" or "client" follows a similar vein.

[2] For a more detailed explanation of the scientific revolution that eclipsed determinism and objectivism, the reader is referred to works on quantum physics, Heisenberg's principle of uncertainty, and Bohr's principle of complementarity. In Floyd Matson's *The Broken Image* (1964), a most readable discourse can be found, and Larry Dossey's *Space, Time and Medicine* (1982) is wonderfully explicit and enjoyable reading on this topic.

[3] As defined in the traditional sense. All the methods presented in this text are considered scientific methods of research.

[4] Additional phenomena are discussed in Chapter 3.