Theory is essential to research. It provides the perspective from which you think about the phenomenon under consideration and then design the research study. This is not a one-way street: not only does theory inform research, but research also informs theory (Figure 3-1). Some research methods have even been specifically designed to generate theory. Glaser and Strauss’s (1967) grounded theory is one example.

In this chapter, we will first review some important terms. Then we will consider the developmental level of various theories and the multiple levels of theory, from the broadest worldviews to the most discrete, specific, operational definitions.

**IMPORTANT DEFINITIONS**

**Discipline**

We often speak of the discipline of nursing without thinking much about what we mean by this term. A discipline is a distinct branch of knowledge with its own set of rules for developing that knowledge and guiding practice (Fitzpatrick, 2014).

**Theory**

There are many definitions of theory. Most simply, a theory may be defined as a statement that describes and/or explains phenomena (Barnum, 1990). Caring theory, for example, provides a description of what occurs between nurse and patient within a caring relationship. Stress theory provides descriptions of what stress is, sources of stress, and how stress affects health.
Here is a more complex but important definition of theory: A set of interrelated concepts and propositions that explain and predict phenomena (Kerlinger, 1986). For example, the six Cs of caring, which are competence, confidence, compassion, comportment, conscience, and commitment, describe the caring behaviors of nurses (Roach, 1984). Similarly, Holmes and Rahe (1967) created a list of 43 life changes that they theorized would contribute to stress including trouble with one’s boss, pregnancy, and divorce. (Note that even positive changes are thought to contribute to stress.)

Induction and Deduction

The terms *induction* and *deduction* describe the interaction of theory and research. They come from ancient Latin words and are used in the study of logic. Induction comes from the Latin term meaning “lead in” or “bring into.” From logic, induction means drawing a conclusion from particular facts. For our purposes it means developing theory (the conclusion) from the results of research (the particular facts).

The Judgment to Delay model, for example, was developed from a synthesis of theory and research findings. O’Mahoney (2014) used it to study women’s help seeking or delay in help seeking after having discovered a breast symptom. Findings from tests of this model can be applied to the development of more effective health promotion and prevention messages. Additional tests of the theory will contribute to its further refinement.

Deduction is the opposite. It comes from the Latin term meaning “lead away.” From logic, deduction means reasoning from a known (generally accepted) principle to the as yet unknown or from the general to the specific. For our purposes, it means using theoretical propositions (a known that is generally accepted) to inform our research study (which, until it is done, is the unknown) (Webster’s Unabridged Dictionary, 1999). You might want to look at Figure 3-1 again to see these relationships illustrated.
Another way to describe the difference between induction and deduction is that induction is the process of theory development, whereas deduction is the process of theory testing (Fawcett, 1999). You can see, then, that research and theory are highly interconnected. Research may be used to generate theory, to test it, or both.

DEVELOPMENTAL STAGES OF THEORIES

Descriptive
At their most basic level, theories simply name, describe, and classify phenomena of interest. You may remember from your basic science courses the complex classification and naming conventions for microorganisms such as the influenza A(H3N2) and A(H1N1)pdm09 strains. In nursing, the stages of grieving or of a decubitus ulcer are familiar examples. All of these are descriptive theoretical statements.

Explanatory
At this next level of development, theories include statements of relationships between phenomena. The relationships are often demonstrated using correlational statistics. For example, high Graduate Record Examination (GRE) test scores have been found to be related to success in graduate school (Brownstein, Green, Hilbert, & Weiner, 1999). Relationships between high levels of stress and a number of health problems have been theorized. Isolation in old age is associated with increased depression. Carotenoids are associated with inhibition of bone breakdown and resorption (Sahni et al., 2009). All of these are at the explanatory or relational stage of theory development.

Predictive
At this highest level of development, theories predict outcomes given one or more specific inputs. For example, the germ theory of disease predicts that the presence of a sufficient amount of a particular microorganism such as Streptococcus pneumoniae (the input) will cause pneumonia (the outcome). Most of these predictions are actually more complex than a single input, however. For example, an individual’s level of resistance and use of prophylactic antibiotics affect whether pneumonia will develop. Likewise, the combination of poor nutrition, immobility, poor circulation, and increased pressure on a bony prominence is predicted to result in a pressure ulcer. Low stimulation is predicted to retard brain development in infants, and inadequate contact is predicted to reduce parent–infant bonding.

USING RESEARCH TO TEST THEORY
Some nursing theorists have put considerable effort into testing their theories and have encouraged others to test them as well.
A number of nurse researchers have tested concepts and propositions derived from King’s systems framework for nursing and related midrange theory of goal attainment. For example, Froman (1995) hypothesized that the greater the perceptual congruence between nurse and client, the greater the degree of goal attainment would be achieved (p. 225). She used a researcher-designed Perceptual Congruency Questionnaire to test this hypothesis and found that many perceptions of the nurse and patient respondents were dissimilar. For example, 53% of the nurses did not know what their patients believed caused their illness, and 35% were unsure what the patients needed to know to care for themselves at home, suggesting that “validation by nurses with their clients about the means to achieve client goals may occur minimally in actual practice” (p. 235). A moderate relationship between perceptual congruency and satisfaction with care \((r = 0.43)\) was also found, providing modest support for the importance of perceptual congruency. Also based on King’s theory, Hobdell (1995) predicted that perceptual accuracy is affected by mood state. She also found partial support for the hypothesized relationship between chronic sorrow and accuracy of parents’ perception of the child’s cognitive development in parents of children with neural tube defects, finding it in the fathers but not the mothers. Studies such as these should eventually lead to refinements of King’s theory.

Kolcaba’s work demonstrates the importance of treating theory as dynamic rather than static in nature. In the development and testing of her comfort theory, Kolcaba (2003) used data from testing of her Radiation Therapy Comfort Questionnaire (RTCQ) to determine whether comfort had both state (immediate) and trait (long-term) dimensions as anxiety has been found to have. To do this, Kolcaba and colleagues compared results on the RTCQ at three time points and found that they were not highly correlated, suggesting that comfort is primarily a state characteristic. Relief and ease seemed to be more state specific than was transcendence. Based on these results, Kolcaba suggested that the characteristic of being able to transcend stressful situations may be a trait (p. 71), but that the relief and ease dimensions of comfort are probably state characteristics.

Zeigler and colleagues (2005) reviewed the research support for a number of midrange theories that are familiar to nurses. Here is what they found about several of them:

**Aguilera’s Crisis Intervention:** Research support is limited but suggests that when the intervention is clearly defined and the interventionists are well trained, crisis intervention may be effective (Jones, 2005).

**Peplau’s Interpersonal Relationships:** Peplau used an approach similar to grounded theory to develop her interpersonal theory. Primarily qualitative studies and case studies supporting this theory were found. Forchuk (1993) notes that researchers such as Morrison and Shealy (quoted by Forchuk) found that both self-disclosure and taking the role of friend, which are discouraged by Peplau, are frequently used by nurses. Similarly, Williams and Tappen (1999) found the sharing of personal

\(r\) = correlation coefficient for bivariate analysis.
information by the nurse to facilitate development of therapeutic relationships with cognitively impaired individuals. These findings suggest possible modifications to Peplau’s theory (Arnold & Nieswiadomy, 2005).

**Lewin’s Change Theory:** Lewin developed action research to evaluate his approach to implementing change, but Chaney and Hough (2005) note that more evidence for its efficacy in practice is needed. Of interest, for example, is Semin-Goossens and colleagues’ (2003) article, the title of which is particularly informative: “A Failed Model-Based Attempt to Implement an Evidence-Based Nursing Guideline for Fall Prevention.”

**Lazarus’s Coping Theory:** Coping has been studied frequently but is difficult to test experimentally. One reason may be that different people find different strategies suit them best, making generalization difficult (Baldwin, 2005).

**Erikson’s Stages of Growth and Development:** These stages were based on Erikson’s observations (qualitative data). It is interesting that, although Erikson’s focus is primarily on childhood, most of the studies using his stages have been concerned with adults. Some research measurement tools have been based on Erikson’s stages (Mobley & Johnson-Russell, 2005).

### USING THEORY TO INFORM RESEARCH

Using theory to guide research has long been a tradition in nursing research (Alligood, 2011). How powerful is the influence of theory on research? The answer is, simply, very powerful. Dan Everett, a linguistics professor who studies the languages of remote Brazilian tribes, explains its power this way, “We ask the questions that our theories tell us to ask” (Colapinto, 2008, p. 27).

We now consider the other half of the research–theory interaction illustrated in Figure 3-1. Every research study has at least an implied worldview, a lens through which the world is viewed and interpreted, even if it is not specifically stated. At the very least, the researcher has elected to use either the scientific methods associated with quantitative research or one of the qualitative approaches with its underlying philosophy. Most studies also have an implied theoretical base upon which they have been developed. This implied theoretical base may be the germ theory, that infectious organisms cause disease; it may simply be the assumption that humans live in a state of either health or illness or somewhere along the health–illness continuum; or it may be that a combination of biopsychosocial factors affects an individual’s health. A few examples follow.

Although not previously well developed according to the researchers, the concept of symptom clusters was the underlying idea for Barsevick, Dudley, and Beck’s (2006) secondary analysis of data from an intervention study. They linked this concept (symptom clusters) to Lenz and colleagues’ midrange theory of unpleasant symptoms. Barsevick and colleagues evaluated the relationship between two cancer treatment–related symptoms, fatigue and depression, and an important outcome, functional status. They found that
their intervention, teaching energy conservation coping skills, changed the relationships among fatigue, depression, and function. In the control group, when fatigue made routine activities difficult to perform, depressive symptomatology increased. This did not occur in the experimental group. They suggested that individuals in the experimental group learned how to prioritize the activities in which they invested their energy, alleviating the depressive reaction.

Limitations and the need for further development of existing concepts, theories, and frameworks are often indicated in the reviews of theory underpinning research studies. For example, Meek and colleagues (2000) noted that existing conceptual frameworks for cancer treatment–related fatigue do not provide specific guidance on factors to include when measuring it. They noted the close association of fatigue with depression, muscle weakness, and functional status. Also of interest is the idea that fatigue is conceptualized to be a sensation and a self-perceived state and, therefore, should be measured using self-report.

The selection and design of an intervention is also influenced by theory. Carrieri-Kohlman and colleagues (2001) tested a theory-based model for the management of dyspnea. Conceptualizing dyspnea as a symptom that induces anxiety, they hypothesized that monitored exposure to greater than usual degrees of dyspnea during exercise in a safe environment would change the individual’s appraisal of this symptom, thereby reducing anxiety and increasing tolerance for dyspnea. This is based on the concept of desensitization: repeated exposure to a fearful stimulus will reduce the fear and anxiety associated with it. The work of Bandura, Williams, and their colleagues, on the other hand, suggested the use of guided mastery, defined for this study as “active guidance with the teaching of coping skills used by a therapist” (Carrieri-Kohlman et al., 2001, p. 137). Their intervention study compared exposure (simple desensitization) to guided mastery, but no differences between the two approaches were found. This necessitated going back to the theory to consider why no difference was found. The researchers suggested several alternative explanations: the classic desensitization theory is sufficient; there may be a learning or practice effect; or the participants may have already adapted to the sensation of dyspnea. Note that these explanations are based on differing but potentially relevant theories.

Crawford Shearer and colleagues (2010) developed an empowerment framework for understanding how a sense of personal control and the behaviors that operationalize it are developed and then tested an intervention based on this middle range theory, the health empowerment intervention. They found no effect on health empowerment per se but did find differences in personal growth and purposeful participation in goal attainment in the intervention group, partial support for their theory-based intervention.

THE CONCEPT TREE

The terms theory, concept, and related words are often used loosely, making it difficult for the new researcher to sort out their interrelationships and clarify the theoretical underpinnings of a research study.
In this section, we look closely at the many levels and degrees of specificity of theoretical works, from the broadest worldviews to the narrowest operational definitions. The purpose of creating a conceptual “tree” (it is a tree only in one’s imagination) is to help you think more clearly about the theoretical aspects of your research.

The concept tree is a heuristic, a guide to thinking about and articulating the theoretical foundation of your research. We begin by looking at an empty tree (Figure 3-2), considering what each level means and how it relates to the levels above and below. The tree illustrates the progression from the concrete to the abstract, from the simple to the complex, and from the micro (small, narrow) perspective to the macro (large, broad) perspective. Next we consider a filled-in tree that illustrates how the levels connect to form a comprehensive theoretical base for a research study. The tree diagram can help you organize ideas, but you will have to contribute the ideas themselves from your own knowledge base, your reading, and discussion with colleagues in the field. We will begin at the top of the tree and work our way down to its roots, the empirical indicators.

Conceptual Frameworks

Conceptual frameworks are the broadest of theories. They have been compared to maps or lenses through which we view the world. Conceptual frameworks developed for nursing usually address very broad (metaparadigm) ideas about person, health, and environment (Frey, 1995). Conceptual frameworks guide our exploration of knowledge (i.e., our inquiries) (Newman, Smith, Pharris, & Jones, 2008) and the way in which we interpret our experience.

Conceptual frameworks usually address foundational ideas, both conceptual and philosophical (Kim & Kollak, 2006). For example, King’s systems framework assumes that humans are open systems transacting with their environment. Human beings are described as unique, holistic, sentient, social, and purposeful. Concepts within the framework include self, perception, communication, interaction, and so forth (King, 1995).

Grand Theory

These are overarching theories that are almost as broad as the conceptual frameworks. In fact, it is not always necessary to identify both a conceptual framework and a grand theory. The grand theories commonly used in nursing research were derived from theories of other disciplines or developed within nursing. The original formulations of most of our grand theories were based primarily on the theorist’s experience and/or theories from other disciplines rather than on research (Im & Chang, 2012). These grand theories provide a structure to organize knowledge and to define practice (Newman et al., 2008).

Many consider Florence Nightingale the first nurse theorist (Fitzpatrick, 2014). Rogers’s (1970) science of unitary human beings is an example of a nursing-based grand theory. Rogers proposed three principles of homeodynamics that evolved as she continued to elaborate upon her theory. Another example is Leininger’s transcultural nursing
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Figure 3-2  The concept tree.
theory (Leininger, 1978; Leininger & McFarland, 2002), which focuses on caring and transculturality. A recent review of nursing theory–related publications from 2001 to 2011 found that the grand theories developed by Newman, Orem, Rogers, and Roy were the most frequently employed (Im & Chang, 2012).

Midrange Theory

Midrange theories are more focused, less grand theories to which much attention has been given recently in nursing. Midrange or middle range theories are sets of related ideas focused on a limited area of knowledge (Smith & Liehr, 2014, p. xiii). You may even find some micro theories that are so limited in scope they do not qualify as midrange (Peterson & Bredow, 2013). These are the workhorses of nursing theory. They connect the grand theories to the constructs and concepts we use in both research and practice. They are far more limited in scope than the grand theories, but they are also more concrete and specific. It is often difficult to bridge the gap between a conceptual framework or grand theory and a research study without midrange theory to provide the link between them. Some middle range theories may be modified even further to become situation specific, that is, to reflect the specific health concern, population, or care environment being studied (Im, 2013). For example, adolescents with diabetes are likely to have different issues related to self-management than would middle-age working adults. Examples of midrange theory include transitions, health empowerment, resilience, uncertainty, chronic sorrow, unpleasant symptoms, and cultural marginality.

Symptom management is a relatively well-developed midrange theory that includes the symptom experiences, symptom management strategies, and outcomes of symptom management (Humphreys et al., 2014). The concept of symptom clusters, such as nausea and vomiting; pain and disturbed sleep; or chest tightness, wheezing, and coughing during an asthma attack is a relatively new addition to the theory of symptom management. Quite a few research studies have used this midrange theory, but there are fewer reports of its use in practice so far (Humphreys et al., 2014).

Im (2013) traced the development of transitions theory (Meleis, 2010), noting that it grew out of research (i.e., inductively) but, was originally borrowed from another discipline, sociology. This middle range theory has well-defined concepts and subconcepts. The properties of the transition, for example, include awareness, engagement, change and differences, time span, and critical points and events (Im, 2013). Nurses encounter a wide range of transitions their patients may be undergoing, from the effects of immigration to becoming a new parent. Transition theory is still evolving; for example, the existing list of responses to transitions has been found incomplete in terms of the patterns of responses to transitions. Ramsay and colleagues (2014) also found what they call an important limitation, that is, failure to encompass the perspectives of multiple stakeholders in one transition. They studied the experience of intensive care unit (ICU) patients transitioning to regular care units. These patients reported a disturbing sense of disconnection from their ICU experience and provider insensitivity to their difficult experience.
Propositions

Propositions are statements about a concept or several concepts (Fawcett, 1999). They may describe the characteristics of a phenomenon or predict a relationship between concepts. Propositions may be quite general, or they may refer to very specific situations. For example, a proposition may state that children with attention deficit disorder (ADD) have lower self-esteem than do children without ADD, specifying the relationship between ADD and self-esteem. The proposition that meditation can lower elevated blood pressure predicts the relationship between blood pressure and meditation.

Constructs and Concepts

Because constructs are simply more abstract, more complex, and less observable concepts, they are listed together with concepts. Concepts are frequently called the “basic building blocks of nursing knowledge” (Waltz, Strickland, & Lenz, 2010, p. 27). They are theoretical definitions of phenomena. It is usually not necessary to include both constructs and concepts on a concept tree.

Concepts familiar in nursing vary widely in the degree to which they have matured, in other words, how stable and well defined they are. Morse, Hupcey, Mitcham, and Lenz (1998, p. 76) list criteria for mature concepts:

- Clearly defined
- Distinct (well differentiated from other concepts)
- Coherent
- Systematically related to other concepts
- Applicable to real-life practice

A few examples of concepts relevant to nursing include gaze, empathy, dignity, perfusion, balance, dyspnea, and rapid eye movement (REM) sleep.

Dimensions

Most concepts and constructs have more than one dimension or attribute. Waltz and colleagues (2010) compared the unidimensional concepts of syringe or perfusion (defined as partial pressure of transcutaneous oxygen) with multidimensional concepts such as activities of daily living (ADLs) that generally include the dimensions of bathing, dressing, toileting, and eating.

Operational Indicators

Operational or empirical indicators are the means by which the theoretical unit (concept) is measured. They are defined by Dubin (1978, p. 182) as the “operation employed..."
by a researcher to secure measurements of [a given] value” on the theoretical unit. Dubin also notes that many behavioral concepts are somewhat vague, making measurement of them a considerable challenge. The author called this a “vexing problem” for researchers.

CONCEPT TREE EXAMPLE

A concept tree created to provide the theoretical foundation for development of a new measure of acculturative stress (E. Millender, personal communication, June 8, 2009) will be used to illustrate use of a concept tree in developing a research study (see Figure 3-3).

**Conceptual framework:** Sir Edward Tylor (1871), a British anthropologist, is credited with the first definition of the term *culture*: “that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society” (quoted by Andrews & Boyle, 1989, p. 11).

**Grand theory:** Leininger’s transcultural nursing theory connects culture with the practice of nursing. Leininger (1978) wrote that transcultural nursing is “the subfield of nursing that focuses upon a comparative study and analysis of different cultures and subcultures in the world with respect to their caring behavior; nursing care; and health-illness values, beliefs, and patterns of behavior with the goal of developing a scientific and humanistic body of knowledge in order to provide culture-specific and culture-universal nursing care practices” (p. 8).

**Midrange theories:** Acculturation is the phenomenon that results “when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original cultural patterns of either or both groups” (Redfield, Linton, & Herskovits, 1936, p. 149). Cultural marginality is defined as “marginal living while recognizing cross-cultural conflicts and striving to ease cultural tension” (Choi, 2014, p. 293).

**Propositions:** The three propositions (Figure 3-3) suggest that immigrants to the United States, particularly those who are members of U.S. minority groups, experience cultural marginality and related acculturative stress that affects both mental and physical health. Andrews and Boyle (1999) defined minorities as “groups of people who, because of physical or cultural characteristics, receive different and unequal treatment from others in society,” and may “see themselves as recipients of collective discrimination” (p. 16).

**Constructs:** The constructs are the problems and conflicts that are frequently linked to acculturation stress. Because they are relatively complex phenomena, they are labeled constructs rather than concepts.

**Dimensions:** Only the dimensions for the language difficulty construct are included in Figure 3-3. These are verbal and written fluency in the dominant language of the host (destination) country.
**Operational indicators:** Several operational indicators are listed. These include the individual's preference for their original language or language of the host country, actual language use, confidence in ability to speak the new language, and actual ability. (Note that language difficulties are experienced primarily by those who come to the United States from non-English-speaking countries.)

**Figure 3-3** Concept tree for the measurement of acculturative stress.

Data from: E. Millender, personal communication, June 8, 2009.
ISSUES RELATED TO THEORY AND RESEARCH

Confirmation Bias

Greenwald and colleagues (1986) have noted what they call a confirmation bias that often occurs in the testing of theory. Particularly, there is always the danger that researchers will see what they expect to see. This is true for both quantitative and qualitative research. For example, Turkel and colleagues (1999) did a phenomenological analysis of nurses’ descriptions of their experiences visiting patients at home after discharge from a rehabilitation unit. The interviewed nurses clearly found the home nursing experience to be very different from their usual role and very satisfying. Viewing the nurses’ narratives through the lens of caring theory, the researchers concluded it was evident “that developing a caring relationship with patients was essential to nurses feeling rewarded in their work” (p. 11). The nurses interviewed had not used the term caring relationship. Was the researchers’ conclusion erroneous? Not at all, but it was expressed in the language of caring theory. Had the researchers come from a different theoretical perspective, they likely would have used different language to characterize the nurses’ experiences.

Those researchers who are interested in a particular theory are also those who are committed to spending time testing it. They are likely to become strong advocates for the theory, which creates the risk of confirmation bias. These researchers may report confirming evidence but ignore or discount disconfirming evidence. Their investment in the theory can also blind them to new theoretical formulations. These are cautionary statements, not a call for ignoring theory but for keeping an open mind about the theory employed and maintaining a willingness to modify theory.

The history of cancer research provides an example of the way in which one’s paradigm guides research but may also inhibit thinking outside the box. Kevles (1995) describes one such example. Once the existence and disease-producing potential of microorganisms was established, scientists began to look for a connection to cancer but without success. Then a biologist at the Rockefeller Institute injected an extract from an avian breast tumor into healthy chickens who developed sarcomas as a result. Researchers tried to replicate his work in other healthy animals but failed. Eventually, scientists concluded that these “infectious” cancers did not occur in humans and, as Kevles puts it, “those who held to the theory of [cancer and] infection risked their scientific reputations” (p. 76).

Then a curious finding led researchers back to the infectious theory, though with initial reluctance. In a lab that produced mice with a tendency to develop tumors, John Bittner noticed that the mice developed breast cancer at a high rate if their mother was part of the high-incidence strain but not if only their father was part of the high-incidence strain. At first, they suggested a “milk factor” as the agent, reluctant to use the word virus. After years of hiding behind the term factor, which hinted of the prevalent genetic theory of causation, and after further research and much debate, the researchers finally recognized the factor for what it was: a mouse mammary tumor virus (Kevles, 1995). The power of theory is evident: it both drove their research and inhibited it, in this case for decades.
Here is another example of how difficult it is to challenge the prevailing paradigm. Stanley Prusiner was interested in spongiform encephalopathies (mad cow and related diseases), which clearly were communicable, but the agent (how they are communicated) was unknown (Corbyn, 2014). He was looking for a virus but only found a protein that he eventually called a prion. You can imagine the skeptical responses (“Who ever heard of infection with a nonliving agent?”) when his discovery was first made public (Zuger, 2014). Prusiner won a Nobel Prize for his discovery of prions and is now working on a treatment for these diseases.

Theory is dynamic, not static. In other words, theory should be modified as new evidence to support or refute it is found. It is more troubling when scholars (researchers and theorists) do not change their conclusions than it is if they propose revisions as they develop their work (Colapinto, 2008).

Nursing or Nonnursing Theory?

There is considerable disagreement within the discipline as to whether a nurse researcher should use only those theories generated within the discipline or use whatever theory, nursing or not, best informs his or her research.

Yarcheski & Mahon (2013) reviewed the theoretical basis of 484 quantitative nursing research studies published over 20 years (1990 to 2010) and found that the use of classic nursing theories had remained at a small but stable percentage. Psychological and sociological theories, especially stress and coping, were more frequently employed than were nursing theories. There is no question that the nursing profession needs a solid scholarly and scientific foundation (Anderson, 1995) based on nursing scholarship and research, not that borrowed from other disciplines. To accomplish this, Fawcett argues that we “must break the intellectual chains ... by rejecting nonnursing knowledge ... and embracing nursing knowledge” (2006, p. 515).

Waltz, Strickland, and Lenz (2010) counter that knowledge is not “owned” by any discipline. Nursing scholars and researchers can use and build on knowledge from other disciplines, but they can do it with a nursing perspective (p. 26) and for the ultimate goal of improving nursing care.

CONCLUSION

The intimate connection between theory and research should now be evident to you. Research always has at least a worldview or framework underlying it, even if it is only implied. Theories need to be tested, and the results should be used to elaborate upon or to modify the theory, but this has not always been done. Further, our theoretical statements and propositions are often too general or poorly developed, posing some challenges for the researcher. Using the concept tree as an organizer can help clarify these relationships before you proceed with designing your research study.
REFERENCES


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Inspiring, thought-provoking essays on mindfulness in nursing practice.


References


