

NURSING THEORY: WHAT IT IS AND WHAT IT IS NOT

Evelyn Adam

Interest in nursing theory, its definition and development, has increased considerably in recent years and such interest, attested by the number of publications on the subject, is more than justified. Three reasons come to mind: nursing's legitimate desire to be recognized as a full-fledged member of the scientific community, nursing's responsibility to contribute to knowledge in the health field and, perhaps most important but less often recognized, nursing's great need to acquire the knowledge essential for practice. As a service discipline, nursing must develop the knowledge that is required for its particular function in society.

The intent of this article is to examine the significance of the term "nursing theory" and to suggest certain conditions that should exist before a theory may be labelled "nursing". To do this, some very basic considerations will be reviewed.

Theory

Before studying "nursing theory", theory alone, be it social, physical or biological theory, must be examined. The definitions of theory offered by various authors (Brodbeck, 1957; Cohen & Nagel, 1934; Dickoff & James, 1968; Kaplan, 1964; Kerlinger, 1964) are well known and have been quoted widely by nurses (Bush, 1979; Chinn & Jacobs, 1983; Fawcett, 1978a; Hardy, 1978; Johnson, 1978; Stevens, 1979). Meleis (1985) classifies theory definitions into seven types, depending on the focus of the definition: structure, research, multiple uses and others.

In most of the definitions are found the words "interrelated propositions" and "describe, explain or predict phenomena". Some definitions contain one or the other of those word combinations; some contain both. Roy and Roberts (1981) have combined the elements of several authors in their definition: "A theory is a system of interrelated propositions used to describe, predict, explain, understand, and control a part of the empirical world" (p. 5). Parse (1987) specifies further that a theory "explains, describes, or makes predictions about the phenomena of a discipline" (p. 2).

Evelyn Adam M.N. is Professor and Faculty Secretary at the Faculté des sciences infirmières of the Université de Montréal.
--

The foregoing definitions cannot be taken lightly. A proposition presupposes at least two variables, and "interrelated propositions" implies at least two propositions. It follows that at least two propositions (validated in several settings) would constitute a theory; the propositions would serve to describe, predict, explain, understand and control The sentence must be completed. This is done by filling in the names of those phenomena that make up the empirical world of the researcher.

As an example, General Systems Theory, developed by the biologist von Bertalanffy, explains and describes systems, because systems were part of the empirical world that interested biologists. That theory now explains open systems as well as closed systems; as such, it is useful to engineers, nurses, physicians and others. Hans Selye's theory of stress describes and predicts stress because the human responses known as the General Adaptation Syndrome were part of the empirical world that interested physicians. Selye's theory is today useful to a variety of disciplines.

Nursing theories may one day be useful to related disciplines in the same way that existing theories, developed in other fields, are today useful to nurses (Adam, 1983). In that regard, it is important to remember that theory in any discipline is developed by the asking of questions that differ substantially from those asked in other disciplines (Johnson, 1978).

Nursing theory

Nursing theory must first of all be a theory – that is, a set of interrelated propositions that serve to predict, describe, etc. a part of the empirical world. But what phenomena of the empirical world will be studied? What part of the empirical world is of particular interest to nursing? In other words, what is nursing's focus of scientific inquiry? The question is important because, for theory to be recognized as nursing theory, it must be a set of propositions of and about those phenomena that make up nursing's focus of enquiry.

That focus of enquiry must be one that is compatible with nursing's practice and education activities. "The focus of any profession's scientific concern is interdependent with the profession's service, its social function" (Johnson, 1974, p. 373). It follows that the conceptual base of the nurse researcher must be one that constitutes the conceptual base of at least some nurse educators and practitioners. If that base is specific to nursing, it is called a conceptual model for nursing and is made up of assumptions, values and six major units (Johnson in Riehl & Roy, 1980).

To the question, "What is nursing's focus of enquiry?", the answer is found in the way nurses conceptualize their discipline; that is, in the chosen conceptual model for nursing. Two brief examples of models will be presented in this article.

Rather than adopt one of the existing conceptual models for nursing, the nurse researcher may of course work from a borrowed perspective – a medical or sociological perspective, to name only two possibilities. She will then study phenomena which are part of medicine's or sociology's focus of inquiry; she will advance medicine or sociology but she will not advance nursing – except perhaps indirectly. Rather than a borrowed perspective, the nurse researcher may have, as her conceptual departure point, her own private and personal conception of nursing. As already stated, that private conception must also be clear and explicit enough to be useful as the conceptual departure point for practice and education.

Nursing's focus of enquiry, specified in the chosen conceptual model, indicates the kind of knowledge that nurses need for their practice. It is important to remember that the knowledge made available in developing and testing nursing theory will not *belong* to nursing. Knowledge does not ever belong to a discipline; discovery does not confer the right of ownership (Johnson, 1968). To return to the two previous examples, knowledge from von Bertalanffy's General Systems Theory does not belong to biology nor does knowledge from Selye's theory of stress belong to medicine; the knowledge generated by the development of those two theories is available to, and used by, a variety of disciplines.

It seems reasonable to expect that, in developing the kind of knowledge essential for nursing practice, nurse researchers will make available knowledge that will be useful to other health disciplines.

Knowledge from anatomy, physiology, psychology, etc., while extremely useful, is no more sufficient for nursing than is knowledge from physiology and biochemistry sufficient for medicine (Johnson, 1968). Medicine's focus of enquiry has long included illness – its prevention, diagnosis, treatment and cure. Medical research has therefore sought knowledge about illness, and physicians are still striving to understand and conquer disease. Their contribution to society's health is well documented.

Most nurses agree that disease is *not* nursing's focus of enquiry. What, then, *is* nursing's particular concern? The question must be asked, because in the answer lies the kind of knowledge that nursing should develop through its research. In the answer will be indicated the phenomena to be studied in order to develop nursing theory.

To that very fundamental question, "What is nursing's focus of enquiry?" several answers have been published in the form of conceptual models for nursing. Two examples follow.

Dorothy E. Johnson's distinct and explicit way of looking at nursing is known as the behavioural system model for nursing (Johnson in Riehl & Roy, 1980, pp. 207-216). The goal of the profession, according to Johnson, is to maintain and restore behavioural system balance and stability. The client is a behavioural system with seven subsystems, each of which is bio-physiological and psycho-sociocultural. Stresses in the structure or function of the subsystems constitute the source of client problems that are considered to be nursing problems.

Nurses who adopt Johnson's perspective will have as their focus of inquiry behavioural system stability and equilibrium. They will, for example, ask questions about dependency behaviours and about affiliative behaviours. They will study the stimulation and the protection requirements of the subsystems; they will seek ways to facilitate efficient and effective behaviours and means to inhibit inefficient and ineffective behaviours. When propositions have been validated and hypotheses tested in a variety of clinical settings, with different age groups, with healthy clients and with those suffering from various illnesses, theories of achievement behaviour or of behavioural system control and regulation might be developed. The knowledge generated would not only be useful to community nurses, hospital nurses and children's nurses but also to gerontologists, pediatricians and psychologists.

Another example of a distinct nursing perspective is Virginia Henderson's complementary-supplementary model for nursing. According to this conceptual departure point, the goal of nursing is to maintain and restore client independence in the satisfaction of fundamental needs (Henderson, 1966). The client is a complex whole with fourteen basic requirements, each of which is bio-physiological and psycho-sociocultural. Nursing problems are dependency problems in need satisfaction; their origin is an insufficiency of strength, will or knowledge.

Nurses who adopt Henderson's model will have as their focus of enquiry such phenomena as need satisfaction, independence in need satisfaction and complementing – supplementing strategies. They will ask questions about client independence, about the need to communicate or about the need to learn. They will study the psycho-social dimension of the need to eliminate body wastes or the bio-physiological dimension of the need to play; they will seek ways to complement client strength and means to supplement client motivation. When propositions have been validated and hypotheses tested in a variety of clinical settings, with different age groups, with

healthy clients and with those suffering from various illnesses, theories of need satisfaction or of complementing and supplementing might be developed. The knowledge generated would not only be useful to nurses working with the newborn, with the elderly or with families in the community but also to cardiologists, oncologists and psychologists.

Research based on Johnson's model might lead to one nursing theory: a system of interrelated propositions which serve to explain, describe, control, etc. behavioural system balance and stability, because the purpose of nursing practice is behavioural system balance and stability.

Research based on Henderson's model might lead to a different nursing theory: a system of interrelated propositions which serve to describe, predict, and make understood client independence in need satisfaction, because the purpose of nursing practice is client independence in need satisfaction.

In this way, *nursing* knowledge would be developed. It would spring from the "behavioural equilibrium" school of thought or from the "independence in need satisfaction" school of thought or, indeed, from another school of thought. Oriented by another conceptual model, another *kind* of knowledge would be developed. Not everyone has to have the same conceptual departure point, but each nurse researcher must start from one of the distinct nursing perspectives that offer direction for practice and education as well as for research. The different kinds of knowledge would constitute a body of nursing knowledge. If knowledge developed by the equilibrium school should prove to be in conflict with that developed by the independence school, more research would be stimulated and the *science* of nursing would develop further.

Nurse theorists will of course look at phenomena that interest other disciplines as well. They must, however, study them from a nursing perspective if they want to develop nursing theory. "Since several sciences may, and often do, study the same phenomenon, it is the distinctive perspective of each science which most clearly discriminates it from others" (Johnson, 1974, p. 373).

If pain, for example, were studied from Johnson's perspective, it would be examined as a phenomenon that interferes with behavioural system stability and equilibrium. Indeed pain would be of interest to nursing inasmuch as it prevents efficient and effective behaviours in any or all of the seven subsystems.

If pain were studied from Henderson's perspective, it would be examined as a phenomenon that interferes with client independence in need satisfaction.

When pain is studied from a psychological perspective, or from a medical or anthropological perspective, interesting knowledge is generated. Pain studied from a nursing perspective might produce equally interesting knowledge.

Theory may be descriptive and developed by exploratory research. It may be explanatory theory, developed by correlational research, or predictive theory, developed by experimental research (Fawcett, 1985). Chinn and Jacobs (1983) point out that such classifications as "macro", "midrange", or "micro" are relative because what is "micro" to one discipline may be considered midrange in another. However theory is classified, it will be *nursing* theory when it is of and about a phenomenon that is part of nursing's focus of enquiry; that is, when it is developed by asking questions that are not asked by other disciplines. A body of nursing knowledge must be one that contributes to the improvement of nursing practice.

This view of nursing theory is more restrictive than the one proposed by Meleis (1985), for whom "all theories used in nursing to understand, explain, predict, or change nursing phenomena are nursing theories, whether or not they evolved out of other theories, other paradigms . . . and whether or not they were developed by nurses" (p. 104).

What nursing theory is not

Various terms are sometimes used as synonyms for theory or nursing theory. While some may be quite correct in certain contexts, in others they are not acceptable and are likely to attract, at worst, the scorn of other professionals, and, at best, their bemused condescension.

Nursing theory is not a philosophy of nursing; nor is it a theory, developed by a nurse, from a borrowed perspective. Nursing theory is not nursing research, it is developed *by* nursing research.

The confusion seems most apparent between a "nursing theory" and a "conceptual model for nursing". The latter is considered a precursor of theory (Adam, 1985; Bush, 1979; Fawcett, 1978 a & b; Newman, 1979; Peterson, 1977). The two examples of conceptual models presented in this paper point out their utility as precursors of theory development.

This position differs from that of Silva (1986) who discusses three ways in which investigators have used models for theory testing: minimal,

insufficient (used as an organizing framework) and adequate. Silva summarizes three studies which exemplify the adequate use of models for theory testing; she entitles the section "Research Testing Nursing Models: Explicit exemplars" (p. 4).

Such a stance seems to contradict those authors cited previously who see models as precursors of theory. The problem may lie in the interpretation of "precursor of theory". To this writer, that expression does not mean a beginning set of concepts which, by means of research, may ultimately be transformed enough to meet the requirements of a theory. A precursor of theory is, rather, the conceptual departure point of theory development. A conceptual model for nursing, indicating the phenomena about which knowledge is required, constitutes the harbinger or forerunner of nursing theory.

The existing conceptual models for nursing, presented initially by their authors, have been the subject of writings by others. It is this writer's conviction that those models have now been sufficiently analyzed, described, critiqued, interpreted and classified. The time has come to build upon those conceptual starting points. Nurse researchers would make encouraging progress in the development of nursing theory, and in the contribution of knowledge in the health field, if they took advantage of the conceptual bases that spell out their discipline's focus of scientific enquiry. It is important that the conceptual base chosen also provide direction for practice and education.

Some other differences between a conceptual model and a theory can be argued. A conceptual model for any discipline is useful only to that discipline – orienting its practice, research and education (Adam, 1985). A theory, on the contrary, is useful to various disciplines.

A conceptual model is not made up of propositions to be validated, nor is it composed of hypotheses to be tested. The criterion of truth is not used in judging a model; the extrinsic criteria of social congruence, social significance and social utility are, however, essential to the evaluation of a model (Johnson, 1974). Intrinsic criteria such as clarity, precision and coherency must of course be used to evaluate the assumptions, values and major units which make up the model.

The distinctions between model and theory are not considered important by everyone. Stevens (1979) sees such arguments as "quibbling [that] leads one to worry over labels rather than to look at the substance of the given thesis" (p. XI). Meleis (1985), while admitting that "there are some differences between models, conceptual frameworks and theory" (p. 95), points out that she wishes to minimize the distinctions in order to "cast

some doubt on the significance of the differences between theories and conceptual models" (p. 96).

Nursing theory is not theory *of* nursing, another distinction which some might consider a particular form of hair-splitting. However, more than one author (Gudmundsen, 1979; Johnson, 1978; Moore, 1968) insist on the impossibility of a theory of nursing. They point out that there is no theory of medicine, no theory of law, no theory of physics. Nursing is no more an object of scientific enquiry than any other profession. No system of interrelated propositions is required to explain and predict nursing. As with other service professions, nursing exists in response to a need in society. Nursing is what we decide it should be; "It is not something which, in and of itself, can be empirically verified" (Moore, 1968, p. 343).

To return to the two examples of theory, General Systems Theory, developed by a biologist, is not a theory of biology and the theory of stress, developed by a physician, is not a theory of medicine.

Conclusion

Nursing theory, or theory in nursing, is theory of and about one of the phenomena that make up nursing's focus of enquiry. Each health discipline contributes to knowledge about health by studying those phenomena that are necessary for its own practice. Nursing alone has not been given a mandate to promote and conserve health (Johnson, 1978).

If nursing theory is about those phenomena that are of concern to nursing, the argument about one or several nursing theories becomes pointless. Discussions about a unique nursing theory, as opposed to pluralism in nursing theory, are worthless. Each one of the conceptual models for nursing indicates several phenomena, each one of which has potential for theory development. The development of a multiplicity of nursing theories is therefore a most desirable goal; each one will add to nursing's contribution to the knowledge about the preservation and promotion of health.

Nursing's interest in theory development underlines its great potential for improving nursing practice and for advancing nursing science. The key word, however, is "nursing". In order to maintain credibility in the scientific community, in order to make a significant contribution to health promotion and in order to acquire the knowledge needed for practice, a nurse researcher must have a conceptual base that is unique to nursing.

REFERENCES

- Adam, E. (1983). *Etre infirmière*, (2nd ed.). Montréal: H.R.W. Ltée.
- Adam, E. (1985). Toward more clarity in terminology: Frameworks, theories and models. *Journal of Nursing Education*, 24, 151-155.
- Brodbeck, M. (1957). The philosophy of science and educational research. *Review of Educational Research*, 28, 427-440.
- Bush, H.A. (1979). Models for nursing. *Advances in Nursing Science*, 1(2), 13-21.
- Chinn, P.L., & Jacobs, M.K. (1983). *Theory and nursing: A systematic approach*. St-Louis: Mosby.
- Cohen, M.R., & Nagel, E. (1934). *An introduction to logic and scientific method*. New York: Harcourt, Brace & World.
- Dickoff, J., & James, P. (1968). A theory of theories: A position paper. *Nursing Research*, 17, 197-203.
- Fawcett, J. (1978a). The relationship between theory and research. A double helix. *Advances in Nursing Science*, 1(1), 49-62.
- Fawcett, J. (1978b). The "what" of theory development. In *Theory development: What, why, how?* (pp. 17-33). New York: National League for nursing, No. 15, 1708.
- Fawcett, J. (1985). Theory: Basis for the study and practice of nursing education. *Journal of Nursing Education*, 24, 226-229.
- Gudmundsen, A.M. (1979). The conduct of inquiry into nursing. *Nursing Forum*, 18, 53-59.
- Hardy, M.E. (1978). Evaluating nursing theory. In *Theory development in nursing: What, why, how?* (pp. 75-86). New York: National League for Nursing, No. 15-1708.
- Henderson, V. (1966). *The nature of nursing*. New York: Macmillan.
- Johnson, D.E. (1968). Theory in nursing: Borrowed and unique. *Nursing Research*, 17, 206-209.
- Johnson, D.E. (1974). Development of theory: A requisite for nursing as a primary health profession. *Nursing Research*, 23, 372-377.
- Johnson, D.E. (1978). State of the art of theory development in nursing. In *Theory development in nursing: What, why, how?* (pp. 1-10). New York: National League for Nursing, No. 15-1708.
- Kaplan, A. (1964). *The conduct of inquiry: Methodology of behavioral science*. San Francisco: Chandler.
- Kerlinger, F.N. (1964). *Foundations of behavioral research*. New York: Holt, Rinehart & Winston.
- Meleis, A.I. (1985). *Theoretical nursing. Development and progress*. Philadelphia: Lippincott.
- Moore, M.A. (1968). Nursing: A scientific discipline? *Nursing Forum*, 7, 340-348.
- Newman, M.A. (1979). *Theory development in nursing*. Philadelphia: Davis.
- Parse, R.R. (1987). *Nursing science. Major paradigms, theories and critiques*. Philadelphia: Saunders.

- Peterson, C.J. (1977). Questions frequently asked about the developemnt of a conceptual framework. *Journal of Nursing Education*, 16(4), 22-32.
- Riehl, J. & Roy, C. (1980). *Conceptual models for nursing practice* (2nd ed.). New York: Appleton-Century-Crofts.
- Roy, C., & Roberts, S.L. (1981). *Theory construction in nursing*. Englewood Cliffs, NJ: Prentice-Hall.
- Silva, M.C. (1986). Research testing nursing theory: State of the art. *Advances in Nursing Science*, 9(1), 1-11.
- Stevens, B.J. (1979). *Nursing theory. Analysis, application, evaluation*. Boston: Little, Brown.

RÉSUMÉ

La théorie infirmière: ce qu'elle est et ce qu'elle n'est pas

L'intérêt des infirmières pour le développement de la théorie fait partie de leur désir légitime de voir leur profession reconnue par le monde scientifique. Afin que les autres disciplines perçoivent la nôtre comme une science, nous nous devons de contribuer aux connaissances dans le domaine de la santé. Il est également important, dans le but d'acquérir la crédibilité que nous désirons, que nous jouions le jeu du monde scientifique; une des règles de ce jeu est d'accorder au mot "théorie" à peu près la même signification que lui confèrent les autres disciplines.

Qu'une théorie soit descriptive, explicative ou prédictive, elle sera reconnue comme une théorie infirmière en autant qu'elle traite d'un phénomène faisant partie du centre d'intérêt scientifique de la profession d'infirmière. Le même phénomène peut être étudié par d'autres disciplines; étudié par la nôtre, la théorie qui en résulte sera une théorie infirmière dans la mesure où l'étude a été menée à partir d'une perspective infirmière. Cette perspective, si elle est précise et explicite, s'appelle alors modèle conceptuel. Elle n'est pas en elle-même une théorie car un modèle conceptuel n'est que le point de départ dans le développement d'une théorie.

Deux modèles conceptuels sont abordés afin d'offrir des exemples de phénomènes présentant un potentiel pour le développement d'une théorie. Le mot théorie est défini et la distinction est faite entre une théorie *de* la discipline et une théorie *pour* la discipline. Appeler théorie ce qui ne l'est pas risque d'entraver notre évolution vers un pluralisme théorique et ainsi de retarder la reconnaissance de notre discipline comme une science parmi les sciences.