5 Nursing theories or nursing models

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Outline of content

In the previous chapter we described how new nursing roles and nursing theories have evolved and the importance of mid-range and practice theories for guiding practice within these new roles. In this chapter we will further explain construction of the theory, talk about the often controversial relationship between theories and models, and show how models can lead to the development of theory. In the following section, we will build on what was described and discussed in previous chapters. We will finish by outlining in detail the advantages and disadvantages of nursing theories.

Learning outcomes

At the end of this chapter you should be able to:

* 1. Explain reasons for the development of nursing theory
* 2. Define nursing ‘theory’ and ‘model’
* 3. Explain the basic parts of the theory
* 4. Differentiate between nursing theory and nursing model
* 5. Discuss theory classification
* 6. Explain the main paradigms used in theoretical nursing
* 7. Describe the elements of the metaparadigm
* 8. Outline the main criticisms and benefits of nursing theories

Introduction

In [**Chapters 1**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_002.xhtml#eid1030) and [**3**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_004.xhtml#eid2686) we explained that there are numerous definitions of nursing theories. You will have seen that the terms grand theory and model are used interchangeably. You saw that one of the most important features of a grand theory/model seems to be its abstract nature (Fawcett [**2005a**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8770); Meleis [**2012**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9133)); mid-range theories are, by contrast, more narrow in scope and more defined and refined. Theories are always in the process of development and the differences between the terms theory and model are at best tentative, semantic and unclear. We have stated on numerous occasions that nurses employ theories in their everyday work, using different types of theories to help describe, explain, predict and, as Dickoff and James ([**1968**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8709)) pointed out, prescribe nursing care. It is also important to bear in mind that different authors have different views on the level of abstraction of their own and others’ theories. One way of classifying nursing theories is according to their level of abstraction (McKenna [**1997**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9081); Meleis [**2012**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9133)); another is by reference to the range of the theory (Marriner Tomey [**1998**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9044)). But first let us explain reasons for nursing theory development.

Reasons for historical nursing theory evolution

In [**Chapter 1**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_002.xhtml#eid1030) it was noted that all the early 20th-century nursing theories emanated from the USA, with theories starting to emerge from the UK some 20 years later (see [**Reflective Exercise 5.1**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_006.xhtml#eid4171)). The exception was that of Florence Nightingale. You saw in [**Chapter 3**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_004.xhtml#eid2686) how in the late 1950s other American nursing theories were developed, essentially to distinguish nursing from other health professions and to define nurses as professionals and their essential obligations to patient care.

In the 1950s, nurse education programmes were increasingly being delivered, not in schools of nursing on isolated hospital sites but in universities. It comes as no surprise, then, that the various curricula had to show that nursing had its own knowledge base and scientific approaches for studying nursing. Otherwise all the lectures would be based on a variant of the biomedical model and of social and psychological theories. You will recall that the basic structure of the biomedical model was discussed in [**Chapter 4**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_005.xhtml#eid3502). Therefore, the reasons why theorising took place in 1950s America were:

* • the desire to develop a scientific basis for nursing practice;
* • the quest for professional recognition;
* • the advent of university education for nurses;
* • the increase in the number of master’s and doctoral-prepared nurses;
* • women’s contribution to the Second World War effort, leading to an increase in the debate around the female role in work and education;
* • the wish to make clear the boundaries of nursing and nurses’ work.

In [**Chapter 4**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_005.xhtml#eid3502) you were introduced to the names of theorists who developed their theories in America in the 1960s and 1970s. Interestingly, many were reluctant to claim theoretical status for their work. It would seem that such reluctance was no longer common in the 1980s and 1990s. For example, in 1970 Orem published her first book *Nursing: Concepts of Practice*, with subsequent editions in 1980, 1985, 1991 and 1995. She worked alone and with colleagues on the continued conceptual development of the self-care deficit nursing theory. The fifth edition is organised into two parts: nursing as a unique field of knowledge, and nursing as practical science. In the 1980s some theorists also tried to revise their earlier work in line with some of the criticisms of meta-theorists (Pajnkihar [**2003**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9241)). Orem developed her theory with the help of theory analysis and evaluation and according to the changes and needs in practice.

Reflective Exercise 5.1: Reasons for the evolution of theories

In [**Chapter 4**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_005.xhtml#eid3502) you saw a long list of theories that were developed in the US and a shorter list of those developed in the UK. Form a small group with your fellow students and consider whether the reasons for their emergence were the same in each country and why the times and places were important.

Also consider the reasons why there was a slowing down in the development of nursing theories in the US in the 1980s and in the UK in the 1990s.

So-called ‘caring theories’ first appeared in the 1980s. Perhaps the most famous was that of Jean Watson. In 1998, Tracey et al. wrote that Watson’s framework was still being taught in numerous baccalaureate nursing curricula in the USA and that these concepts were also widely used in nursing programmes in many countries, including the UK. Morris ([**1996**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9177)) noted that Watson’s human care theory was used as the basis for doctoral nursing programmes in the USA and Canada. The incorporation of this theory model into nursing curricula added a new dimension to nursing as a whole (Pajnkihar [**2003**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9241)). As the recognition of the importance of caring in nursing has grown, researchers in middle and eastern Europe have explored the value of nursing theories. In Poland, for instance, Zarzycka et al. ([**2013**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9628)) noted the importance of caring theories. There is also great interest in caring theories in some southern European countries and Russia, where research projects on the value of Watson’s theory for education and practice have been undertaken but not yet published.

In the 1980s it was generally accepted among most theorists that a qualitative research methodology with a historicist paradigm (see [**Chapter 2**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_003.xhtml#eid1599)) was the basic methodology for nursing. Therefore, many nursing theorists started to revise their work, thus increasing the number of mid-range theories (Pajnkihar [**2003**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9241)). As a result, in the 1990s, numerous research studies were carried out in a drive to test nursing theories (Hickman [**1995**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8887)) and many mid-range theories emerged from this work (Pajnkihar [**2003**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9241)).

The stimuli for the development of theories in the UK in the 1980s, just as nurse theorising was slowing down in the USA, are interesting. These may have followed from the perception that American theories were not suitable for practice in the UK. As with the US, the introduction in the UK of university education for nurses in the late 1970s forced many lecturers and students to look at how knowledge unique to their discipline might be developed and taught. A similar trend can be seen in other European countries and in Australia, where nursing programmes were being delivered in universities. In addition, as had happened previously with their American counterparts, UK nurses began to examine the biomedical model and found it an inappropriate framework to guide nursing care. The biomedical model was also questioned in some other European countries but later than in the USA and the UK.

Model

In [**Chapter 4**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_005.xhtml#eid3502) you saw that the term model, in the eyes of most meta-theorists (apart from Jacqueline Fawcett), is synonymous with grand theory. However, the term model continues to be referred to in the literature and in practice. You will hear practising nurses talking about Orem’s model or Roper, Logan and Tierney’s model. They would seldom refer to these conceptualisations as theories. Therefore, in this short section we will discuss what is meant by models. You can decide for yourself if you think that model or theory is the best way to describe the work of the various theorists.

The term ‘nursing model’ has been defined as (Chinn & Kramer [**2004**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8659): 264)

* a symbolic representation of empirical experience in words, pictorial or graphic diagrams, mathematical notations, or physical material [and] a form of knowledge within the empirical pattern.

Some of the simplest definitions of a model describe it as a representation of reality (McFarlane [**1986**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9071)) or a simplified way of organising a complex phenomenon (Stockwell [**1985**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9502)). Other authors have elaborated on both these descriptions. Fawcett ([**2006**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8777)) stated that a model comprises a set of concepts and the assumptions that integrate them into a meaningful configuration. Thus models are tools that enable users to understand more complex phenomena in a simple way.

Models are highly abstract and represent a world view that helps nurses to understand easily the many such world views that are encountered every day (Theofanidis & Fountouki [**2008**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9529)). McKenna ([**1994**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9074)) suggested that a model is a mental or diagrammatic representation of care that is systematically constructed and assists practitioners in organising their thinking about what they do. In addition, transferring their thinking into practice benefits the patient and the profession. Models can therefore be seen as conceptual tools or devices that can be used by an individual to understand complex situations and put them in perspective.

Models take various forms. Some are presented in a one-dimensional format as verbal statements or philosophical beliefs about phenomena. One-dimensional models tend to be at a high level of abstraction. They cannot be taken apart or explicitly observed, but they can be thought about and mentally manipulated. Two-dimensional models include diagrams, drawings, graphs or pictures, such as those that show how parts fit together into a whole. Think of a diagram of a plant in a gardening book - this is a perfect illustration of a two-dimensional model. Most models tend to begin as a one-dimensional conceptualisation and later develop into a two-dimensional format.

Three-dimensional models are what Craig ([**1980**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8682)) referred to as physical models. These are scale models or structural replicas of things. In this form they may be intimately examined and manipulated. Examples of three-dimensional models are an architect’s model of a building or a model of a car.

All three classes of model provide enormous amounts of information to those who use them. They tend to give a structured view of the particular circumstances under consideration. In this way users are able to understand the represented concepts and the relationship of those concepts (propositions) to each other.

One-, two- and three-dimensional models try to represent reality, from a high level of abstraction to the concrete, giving a structured view of how the parts fit together as a whole (see [**Reflective Exercise 5.2**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_006.xhtml#eid4213)).

Reflective Exercise 5.2: The three model dimensions

Think of an object and conceptualise it, using all three dimensions described. For instance, you could take the example of a bodily organ. If you were to describe what it is and what it does, this would be a one-dimensional model. Now, if you were to draw a rough diagram of the organ, this would be a two-dimensional model. This model is likely to provide you with more information than the one-dimensional version. If you were next to obtain a plastic teaching replica of the organ in your school of nursing, one that can be taken apart and its internal structures manipulated, this would be a three-dimensional model, providing even more information about the structure of the organ than the previous two models. You could do the same exercise with kitchen appliances, methods of transport and so on.

Now carry out the exercise and write a short note about the different dimensions and whether they provided you with increasing knowledge about the object.

We can define models as describing nursing phenomena and assumptions in very abstract and logical ways. They can then be presented and organised into whole pictures using nursing language, words, mental pictures, diagrams, drawings or logical structures to help understand what was observed in practice. In this way, models help in organising and understanding situations in practice and in thinking about their reality. Models are very abstract tools in research for developing a theory. They are used in all disciplines and also in everyday life, e.g. toys and instructions on how to put together a new bookshelf. The oldest model in nursing is the biomedical model, which you saw in [**Chapter 4**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_005.xhtml#eid3502) and which still influences nursing education and practice.

Theory

In [**Chapter 1**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_002.xhtml#eid1030) we explained that there are numerous definitions of nursing theories. The theories describe, explain or predict how nursing may concisely but holistically and individually support and help patients, families or society at large, and support practice, education and research (see [**Reflective Exercise 5.3**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_006.xhtml#eid4228)).

Reflective Exercise 5.3: Defining theory

Refer back to [**Chapter 1**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_002.xhtml#eid1030) to review the different definitions of nursing theory that were identified.

It is not necessary to reiterate the various descriptions of theory here, but the following section will show there that is still some confusion as to whether the work of a theorist is a model or a grand theory or a paradigm. Readers should select the view they feel comfortable with and be aware that not everyone will agree with them. McKenna ([**1997**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9081)) suggested that nurses selected the term model rather than theory because of their lack of confidence as a profession. At the time, they had only just entered the hallowed surroundings of the university, so how could they suddenly come up with all these theories. To call them models and steps towards theory building was more acceptable (see [**Reflective Exercise 5.4**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_006.xhtml#eid4238)).

Reflective Exercise 5.4: Model or theory - you decide

In [**Chapter 1**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_002.xhtml#eid1030) you were introduced to theory and its working elements of concepts, propositions and assumptions. In this chapter, the term model has been described. Think of those theorists whose work you are most familar with and decide whether you think ‘model’ or ‘theory’ is the best descriptor.

Discuss your thinking with a fellow student or colleague - remember, they may not ageee with you but that does not mean you are wrong.

Theory or model?

Peplau published her theory of *Interpersonal Relations in Nursing* in 1952. You will learn more about her work in the next chapter. With no obvious explanation, she called it a ‘partial theory for the practice of nursing’. A second edition of the book appeared in 1988 with little change. The aim of the theory, as Peplau ([**1952**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9278): xiii) said, was ‘helping nurses to understand the relationship of nurse personalities to these functions’. Later, the meta-theorist Marriner Tomey ([**1998**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9044)) classified Peplau’s work as a mid-range theory, whereas Belcher and Fish ([**1995**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8585)) described it as a theory! In contrast, Reed ([**1996**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9338)) classifies it as a practice theory (Pajnkihar [**2003**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9241)). More recently and shortly before her death, Peplau ([**1995a**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9302)) did explicitly refer to her work as a theory.

Analyses of Orem’s theory are replete with controversy. Meleis ([**1997**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9121): 398) asserted that it is a descriptive theory. According to Feathers ([**1989**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8789)), Orem had developed a complete descriptive theory, adding some elements of explanatory theory. More recently, Marriner Tomey ([**1998**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9044)) and Pajnkihar ([**2003**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9241)) both saw Orem’s work as a grand theory. Watson ([**1988**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9576): 1) argued that her caring theory is ‘not hard scientific theory’ but is still a theory - a descriptive theory. Some explanation from her as to why she thought this would have been helpful but it was not forthcoming. Tracey et al. (1998) confusingly stated that it could be called a conceptual model, a framework and a theory. Morris ([**1996**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9177)) maintained that Watson’s work is a conceptual model and Marriner Tomey ([**1998**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9044)) classified it as a philosophy!

Some authors accept that models are the most appropriate precursors of theory (Chinn & Kramer [**2004**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8659); Fawcett [**2005a**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8770)). This position centres on their belief in the rigid criteria necessary for theory recognition, and the inability of many models to meet them. In essence, their position is that models are believed to lead to the identification of concepts and assumptions and that, when tested by research, they will ultimately lead to the formation of theory.

The theory-model debate may best be understood by looking at the views of the chief protagonists. Jacqueline Fawcett was a firm believer in differentiating models from theories. In the opposite corner is Afaf Meleis, who has a determined view that all these conceptualisations are theories. Both are respected meta-theorists; let’s examine their arguments.

According to Jacqueline Fawcett ([**2005a**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8770)), models are more abstract than their theoretical counterparts. They present a generalised broad and abstract view of phenomena. To underpin her strong views Fawcett wrote several editions of two distinct books, one on nursing theories and the other on conceptual modes. She maintained that theories are more specific and precise, containing more clearly defined concepts with a narrower focus. So, as we have seen in earlier chapters, the difference is one of abstraction, explication and application. Let’s refer to this argument as ‘position A’ ([**Figure 5.1**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_006.xhtml#eid4272)).



Figure 5.1 The theory-model controversy: position A.

This differentiation would appear to clear up the confusion, but Meleis ([**2007**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9130)) argued that it matters little what we call these ‘things’. She believed that much time has been wasted debating the differences between models, theories and paradigms. Rather, she maintains that time would be better spent evaluating the effects of these conceptualisations on patient care.

Meleis based her argument on her desire to concentrate on content and not on labels. She asserted that theory exists at different stages of development, from the most primitive to the most sophisticated form, and therefore even the simplest conceptualisation is a theory. Her stance would be that models are theories, but at a more abstract level than the theories developed through research. The most primitive may be referred to as grand (or broad) theories, while the most sophisticated are referred to as mid-range or practice theories. We will refer to this view as ‘position B’ ([**Figure 5.2**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_006.xhtml#eid4281)).



Figure 5.2 The theory-model controversy: position B.

However, for the purpose of this book you will have detected that the term we will use throughout will be theory (position B). The basis for this decision lies with Meleis’s call for professionals to concentrate on substance (content) rather than structure (terminology). When theories or models are mentioned in the remainder of this book, we will be referring to grand theories, unless otherwise specified (see [**Key Concepts 5.1**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_006.xhtml#eid4290) and [**Reflective Exercise 5.5**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_006.xhtml#eid4299)).

It is important that both theories and models present phenomena in systematic ways, that both help to organise the work of nurses in practice as well as in education, and both develop the body of nursing knowledge and science.

 Key Concepts 5.1

**Theory and model**

Theory exists at different stages of development and a conceptual model is a stage of development on the way to becoming a theory.

Reflective Exercise 5.5: Position A or position B?

Both positions can be supported by referring to various bodies of literature. We would urge you to view both approaches as worthy of consideration. However, for the purposes of this exercise, consider which position you are attracted to. Think of those theorists whose work you are most familar with and decide whether you think models or theories are the best descriptors. Write down the pros and cons of each and your justification for selecting your favoured position.

Discuss your thinking with a fellow student or colleague - remember, they may not ageee with you but that does not mean you are wrong. Check if they have identified the same or different advantages and disadvantages.

The classification of theories

Since the mid-1970s there have been various attempts to categorise the large number of grand theories into a number of common types. Aggleton and Chalmers ([**2000**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8524)) believed that this trend would help nurses to make some preliminary decisions about the choice of theory that was most appropriate for a particular clinical setting. This grouping of theories by some specific trait also leads to an understanding of the various schools of thought that underpin each theory. Systems of cataloguing theories often arise when the editors of a book try to arrange them into some orderly scheme.

The following section gives some examples of theory classification. Different authors classified theories according to the level of use that can be made of them in describing, explaining, predicting or (according to Dickoff & James, 1967) prescribing (McKenna [**1997**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9081); Meleis [**2012**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9133)). Within the classification this means that descriptive theory is the least developed theory because it has no explanation, prediction or prescription power (Pajnkihar [**2003**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9241)).

For example, Meleis ([**2007**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9130)) organised theories into those that ‘describe what we do’; ‘those that describe how we do it’; and ‘those that describe the why of practice’. More recently, Wright and Gros ([**2012**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9611)) refered to Meleis ([**2007**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9130)) four schools of thought that provided an orientation of nursing theories: needs, interaction outcome and caring/becoming. In contrast, Stevens Barnum ([**1998**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9499)) used the following classifications: intervention, conservation, substitution, sustenance and enhancement. Alligood and Marriner Tomey ([**2006**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8540)) sorted theories into humanistic, interpersonal, systems and energy fields. Fawcett ([**2012b**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8782)) talks about empirical, aesthetic, ethical theories, sociopolitical or emancipatory theories, and theories of personal knowledge. She differentiated theories according to organisational and individual factors that influenced evidence-based nursing practice.

Marrs and Lowry ([**2006**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9050)) proposed an expanded hierarchy of nursing knowledge in which theories are classified. They sort components of nursing knowledge by level of abstraction: metaparadigm as the most abstract component, then philosophies, conceptual models, grand theories, mid-range theories, practice theories and empirical indicators as the most concrete.

Colley ([**2003**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8674)) classified nursing theories based on the philosophical underpinnings of the theories (need, interaction, outcome and humanistic theories) and according to Polit et al. (2001) on the generalizability of their principles (meta-theory, grand theory, mid-range theory, practice theory) and to function (descriptive, explanatory, predictive, prescriptive).

 Key Concepts 5.2

**Classification of theories**

Theories can be classified according to the level of use or function, their generalisability, level of development, philosophical underpinnings and their paradigmatic roots.

Classification of theories according to their paradigm roots

As you can see from the preceding section, theories are classified in many different ways. One of the most popular is a categorisation according to their paradigmatic roots. These are the systems, interactional, developmental and behavioural paradigms. You will recall from [**Chapter 1**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_002.xhtml#eid1030) that a paradigm represents a broad worldview.

*Systems paradigms*

These theories are largely based on the ‘general systems’ paradigm put forward by Von Bertlanaffy ([**1951**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9549)). Put simply, a system is a collection of parts that function as a whole entity for a particular purpose. Therefore, the parts within a particular system are interrelated. These interrelationships may form ‘subsystems’ within the parent system. Similarly, the system itself may form part of an overall ‘suprasystem’. If the system has permeable boundaries, it is called an ‘open system’. If not, it is referred to as a closed system. In system theories, the patient is often referred to as an ‘open system’ (see [**Reflective Exercise 5.6**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_006.xhtml#eid4352)). The work of Roy ([**1970**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9377)), Neuman ([**1982**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9202)), Johnson ([**1959**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8947)), Parse ([**1981**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9266)) and Fitzpatrick & Whall [**1983**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8801)) may be grouped under the systems paradigm.

Reflective Exercise 5.6: Systems

A system is made up of subsystems. Think of the human body as a system, with subsystems including the respiratory system, cardiac system, and so on. But systems exist in a larger suprasystem (e.g. family, class grouping). The ‘human body’ system interacts with other systems and has permeable boundaries because there are inputs into the system (e.g. knowledge, food, water) and outputs (e.g. waste, speech, perspiration). Therefore it is an open system.

Think of a hospital ward as a system. What subsystems could exist in that system? What suprasystem is the ward part of and what are the inputs and outputs to the system? What are the permeable boundaries that exist between this system and other similar systems?

Identify two other things that may be conceptualised as a system.

*Interactional paradigms*

Interactional theories have their origin in the symbolic interactionist paradigm (Blumer [**1969**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8600)). This paradigm emphasises the relationships between people and the roles they play in society. Nursing activities are perceived as interactional processes between practitioners and patients. Among the better-known interactional theories are those of Riehl ([**1974**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9346)), Orlando ([**1961**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9235)), Patterson and Zderad ([**1976**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9272)), Levine ([**1966**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9025)) and King ([**1968**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8982)).

Take the example of a nurse assessing a patient. Here an interaction is taking place in which there is a transaction of information. The interaction and its results may be decided by the various roles played by the nurse and the patient. The nurse also reacts to the patient’s interaction and vice versa, and both may alter their own interactional processes as a result of reactions from each other. This shows how the interactional theories can be applied to practice situations (see [**Reflective Exercise 5.7**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_006.xhtml#eid4380)).

*Developmental paradigms*

The developmental paradigm originated from the work of Freud ([**1949**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8808)) and Sullivan ([**1953**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9511)). The central themes are growth, development, maturation and change. It is argued that human beings are constantly developing, whether this be physiologically, socially, psychologically or spiritually. Development is seen as an ongoing process in which the person must pass through various stages. The nurse’s role is to encourage positive development and to discourage the formation of barriers to natural development. The works of Peplau ([**1952**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9278)), Travelbee (1964) and Newman ([**1979**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9208)) are often perceived as having their foundations in developmental theory. Some of these theories will be discussed in greater detail in the next chapter.

Reflective Exercise 5.7: Interactional paradigms

Interaction theorists focus their attention on the relationship between the patient and the nurse and these theories can be applied to practice situations.

Think about a particular patient with whom you have worked. Think of the interaction that took place. Was it two-way or just one-way? How did you react to the patient’s interaction and how did the patient react to your interaction? Was it an equal interaction or was one of you taking the lead?

Within a developmental paradigm, nurses are often encouraging growth and development, much as a gardener would do with plants. The patient may have had a stroke and have to live with a new disability or be a mother who has given birth to a handicapped child. Initially, care will be required for these patients to learn new attitudes, knowledge and skills in order to mature in the new situation in which they find themselves. Hopefully, their care will reach a point where they will no longer require the support and presence of the nurse or midwife because they will have changed to a higher level of growth within the limits of the disabilities.

*Behavioural paradigms*

These theories owe much to the theoretical formulations of Maslow ([**1954**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9054)). Because of this, they are often referred to as ‘human needs theories’ (Webb [**1986**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9583)). Behavioural theories assume that individuals normally exist and survive by meeting their own needs. Included in this category is the work of Henderson (1955), Roper et al. ([**1980**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9365)), Orem ([**1958**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9220)), Minshull et al. ([**1986**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9156)) and Wiedenbach ([**1964**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9594)) (see [**Reflective Exercise 5.8**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_006.xhtml#eid4409)).

Because there are no rigid criteria available to place theories into these paradigmatic classifications, it will not surprise you that there are disagreements among authors as to which grouping a particular theory belongs in. For instance, Orem’s work has been seen as having its basis in the systems paradigm by Suppe and Jacox ([**1985**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9514)), in the interactional paradigm by Greaves ([**1984**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8838)), in the developmental paradigm by McFarlane ([**1986**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9071)), and in the behavioural paradigm by Chapman ([**1985**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8653)). Despite these disagreements, this method of classification has been considered a valid one for categorising nursing theories.

Current trends in nursing theories

Im and Chang ([**2012**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8917)) described current trends in nursing theories and categorised theories into six major themes: focus on specifics, coexistence of various types of theories, close link to research, international collaborative works, integration into practice and selective evolution.

Reflective Exercise 5.8: Behavioural paradigms

You will recall from a previous chapters that Roper, Logan and Tierney’s theory focuses on 12 activities of daily living (ADLs) and Orem’s work focuses on self-care. In each case the nurse’s role is to identify the patient’s needs. In the former case, the needs are those where the patient is dependent for some of their ADLs; in the latter, the needs result from the fact that the patient cannot self-care.

In the UK, the most popular nursing theories in use in clinical settings are those of Roper et al. and Orem. Discuss with fellow students why human needs theories are so popular.

An easily understood article on human needs is that of Minshull et al. ([**1986**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9156)). Read it and decide whether you see validity in this approach to theorising.

Theofanidis and Fountouki ([**2008**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9529)) agreed that if a theory is adopted too rigidly, the care becomes vague. Even if theories are weak, there is still value in them because they may stimulate discussion and debate about the best nursing practice. Despite all that has been written, Schmenner et al. ([**2009**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9421)) claimed that we cannot just criticise existing notions of theory and models without offering feasible alternatives. Nurses must appreciate different types of theories and critique them, and in this way contribute to the continued development of nursing (Colley [**2003**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8674)). It is possible that new interdisciplinary theories are needed to improve patient care (Bond et al. [**2011**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8607)).

What is important for the future development of theories is reflection on practice needs and to take into account situations in health care systems where interdisciplinary knowledge is needed. The point is not to develop new theories for their own ends, but to analyse, evaluate, test and apply current theories in practice to evaluate their usefulness. More attention is needed to develop clear criteria for theory analysis and evaluation. A strong connection between practice, research and theories has to be established.

The nursing metaparadigm

Regardless of how theories are categorised, there is a consensus of opinion that each meta-paradigm must specify certain central concepts. These ‘essential elements’ have been referred to as the ‘metaparadigm’ of nursing (Fawcett [**2005a**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8770)). The metaparadigm is the overall paradigm or world view of a discipline. The metaparadigm in nursing is composed of four essential elements: person, nursing, health and environment (see [**Key Concepts 5.3**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_006.xhtml#eid4430)).

 Key Concepts 5.3

**Metaparadigms:** abstract components to cover practice phenomena, which usually include four essential elements - person, nursing, health and environment.

For Hardy ([**1978**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8862): 89), a metaparadigm is the ‘broadest consensus within a discipline’ or ‘a gestalt or total view within a discipline’. Hardy also calls it the ‘prevailing paradigm’, presenting ‘a general orientation or total worldview that holds the commitment and consensus of the scientists in a particular discipline’.

Fawcett pointed out that every discipline singles out certain named phenomena (broad concepts) with which it will deal uniquely and such phenomena combine to form the meta-paradigm for that discipline. The metaparadigm acts as a vital unit or framework within which the more specific structures develop. Most professions have a single metaparadigm from which numerous theories emerge; contemporary nursing appears to have reached this level of theoretical sophistication.

During the 1970s and 1980s, authors wrote extensively about the importance of the essential elements of nursing science. The argument was put forward that if a nursing theory did not include assumptions about ‘nursing’, ‘health’, ‘person’ and ‘environment’, it could not be considered to be a theory (see [**Reflective Exercise 5.9**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_006.xhtml#eid4443)).

Reflective Exercise 5.9: The metaparadigm

Get three or four of your colleagues together and spend 15 minutes considering how each of you describes ‘nursing’, ‘health’, ‘person’ and ‘environment’. Write one sentence on each and try to refrain from using quotations from well-known theorists. Once you’ve all done this, compare what you have all written and then as a group attempt to categorise the views in the systems, interactional, developmental or behavioural paradigms.

However, the complete four-element metaparadigm has its dissenters. For example, Stevens Barnum ([**1998**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9499)) excluded ‘environment’, and Kim ([**1983**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8976)) excluded ‘health’. Some authors believe that ‘nursing’ should be omitted as a concept, maintaining that its inclusion is a redundancy in terms and that instead the term ‘caring’ should be included (Leininger, cited in Huch [**1995**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8910)). Plummer and Molzahn ([**2009**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9308)) found, from a review of the theories of Peplau, Rogers, Leininger, King and Parse, that health could be replaced by quality of life as a meta-paradigm element. Schim et al. ([**2007**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9417)) explored community and public health nursing in urban settings and suggested the inclusion of social justice as a fifth element of the nursing metaparadigm.

Kao et al. ([**2006**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8962)) explored the western nursing four-element metaparadigm through a Chinese lens. Shattell ([**2006**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9458)) commented that this provided nurses with theoretical knowledge of other ways of viewing the nursing metaparadigm by giving a refreshing look at an ‘alternative’ way of seeing the world.

As the metaparadigm represents the foundation stones for various theories, one would expect each theory to outline its beliefs and assumptions regarding the ‘person’, to present an identification of the person’s ‘environment’, to define what ‘nursing’ is (and/or midwifery) and to discuss the theorist’s views on ‘health’.

Although each grand nursing theory conceptualises the four essential elements of the metaparadigm, they tend to view them from different perspectives. Therefore, how nursing, health, person, and environment are described and defined varies greatly from theorist to theorist. So while theorists consider the same metaparadigmatic elements, they may emphasise different aspects and see them in different relations to one another. Such a rich diversity of assumptions concerning the same factors can only enrich the nursing profession (see [**Reflective Exercise 5.10**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_006.xhtml#eid4461)).

Reflective Exercise 5.10: Metaparadigms in different professions

Each profession has its own metaparadigm, which encapsulates the central elements of that discipline. For architecture, they could be structure, design, aestheticism and materials. For the legal profession a metaparadigm might include, law, crime and justice.

Think about the professions of teaching and religion. For each one, identify what you believed the mataparadigm elements would be. You may want to compare these with what other students or colleagues thought.

How different theorists viewed the metaparadigm

In the following we extract the metaparadigm concepts from the works of Henderson ([**1966**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8881)), Orem ([**1991**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9229), [**1995**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9232)), Watson ([**1988**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9576)) and Peplau ([**1952**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9278)).

*Person*

* • Henderson ([**1966**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8881), [**1991**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8884)) believed that body and mind are inseparable, and viewed the patient as a person who needs help with basic life activities and with achieving health and independence, or to die peacefully.
* • Orem ([**1991**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9229): 181) described a person or human being as ‘a unity that can be viewed as functioning biologically, symbolically, and socially’.
* • Watson ([**1988**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9576): 45) viewed the person as ‘a being in the world’ who is the locus of human existence. A person exists as a living and growing gestalt and possesses the three dimensions of being - mind, body and soul - which exist in harmony in good health, where the essence of the person is the soul, which is ‘spirit, or a higher sense of self’.
* • Peplau ([**1952**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9278): 82) defined humans as organisms that live in an unstable equilibrium (i.e. physiological, psychological and social fluidity). She asserted that all individuals have physical, psychological and social needs, and that in an unstable environment, they constantly meet new situations and new problems.

*Nursing*

* • Henderson ([**1966**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8881)) described nursing as a profession that helps people, sick or well, in the performance of the 14 basic life activities that contribute to health or its recovery (or to a peaceful death) that they would perform unaided if they had the necessary strength, will or knowledge.
* • Orem ([**1995**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9232)) described nursing as a specialised human service to society. She characterised nursing as action and assistance with the goal of helping people to meet their own demands for self-care on a therapeutic and continuous basis.
* • Watson ([**1988**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9576): 73) asserted that caring is essential to nursing and is ‘a moral ideal that includes concepts such as a phenomenal field, an actual caring occasion, and transpersonal caring’, which are central to her theory. She saw nursing as both a science and an art. Watson ([**1988**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9576): 54) defined nursing as ‘a human science of persons and human health-illness experiences that are mediated by professional, personal, scientific, aesthetic, and ethical human care transactions’. Watson ([**1988**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9576): 17) further explained that in this view of nursing as a human science, nursing can combine and integrate science with beauty, art, ethics and aesthetics of the human-to-human care process.
* • Peplau ([**1952**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9278)) defined nursing as a significant, therapeutic, interpersonal process. It functions cooperatively with other processes that make health possible for people and communities. ‘Nursing is an educative instrument, a maturing force, that aims to promote forward movement of personality in the direction of creative, constructive, productive, personal, and community living’.

*Health*

* • Henderson ([**1966**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8881), [**1991**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8884)) did not specifically define her own concept of health, but she sees it as the ability of people to function independently by reference to the 14 basic life activities. Therefore, health relates to independence.
* • Orem ([**1995**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9232): 96) suggested that the ‘term health has considerable general utility in describing the state of wholeness or integrity of human beings’. Orem ([**1995**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9232): 101) explained that well-being is used in the sense of an individual’s ‘perceived condition of existence’. The nursing domain concerning health involves the promotion and maintenance of health and protection against specific diseases and injuries.
* • Watson ([**1988**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9576): 48) referred to health as ‘unity and harmony within the mind, body, and soul’. To her, health is associated with ‘the degree of congruence between the self as perceived and the self as experienced’. A person becomes ill when there is conscious or unconscious disharmony between these. ‘Illness is not necessarily disease.’
* • Peplau ([**1952**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9278): 12) maintained that health ‘is a word symbol that implies forward movement of personality and other ongoing human processes in the direction of creative, constructive, productive, personal, and community living’. She saw health as a process whereby an individual has a quality of life that enables the contribution to personal and community living.

*Environment*

* • Henderson ([**1966**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8881), [**1991**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8884)) did not explicitly define the environment, but through her explanation of what a patient is, it is evident that she was concerned with the influences affecting the life and health of patients, especially the family and cultural influences.
* • For Orem ([**1991**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9229): 38), the person and the environment are in constant interaction and the nurse must consider the human environment, analysing and understanding the various ‘physical, chemical, biological, and social features’.
* • Watson ([**1988**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9576): 75) did not explicitly define environment, but the environment is specifically used in her 10 carative factors, in particular, the promotion of a ‘supportive, protective, and/or corrective mental, physical, societal, and spiritual environment’. Nurses must recognise the influence of internal and external environments on the health and illness of individuals and also the need to support and protect individuals.
* • Peplau ([**1952**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9278): 14) defined the environment as forces existing ‘outside the organism and in the context of the culture’.

Students often have problems differentiating between concepts of metaparadigms and basic concepts of theory and their interactions (see [**Reflective Exercise 5.11**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_006.xhtml#eid4581)). Basic concepts of the theory are always synchronised and well connected with concepts of metaparadigms. For example, the central concepts of Watson’s theory are human care, transpersonal care relationships, the self, the phenomenal field, events, actual caring occasions and carative factors.

Reflective Exercise 5.11: Differentiation between concepts of metaparadigms and basic concepts of theory

Go to the library or online and read up on Swanson’s ([**1991**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9518)) theory of caring. She explicated her beliefs about the four metaparadigm elements of concern to the discipline of nursing (nursing, person/client, health and environment) and defined the main concept of the theory: caring and five concepts of the caring process.

Consider whether nursing, health, environment and person capture the essence of nursing. Would you change any of these or add anything?

Limitations of nursing theories

We touched a little bit on the disadvantages of nursing theories in [**Chapter 1**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_002.xhtml#eid1030), and throughout the chapters we have alluded to their advantages. However, the following sections offer a comprehensive overview of the limitations and benefits of theories (see Tables 5.1 and 5.2). It will not surprise you that nursing theories have a number of well-publicised limitations and an equally large number of less well-publicised benefits. However, all theories can have benefits if they are analysed, evaluated and tested before being applied. Selecting a theory for practice and for education needs careful consideration as to what is needed, what can be gained or strengthened, and what characteristics have particular nursing and patient outcomes, as well as the level of knowledge development needed by nurses. There is no theory that can be right for all environments or fit into all nursing fields, or simply be the perfect one. If the wrong theory is selected, we cannot blame the theory for being wrong.

Grand theories have been well criticised and their disadvantages have not been ignored. The two major denunciations are the belief that most theories are abstract and therefore are merely untestable conceptual models (Fawcett [**1995**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8764)). Research carried out in Slovenia found nurses clearly wishing to use nursing theories but finding that there were too many of them and they were too hard to understand (Pajnkihar [**2003**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9241)). McCrae ([**2012**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9065)) believed that some fail to bridge the gap between theory and practice due to misunderstanding and misuse. He believed that there are various reasons for this: nursing eludes definition; theories are not compatible with evidence-based practice; there is a lack of prescription for practice; there are limits to professional demarcation and autonomy; they are irrelevant to modern health care; and too much documentation and specific jargon prevent nurses from giving individual care. Theories are also not part of everyday practice, are often too generalised and complicate practice (Colley [**2003**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8674)).

Table 5.1 Perceived benefits of theories for practice.

|  |
| --- |
| * • Assist student learning
* • Help to structure patient assessment
* • Permit meaningful communication between nurses
* • Improve problem-solving
* • Increase patient’s satisfaction
* • Identify the goals of practice
* • Substantially improve quality of care
* • Clarify nurses’ realm of accountability
* • Focus observations on important phenomena
* • Guide and justify actions
* • Clarify thinking among nurses about practice
* • Provide others with a rationale for nurses’ work
* • Direct research into clinical needs
* • Help to establish more holistic, compassionate, person-centred and individualised care
 |

Table 5.2 Perceived limitations of theories for practice.

|  |
| --- |
| * • Do not prepare nurses for the reality of practice
* • Offer little guidance for action
* • Too abstract, academic, idealistic and irrelevant
* • Are not responsible for any change in practice
* • Lead to premature closure on ideas
* • Their application is a criticism of current practice
* • Provide only tentative ideas about practice
* • Unable to cope with multiple clinical foci
* • Not empirically tested or evaluated in practice
* • In some cases, they demand more staff than are available
 |

Webb ([**1986**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9583)) differentiates between low- and high-level criticisms, the former being more easily overcome than the latter.

Low-level criticisms

*Documentation*

The emphasis on increased paperwork when using theories has alienated many practising nurses. For most nurses, the implementation of theories is seen as a paper exercise. According to Miller ([**1985**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9152)), Roy’s theory requires 16 pages of A4 to apply it properly! Wimpenny ([**2002**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9604): 350) explored the meaning of ‘models of nursing’ by practising nurses and one nurse’s comment was, ‘When I see models, I see documentation.’

*The suitability of American theories*

As most nursing theories have their origin in the US, it has been debated as to whether these theories are transferable to practice elsewhere. Wright ([**1986**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9619)) suggested that there is nothing wrong with professionals from different nations swapping ideas, but that the application of one group’s practices to another may not always be appropriate. If European nurses continually look to America for conceptual guidance, a manipulative process will have to be employed to assure the validity of US theories within European health services. Nursing theories from the US have their roots in a different culture, a different health care structure and a different training scheme. American nursing theories accepted uncritically and without previous analysis and testing into Slovenian nursing education and practice created difficulties for nurses (Pajnkihar [**2003**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9241), [**2011**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9247); Pajnkihar & Butterworth [**2005**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9256)). Culturally, different knowledge bases or beliefs and expectations can make some theories unworkable. For example, Orem’s theory was typically developed for the American insurance-based health care system, while the health care system in many parts of Europe provided public health care for its citizens. On the other hand, McCrae ([**2012**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9065)) questioned whether British models can be successfully introduced to the USA.

*Jargon*

Most of the available theories are characterised by elaborate and abstruse language. This has been referred to as ‘abstract jargon’ (Wright [**1985**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9615)) and ‘semantic confusion’ (Hardy [**1986**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8858)). This contributes much to the unmanageability of theories in practice. There is also the danger that the use of this ‘jargonese’ will lead to widespread confusion not only among practising nurses but also among the public and multidisciplinary colleagues. Cavanagh ([**1991**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8650): 127) explained that ‘nurses are obliged to grapple with a new and often bewildering vocabulary before they can examine the model’s utility in practice’, and that some models may be ‘too esoteric for nursing today’. One of the criticisms of nursing theory is that they are too generalised, overcomplicate practice and have very complex terminology, which means that nurses end up spending too much time trying to understand the new concepts and, as a result, overlook their relevance to practice. Inconsistent and interchangeable use of terminology in nursing theory aggravates poor communication in nursing and across multidisciplinary teams (Colley [**2003**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8674)).

A good theory should be stated in the simplest terms possible. Theorists therefore have a responsibility to put forward their theory in as simple a form as possible. Unfortunately most nursing theories have paid little attention to this concept of simplicity. For example, although Rogers ([**1970**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9352)) is quoted as emphasising the need to avoid jargon, she sees the environment as ‘a four dimensional negatrophic energy field identified by pattern and organisation, and encompassing all that is outside any given human field’. Similarly, ‘adaptation’ in Roy’s (1971) theory means something totally different from ‘adaptation’ in Levine’s ([**1966**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9025)) theory. A ‘stressor’ is viewed as a negative stimulus by Roy ([**1971a**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9381)), while it is defined as a positive force by Neuman ([**1982**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9202)). As Bartle ([**1991**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8567)) noted, theory is complex and effort is required to understand the specific language. If the reader needs to use a glossary or dictionary to understand typical terms included in the theory, the theory lacks semantic clarity, creating difficulties in practice and education (Pajnkihar [**2003**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9241)). Theofanidis and Fountouki ([**2008**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9529)) maintained that the complex terminology represents a true problem for non-native speakers of English and therefore it would be better to focus on the content rather than the context. That is why Webber ([**2010**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9586)) recommends reaching a consensus of key words and meanings associated with theory.

Although acknowledging the over-use of jargon in theories, Aggleton and Chalmers ([**2000**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8524)) believed that singling it out as a major criticism was unduly cynical. Modern nursing is highly complex and so theory must have complexity to be significant. As the concepts under study are abstract, precise theoretical language is inevitably complex. The problem is not reserved to theories within nursing: remember that Freud’s theory introduced the terms ego, superego, id, Oedipus complex and Electra complex, while Jung’s theory introduced extrovert and introvert!

*Staffing issues*

There is much discussion worldwide about nursing shortages. If a theory identifies goals that cannot be met due to lack of time, the hard-pressed nurses are likely to become extremely frustrated. This may also raise ethical issues. One wonders if it is morally right to uncover multiple needs in a patient when, because of staff shortages or short lengths of stay, only a few will be addressed. A nurse taking part in research investigating the acceptance of a nursing theory in practice said, ‘Generally, theories are not well enough known. We do not have enough personnel and knowledge… We need theories to help us know the clients and to improve our work’ (Pajnkihar [**2003**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9241)).

In addition to the lack of knowledge, there is the shortage of nurses, which often leads to the inadequate use of the biomedical model. Shorter duration of hospitalisation of clients is also regarded as important, because, as a consequence, a more intensive diagnostic therapeutic programme is required, which further compounds the neglect of new theories and adherence to the old and familiar (Pajnkihar [**2003**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9241)).

High-level criticisms

*Conceptual substance*

Many theories have been criticised for adopting a restricted view of nursing. Some authors believe that theorists have trodden a narrow path in their efforts to theorise. Elsewhere in this book we castigated the biomedical model for its emphasis on reductionism. However, the theories of Roper et al., Roy, Henderson, King, and Orem could also be ridiculed for being reductionist - after all they reduce the patient to a list of activities, needs or modes of adapting or to a set of self-care needs.

In Slovenia, eight different nursing theories are taught to nursing students. However, the overall curriculum is based on Henderson’s theory of 14 activities of living, which has been criticised on the grounds that it is too narrow, does not encompass the client holistically, and leads practitioners mostly to physical care, washing and feeding. Only recently have some other nursing theories been introduced into practice, but Henderson’s theory still dominates. A nurse taking part in a study explained that: ‘Henderson is applied, as she brought some system into routine work, but, emphasising only the patient’s physical needs, she proves too narrow’ (Pajnkihar [**2003**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9241)).

This reflects a similar situation as that in the UK, where Roper et al.’s theory of Activities of Daily Living predominates. Readers may find it interesting to reflect that of all the nursing theories in existence, perhaps those of Henderson and Roper et al are the closest to the bio-medical model.

There are also the contrasting accusations that, in an attempt to be all-inclusive, nursing theories provide inadequate guidance for practice. The belief that grand theories are general statements about care has led some nurses to think that a theory can be used in a wide range of settings. A blanket application of one theory may, according to Hardy ([**1986**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8858)), be unwise and even dangerous.

However, Theofanidis and Fountouki ([**2008**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9529): 19) consider that ‘models do not imply that everyone’s world view is, or ought to be, the same; they merely help nurses to conceptualize the accumulative world views in a single, highly abstracted way and if a model was to provide all existing different world views, then the model would be a world size one.’

*Ideal concepts versus practical reality*

Most theories deal with practice as it ought to be, and not as it is. However, if we do not know what nursing or midwifery is, how can we work in the real world of practice? In considering this problem, Meleis ([**2007**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9130)) felt that theorists were becoming more competent in articulating what theory is, rather than what is the substance of the practice itself. McCrae ([**2012**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9065): 224) believed that ‘however cogent a theory is, it is soon redundant if it does not make sense to the practitioner’.

Nurses are often characterised as being anti-intellectual when it comes to research and theories. Although the apparent gap between what theorists believe and what goes on in the clinical setting is one reason for this, the imposition of theories by management encourages such reactions. The introduction by force of a theory that is supposed to be based on individual choice is an obvious contradiction. Watson ([**1988**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9576)) explained that in formulating her theory she used knowledge from other disciplines and philosophies, as well as from eastern philosophy. For European nurses it may be difficult to understand nursing theories that have roots in a different culture, in eastern philosophy, a different health care structure or a different nurse education system. The need to be familiar with eastern philosophy and to have a liberal arts background may be asking too much (Pajnkihar [**2003**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9241)) (see [**Reflective Exercise 5.12**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_006.xhtml#eid4766)).

Those who wish to introduce a theory into the clinical setting may be met by sceptical practising nurses who see theories merely as the results of academic exercises aimed at increasing the complexities of their already busy lives. In the UK, nursing theories have taken over the unpopular positions recently vacated by the ‘nursing process’ and ‘primary nursing’.

Reflective Exercise 5.12: Limitations of theories - what do others think?

The main limitations of nursing theories have been outlined here. Can you think of any others that we have not identified? To help you to consider this, we would like you to take the views of patients, family members and other health care professionals into account. Write down what you believe they would think of all these nursing theories.

Benefits of nursing theories

Those who advocate the use of theories do so for a number of reasons. The two distinct benefits are the substitution of the biomedical model for delivering care and the understanding that theories lead to the development of nursing knowledge. These have already been discussed. However, the literature highlights several other equally favourable advantages.

Alligood ([**2010a**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8530)) pointed to the important benefits of theories from patients’ and professionals’ perspectives, considering them a systematic approach to care that is patient-oriented. According to Marrs and Lowry ([**2006**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9050): 49) ‘nurses who use nursing theories provide an alternative base for nursing practice from a theoretical perspective’. There is no doubt that nursing as a profession and as a discipline needs a unique body of knowledge and that nursing theory provides an organised, systematic, empirical and logical view of the knowledge that nurses need for everyday practice, education and research in order to benefit their patients (Pajnkihar [**2003**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9241)).

A guide to practice

Colley ([**2003**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8674): 33) wrote: ‘Ideally, nursing theory should provide the principles that underpin practice.’ There is a consensus of opinion that the implementation of the nursing process without a theory to underpin it is an empty exercise akin to ‘practising in the dark’ (Aggleton & Chalmers [**2000**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8524)). Although British nurses have only recently been introduced to theories, they have been wrestling with the nursing process for some decades. It could be argued that they have put the ‘cart before the horse’. By providing a systematic basis for assessment, planning, implementing and evaluating, theories offer a way to ‘revitalise’ the nursing process.

The nursing process is a problem-solving approach involving ‘critical, logical and creative thinking’, which is one of the bases of nursing practice (Leddy & Pepper [**1998**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9016): 9). In many instances, the nursing process was also introduced in many European countries before an understanding of nursing theories. Therefore, nurses knew that they had to assess but did not always know what to assess; they knew they had to plan but did not always know what to plan; and they knew they had to intervene but did not always know what interventions to use. Nursing theories would have provided them with the missing details (McKenna [**1997**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9081); Pajnkihar [**2003**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9241)).

In order to be implemented successfully and to have meaning for practitioners, the nursing process as a problem-solving exercise must be framed in a theory. Nursing theories also stress the importance of the wholeness and integrity of the person, thus further enhancing the practitioner’s ability to provide individualised care. These theories are essential guides for practice, and as such they help to bring theory and the process of practice closer together. Theories are the best evidence for evidence-based nursing practice (Fawcett [**2012b**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8782)).

The usefulness of these frameworks has also been recognised in the areas of nursing education, administration and research (Nicholl [**1992**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9211)) (see [**Reflective Exercise 5.13**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_006.xhtml#eid4796)). American nursing theories were first adapted for European countries and were used in nursing education rather than in practice. The same thing happened with the nursing process. Without nursing theory, which guides nurses in terms of what to observe and what kind of questions they need to ask, practice can prove to be problematic. When nursing education accepted theories, there was not enough knowledge in practice to deal with them. A nurse who took part in a research project observed: ‘Practical work is not possible without theories, but many of them are hard to understand and the nurses’ level of knowledge does not allow them to use the theories’ (Pajnkihar [**2003**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9241)).

Reflective Exercise 5.13: Using Roper, Logan and Tierney’s theory (RLT) for assessing patients’ needs

Think back to your previous placements and choose one suitable patient you have looked after whose assessment notes you can access. Find a description of RLT model, read it and use this model to assess this patient’s needs.

Did you find the RLT model understandable and useful in assessing the patient’s needs? What were the pros and cons?

Education

Although the dichotomy between the classroom and the ward is well documented (Meleis [**2007**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9130)) and much was made of the theory-practice gap in earlier chapters, there is evidence to suggest that the structuring of an education programme around a theory is extremely beneficial for students (Aggleton & Chalmers [**2000**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8524)) and, as a result, theory and practice may eventually meet. Alligood ([**2011**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8536)) stated that nursing theories provide important frameworks for nurse educators. To ensure a strong theory-practice relationship, we have to incorporate theory into the curricula. Educators must be familiar with strategies to ensure this and also know how to implement such strategies (Donohue-Porter et al. [**2011**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8719)).

However, if theories are only taught in the classroom and if students do not come across them in practice, theories will remain ‘only academic theories’. They can be properly understood by students only if they can experience and see them in practice. It can be difficult for students to understand and see the usefulness of theories when they cannot see those theories they learned in the classroom playing a part in how care is delivered in practice. Nurses have become aware that practice based on theory shapes their professional work and that a discrepancy exists between education and practice. Accordingly, they have started to move away from the widely used biomedical model towards client-based care and to define their unique contribution in the health care system in specific nursing terms (Pajnkihar [**2003**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9241)).

Professionalisation

Johnson ([**1959**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8947): 212) stated that ‘no profession can exist for long without making explicit its theoretical basis for practice’. Smith ([**1986**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9485)) maintained that nursing can achieve full professional status comparable with other professions by basing its practice on theories. Theories were also seen as harbingers of autonomy, responsibility and leading to professional accountability (Meleis, [**2007**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9130)). Pajnkihar ([**2011**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9247)) argues that without care there is no medical treatment, and without theory there is no nursing, no profession and no discipline. Bond et al. ([**2011**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8607): 404) stressed that ‘a meaningful triadic relationship in theory, research and practice is essential for nursing to be recognised as a profession’. Nursing cannot claim to be a profession if its scientific knowledge is not developed and applied for clients’ benefit. Theory helps to develop the discipline and profession of nursing. Colley ([**2003**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8674)) also stated that ‘it would benefit the profession as a whole if nurses would develop the skills required to perform research and understand theory’. A typical interviewee’s convictions about the usefulness of nursing theories are as follows (Pajnkihar [**2003**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9241)):

* Nursing theories are the basis of the profession. We need them if we want nursing care to be acknowledged publicly. Theories are our groundwork; we build on them. Without nursing theory and history, there is no profession. If we fail to see that, we fail to acknowledge our status and our profession.

To be acknowledged as a profession, nursing needs to define its theoretical body of knowledge, which should not only be present during training, but also find application in clinical practice.

Quality of care

In his research, McKenna ([**1994**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9074)) found that the quality of care given by a practitioner using a theory is high, because practice is built on a systematic knowledge base. The quality of a service cannot be assessed unless there are standards against which an appraisal can be made. Quality of care evaluation in contemporary practice is becoming increasingly related to cost-effectiveness. If used appropriately, nursing theories can demonstrate cost-effectiveness through reducing dependency, encouraging self-care and the early detection of patients’ problems. A nursing theory also allows staff a greater articulation of health goals, hence identifying more efficiently the resources and skills needed to achieve them.

Conclusions

Theories and models have numerous definitions and mean different things to different people; thus a model is often seen as interchangeable with a theory. Fawcett ([**2005a**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid8770)) saw models as more abstract than theories because they present a more generalized and abstract view of phenomena, but when they are tested by research, they could lead to the formation of theory. From Meleis’s perspective, theories exist at different stages of development, and therefore models are also theories, but at different levels of construction and abstraction.

It is important to bear in mind that each theory also says something about the essential elements of metaparadigms. A metaparadigm in nursing is the global consensus that refers to the foundation elements of the profession and generally includes the ‘person’, ‘nursing’, ‘health’ and the ‘environment’. It also explains the theorist’s view, conceptualisation, perspectives and relationships among the four elements that cover the field of nursing (Pajnkihar [**2003**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9241)).

There are also numerous different classifications of nursing theories. However, it is more important to concentrate on the use of the theory and its testing in practice. Nursing does not exist without theories, but not all authors agree on this. Some see that theory has no relevance to practice and therefore to nursing. The limitations and benefits of theories have been questioned.

Compared with other professions, such as law, medicine and religion, the development of scientific knowledge in nursing is still in its early stages and has depended a great deal on knowledge from other disciplines. However, basing nursing education and practice on a borrowed model is not satisfactory. For nursing to advance it must generate nursing knowledge, help to progress nursing science and help practising nurses to carry out their primary caring function.

Revision Points

* • We have different definitions for nursing theories and nursing models, and sometimes the terms are used interchangeably.
* • A theory is a creative and scientific practice-based text that describes, explains and predicts specific nursing phenomena within the interrelated concepts, definitions and propositions.
* • A conceptual model is a stage of development on the way to becoming a theory.
* • Theories can be classified according to the level of use or function, their generalisability, level of development, philosophical underpinnings and their paradigmatic roots.
* • Theories are classified into grand theory, mid-range theory and practice theory.
* • Theories can have their basis in one or more paradigms: system, behavioural, development or interactional.
* • The consensus is that metaparadigms include the concepts of person, health, environment and nursing.
* • The main limitation of nursing theories is that there is a gap between theory and practice.
* • Criticisms of nursing theories relate to the following: documentation, the suitability of American nursing theories to other countries, the jargon used by theorists, nurses in practice and their (lack of) theoretical knowledge, the conceptual substance of the theory and what kind of theory we are looking for: ideal or practical reality.
* • The benefits of nursing theories are as follows: a replacement for the biomedical model, a guide for practice, education and research, development for the nursing profession, discipline and science of nursing. The greatest benefit is that theories help nurses to provide individual, humane and patient-oriented care. Nursing theories help with the use of nursing science and the art of nursing in everyday practice and have the potential to make nurses’ work more satisfying and respected.

Additional reading

McCrae N. ([**2012**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9065)) Whither nursing models? The value of nursing theory in the context of evidence-based practice and multidisciplinary health care. *Journal of Advanced Nursing*, **68**(1), 222-229.

Theofanidis D. & Fountouki A. ([**2008**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9529)) Nursing theory a discussion on an ambiguous concept. *International Journal of Caring Sciences*, **1**(1), 15-20.

Webber P.B. ([**2010**](https://jigsaw.vitalsource.com/books/9781118857854/epub/OPS/loc_011.xhtml#eid9586)) Language consistency: a missing link in theory, research and reasoning? *Journal of Advanced Nursing*, **66**(1), 218-227.

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