The fourth edition of this invaluable publication on middle range theory in nursing reflects the most current theoretical advances in the field. With five additional chapters, new content incorporates exemplars that bridge middle range theory to advanced nursing practice. Additional content for DNP programs includes two new theories: Bureaucratic Caring and Self-Care of Chronic Illness. This user-friendly text stresses how theory informs practice and research in the everyday world of nursing. Divided into four sections, content sets the stage for understanding middle range theory by elaborating on disciplinary perspectives, an organizing framework, and evaluation of the theory. Middle Range Theory for Nursing, Fourth Edition, presents a broad spectrum of 13 middle range theories. Each theory is broken down into its purpose, development, and conceptual underpinnings, and includes a model demonstrating the relationships among the concepts, and the use of the theory in research and practice. Including concept building for research through the lens of middle range theory, a rigorous 10-phase process that moves from a practice story to a conceptual foundation, and exemplars that clarify the concept building process, this new edition remains an essential text for advanced practice theory and research courses.

New to the Fourth Edition:
- Reflects new theoretical advances
- Five completely new chapters
- New exemplars linking middle range theory to advanced nursing practice
- New content for DNP programs
- Two new theories: Bureaucratic Caring and Self-Care of Chronic Illness
- Two articles from Advances in Nursing Science documenting a meta-perspective about middle range theory development over the decades

Key Features:
- Provides a strong contextual foundation for understanding middle range theory
- Introduces the Ladder of Abstraction to clarify the "range" of nursing’s theoretical foundation
- Presents 13 middle range theories with philosophical, conceptual, and empirical dimensions of each theory
- Examines research application through exemplars demonstrating the use of middle range theory for advanced practice nursing
- Includes Appendix summarizing middle range theories from 1988 to 2017
Middle Range Theory for Nursing
Mary Jane Smith, PhD, RN, FAAN, earned her bachelor’s and master’s degrees from University of Pittsburgh and her doctorate from New York University. She has held faculty positions at the following nursing schools: University of Pittsburgh, Duquesne University, Cornell University-New York Hospital, and The Ohio State University. Currently, Dr. Smith is a professor of nursing at West Virginia University School of Nursing; she has been teaching theory to master’s and doctoral nursing students for over four decades.

Patricia R. Liehr, PhD, RN, graduated from Ohio Valley Hospital, School of Nursing in Pittsburgh, Pennsylvania. She completed her bachelor’s degree in nursing at Villa Maria College, her master’s in family health nursing at Duquesne University, and her doctorate at the School of Nursing, University of Maryland, Baltimore. She did postdoctoral education at the University of Pennsylvania as a Robert Wood Johnson scholar. Currently, Dr. Liehr is a professor of nursing at the Christine E. Lynn College of Nursing at Florida Atlantic University; she has taught nursing theory to master’s and doctoral students for over three decades.
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Contributors

Melinda S. Bender, PhD, RN, PNP-BC, Assistant Professor, School of Nursing, University of California, San Francisco, California

Heeseung Choi, PhD, MPH, RN, Professor, College of Nursing and The Research Institute of Nursing Science, Seoul National University, Seoul, Korea

Margaret F. Clayton, PhD, APRN, Associate Professor, College of Nursing, University of Utah, Salt Lake City, Utah

Marleah Dean, PhD, Assistant Professor in Health Communication, University of South Florida, Tampa, Florida

Linda S. Franck, PhD, RN, FRCPCH, FAAN, Jack and Elaine Koehn Endowed Chair in Pediatric Nursing, Professor, Department of Family Health Care Nursing, University of California, San Francisco, California

Shelley J. Greif, PhD, MPH, RN, CBIS, Senior Registered Nurse Supervisor, Florida Department of Health, Children’s Medical Services, Ft. Lauderdale, Florida

Eun-Ok Im, PhD, MPH, RN, CNS, FAAN, Mary T. Champagne Professor of Nursing, Duke University School of Nursing, Durham, North Carolina

Susan L. Janson, PhD, RN, ANP-BC, CNS, FAAN, Professor Emerita, University of California, San Francisco, California

Tiny Jaarsma, PhD, RN, FAAN, FAHA, NFESC, Professor in Caring Sciences, Faculty of Health Sciences, University of Linköping, Sweden; Professorial Fellow, Mary MacKillop Institute for Health Research, Australian Catholic University, Melbourne, Australia

Kathryn Aldrich Lee, PhD, RN, University of Southern California-San Francisco, School of Nursing, San Francisco, California

Elizabeth R. Lenz, PhD, RN, FAAN, Professor and Dean Emerita, The Ohio State University, College of Nursing, Columbus, Ohio

Patricia R. Liehr, PhD, RN, Professor of Nursing, Christine E. Lynn College of Nursing at Florida Atlantic University, Boca Raton, Florida

©Springer Publishing Company
John Lowe, PhD, RN, FAAN, Endowed McKenzie Professor for Health Disparities Research, Florida State University College of Nursing, Tallahassee, Florida

Merle Mishel, PhD, RN, FAAN, Professor Emerita, School of Nursing, The University of North Carolina at Chapel Hill, Chapel Hill, North Carolina

Misako Nagata, RN, HNP, MA, APHN-BC, CCRN, Christine E. Lynn College of Nursing, Florida Atlantic University Graduate College, Boca Raton, Florida

Alvita K. Nathaniel, PhD, APRN-BC, FNP, FAANP, Professor, Charleston Division, West Virginia University, Health Sciences Center, Charleston, West Virginia

Linda C. Pugh, PhD, RNC, FAAN, Professor, University of North Carolina Wilmington, Wilmington, North Carolina

Marilyn A. Ray, PhD, RN, MS, MA, CTN-A, FSfAA, FAAN, Colonel (Retired) United States Air Force, Nurse Corps; Professor Emerita, Florida Atlantic University, The Christine E. Lynn College of Nursing, Boca Raton, Florida

Pamela G. Reed, PhD, RN, FAAN, Professor, The University of Arizona, College of Nursing, Tucson, Arizona

Barbara Resnick, PhD, RN, CRNP, FAAN, FAANP, Professor, OSAH Sonya Ziporkin Gershowitz Chair in Gerontology, University of Maryland School of Nursing, Baltimore, Maryland

Barbara Riegel, PhD, RN, FAAN, FAHA, Edith Clemmer Steinbright Professor of Gerontology, University of Pennsylvania School of Nursing, Philadelphia, Pennsylvania

Teresa Daniel Ritchie, DNP, APRN, FNP-BC, Assistant Clinical Professor, West Virginia University School of Nursing, Morgantown, West Virginia

April L. Shapiro, PhD, RN, Chair, Bachelor of Science in Nursing Program, West Virginia University School of Nursing, Potomac State College, Keyser, West Virginia

Marlaine C. Smith, PhD, RN, FAAN, Dean and Professor, Christine E. Lynn College of Nursing, Florida Atlantic University, Boca Raton, Florida

Mary Jane Smith, PhD, RN, FAAN, Professor, West Virginia University School of Nursing, Morgantown, West Virginia
Patricia Starck, DSN, RN, FAAN, Professor Emerita, University of Texas Health Science Center at Houston, Houston, Texas

Anna Stromberg, PhD, RN, FAAN, NFESC, Professor of Nursing Science, Linköping University and Linköping University Hospital, Sweden

Kimberly Ann Wallace, MSN, FNP-C, Lecturer, West Virginia University School of Nursing, Morgantown, West Virginia

Suzy Mascaro Walter, PhD, FNP-BC, Assistant Professor, School of Nursing, West Virginia University, Morgantown, West Virginia
This fourth edition of *Middle Range Theory for Nursing* by Mary Jane Smith and Patricia R. Liehr deepens our understandings of the importance of theory in developing the science of nursing. Particularly noteworthy is the extent to which the editors and chapter contributors articulate the relevance of the theoretical content for both research and professional nursing practice.

Smith and Liehr were pioneers in nursing knowledge development with the publication of the first edition of this middle range theory book. The demand for information about middle range theories has substantially increased since the publication of the first edition, and Smith and Liehr have remained in the forefront in expanding the boundaries of knowledge development, sustaining their focus on middle range theories. In the first edition of their book, eight middle range theories for nursing were presented. In this latest edition of the book, 13 theories are included, several of which were included in prior editions. For each of the theories there is an update provided; the new theories include the most recent supportive background literature. Each chapter includes the relevance of the theory to professional practice and research. Thus, for each of the theories, faculty and graduate students will have access to the most recent developments in disciplinary knowledge. Further, this book ensures ease of understanding through the consistent structure within each chapter. Each theory is connected to a paradigmatic perspective within nursing, thus offering the reader a view of how knowledge development in nursing moves from the broad philosophical and conceptual perspective to the pragmatic use in professional practice and research. This comprehensive view of theoretical development in nursing will be especially useful for graduate students new to theoretical thinking as well as to expert clinicians who are challenged to embed their practice in the disciplinary perspective of nursing. Throughout the chapters there is evidence that the discipline has moved forward in the development of theoretical knowledge, a heartening and welcomed development and a testament to the maturing of the nursing discipline.

As with the prior edition, the focus on concept building is particularly instructive, especially to nurses newly introduced to the theory development process. This process of concept building enhances our understandings of the concepts relevant to nursing and represents a complementary process to concept analysis. Yet an important distinguishing factor between concept building and concept analysis is the origin of the concept. The concept building process unfolds through a practice story, thus directly linking to clinical knowledge that
is familiar to nurses. Through the rigorous 10 step process of concept building clinicians are led from the identification of an important clinical phenomenon to the development and expansion of their conceptual understandings. In this fourth edition, two chapters are included in which authors demonstrate use of the concept building process and in two other chapters, authors describe the movement of concept building to research proposal development. This concept building process continues to hold great potential for future theoretical and scientific development of the discipline, and should be introduced in all introductory courses in nursing theory development.

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

Particularly noteworthy in this fourth edition is an added section that documents the historical development of middle range theory in nursing. Two articles from Advances in Nursing Science have been reprinted as they provide the historical insight into middle range theory development. The editors thus demonstrate the continuing value of middle range theory development as embedded within nursing science.

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

Joyce J. Fitzpatrick, PhD, MBA, RN, FAAN, FNAP
Elizabeth Brooks Ford Professor of Nursing
Frances Payne Bolton School of Nursing
Case Western Reserve University
Cleveland, Ohio

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Preface

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

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

The middle range theories chosen for presentation in this book cover a broad spectrum—from theories that were proposed decades ago and have been used extensively to theories that are newly developed and just coming into use. Some of the theories were originated by the primary nurse–author who wrote the chapter, and some were originally created by persons outside of nursing. After much thought and discussion with colleagues and students, we have come to the conclusion that theories for nursing are those that apply to the unique perspective of the discipline, regardless of origin, as long as they are used by nurse scholars to guide practice or research and are consistent with one of the paradigms presented by Newman and colleagues (Newman, Sime, & Corcoran-Perry, 1991). These paradigms, which are recognized philosophical perspectives unique to the discipline, present an ontological grounding for the middle range theories in this book. By connecting each theory with a paradigmatic perspective, we offer a view of the middle range theory’s place within the larger scope of nursing science. We have structured the book in four sections.
The first section includes three chapters that present a meta-perspective on middle range theory, thereby setting the stage for the subsequent sections. The first chapter in this section, “Disciplinary Perspectives Linked to Middle Range Theory,” elaborates on the structure of the discipline of nursing as a present and historical context for the development and use of middle range theories. The second chapter, “Understanding Middle Range Theory by Moving Up and Down the Ladder of Abstraction,” offers a clear and formal way of presenting the theories. The ladders were created by the editors and represent the editors’ view of the philosophical grounding of the theory rather than the chapter authors’ view. We have found that a ladder of abstraction can provide a starting place to guide students’ thinking when they are trying to make sense of a theory. In addition, moving ideas up and down the ladder of abstraction generates scholarly dialogue that spurs reflective critique of ideas in a structured and manageable way. The third chapter in this section is titled “Evaluation of Middle Range Theories for the Discipline of Nursing.” Students have told us that understanding the way in which theory is evaluated helps further understanding of the theory. So, we have included this chapter in the first section of the book. Certainly, evaluation of theory is a critical skill required for those who strive to move a theory onward in their own work. A unique feature of the evaluation process described in this chapter is that it is based on postmodern assumptions in which context is appreciated as an essential dimension thus, creating an always tentative theory critique.

In the second section of the book, thirteen middle range theories are included. Eleven of these were presented in the third edition: Uncertainty, Meaning, Self-Transcendence, Symptom Management, Unpleasant Symptoms, Self-Efficacy, Story, Transitions, Self-Reliance, Cultural Marginality, and Moral Reckoning. Two new theories are included in this fourth edition: Bureaucratic Caring and Self-Care of Chronic Illness. Although both focus on caring, one addresses system issues affecting a culture of care and the other addresses individual issues of self-care across chronic conditions.

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

The third section contains five chapters that frame a systematic approach for concept building and provide exemplars that highlight the approach. The first chapter in this section, “Concept Building for Research—Through the Lens of Middle Range Theory,” is one that was first introduced in the second edition. It has been further developed to refine a 10-phase process, guiding conceptualization of ideas for research. The process presented in the chapter can be used by faculty who teach courses on concept development, students who are working to establish their ideas for research, and scholars who are seeking to
systematically shape ideas. Included in this section are two chapters written by students demonstrating use of the concept building process and two chapters that describe the movement of concept building to research proposal development. While this concept-building effort shares some of the processes of concept development, it is distinguished by its foundation in nursing practice stories, use of a theoretical lens that shapes concept structure, and the systematic inclusion of inductive and deductive processes that culminate in a newly created model to be used in research.

A fourth section of the book has been added in this fourth edition. It contains two articles from Advances in Nursing Science that document a historical meta-perspective about middle range theory development over decades. We believe that the guidance derived from this meta-perspective provides direction for scholars wishing to ensure that disciplinary knowledge remains a lively dimension of research and practice.

The reader will notice when reading this book and comparing the theory descriptions from one edition of the book to the next that some theories have had ongoing development and use while others have received less attention and use during the past 5 years. The vibrancy of theory is dependent on its use by scholars who critique and apply it, testing its relevancy to real-world practice and research. Proliferation of middle range theory without ongoing critique, application, and development is a concern that requires ongoing attention.

As noted in the third edition of the book, there are beginning clusters of middle range theories around important ideas for the discipline, such as symptoms (Theories of Unpleasant Symptoms and Symptom Management) and moving through difficult times (Theories of Meaning, Self-Transcendence, and Transitions), and this edition adds the cluster of caring (Bureaucratic Caring and Self-Care of Chronic Illness). It would be useful to evaluate theory clusters, noting the common ground of guidance emerging from the body of scholarly work documented in the theory cluster. An advantage of this effort would be that the thinking of unique nurse scholars would come together around a central idea. One might expect that essential dimensions of the discipline could be made explicit by distilling and synthesizing ideas from a theory cluster. Although the analysis of theory clusters is not undertaken in this book, the information about middle range theory provided here creates a foundation for considering theory-cluster analysis.

In the appendix to the book, readers will find a table of middle range theories published from 1988 to 2017 in which the year, full citation, and name of the theory is noted. This table is useful as a starting place for scholars who want to find additional middle range theories in the literature.

In conclusion, this fourth edition presents an organization of chapters by meta-theory, middle range theories for nursing, concept building through a theoretical lens, and historical meta-perspective. The added theory chapters focused on dimensions of caring introduce a core element expressive of the

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disciplinary perspective (Newman, Sime, & Corcoran-Perry, 1991). The addition of the section describing the historical meta-perspective provides a dimension of context for scholars wishing to advance the body of nursing knowledge articulated through middle range theory. As with previous editions, we have edited and written with the intention of clarifying the contribution of middle range theory. We believe this clarification serves established as well as beginning nurse scholars seeking a theoretical foundation for practice and research.

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

REFERENCE
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An endeavor like this book is always the work of many. We are grateful to our students, who have prodded us with thought-provoking questions; our colleagues, who have challenged our thinking and writing; our contributors, who gave willingly of their time and effort; our publishers, who believed that we had something to offer; and our families, who have provided a base of love and support that makes anything possible.
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Middle Range Theory for Nursing, Fourth Edition
CHAPTER 2

Understanding Middle Range Theory by Moving Up and Down the Ladder of Abstraction

Mary Jane Smith and Patricia R. Liehr

Every discipline has a process of reasoning that is rooted in the philosophy, theories, and empirical generalizations that define it. The reasoning process is logical when all levels come together and make sense in an orderly and coherent manner. The ladder of abstraction is a logical system for locating and relating three different and distinct levels of discourse: the philosophical, theoretical, and empirical. The purpose of this chapter is to describe the ladder of abstraction as central to understanding and using middle range theory in research and practice. The ladder of abstraction is a structure that maps the connection between levels of discourse (see Figure 2.1). If one pictures a ladder with three rungs, the highest is the philosophical, the middle the theoretical, and lowest is the empirical. These rungs represent levels of discourse, or differing ways of describing ideas.

PHILOSOPHICAL LEVEL

The philosophical is the highest level, representing beliefs and assumptions that are accepted as true and fundamental to any theory. It represents belief systems essential to understanding the reasoning found in the theoretical and empirical expression of middle range theories. The philosophical level includes assumptions, beliefs, paradigmatic perspectives, and points of view. Reasoning through a nursing situation for practice and for research is based on assumptions and beliefs accepted as true about what constitutes reality.

A paradigm is a worldview including disciplinary values and perspectives that are at the philosophical level. Multiple paradigmatic schemas have been developed in nursing, and several of these are discussed in Chapter 1. The schema used to guide discussion of the theories in this book is the one developed by Newman, Sime, and Corcoran-Perry (1991), who identified caring in the human health experience as the focus of the discipline of nursing. They also identified three paradigms that structure the disciplinary perspective: the particulate–deterministic, interactive–integrative, and unitary–transformative.
Each paradigm incorporates unique values about the person, change, and the knowledge base of the paradigm. In the particulate–deterministic paradigm, the person is viewed as an isolated entity, change is primarily linear and causal, and the knowledge base is grounded in biophysical sciences. The interactive–integrative paradigm describes persons as reciprocal interacting entities, change is probabilistic and related to multiple factors, and the knowledge base is that of the social sciences. In the unitary–transformative paradigm, the person is viewed as unitary evolving in a mutual and simultaneous process, change is creative and unpredictable, and the knowledge base is grounded in the human sciences.

One can clearly see that the three paradigms are at differing levels of philosophical abstraction. All three hold assumptions, values, and a point of view at differing levels of abstraction. The most abstract is the unitary–transformative, next is the interactive–integrative, and lowest in level of abstraction is the particulate–deterministic. This is an example of levels of abstraction within the philosophical rung of the ladder. Although theorists may not explicate their assumptions or paradigmatic perspective, a careful reading of the theory will lead to understanding where each stands in relation to what are the philosophical underpinnings of the proposed theory. The ladder of abstraction (Figure 2.1) depicts the highest level of abstraction as the philosophical level, including the particulate–deterministic, interactive–integrative, and unitary–transformative paradigms.

The middle range theories presented in this book have been placed by the editors in one of these paradigms on the philosophical rung of the ladder. This was a judgment reflecting the view of two people that was made through scholarly discourse. It is important for the reader to understand that different
judgments may be made by different people who have a different understanding of the theory and the paradigms. There isn’t a “right” way to link a theory with a paradigm, but there are always reasons for the linking decisions that are based on logical coherence. The editors made the decision about the theory–paradigm link based on an understanding of the knowledge roots of the middle range theories.

The middle range theories of Uncertainty, Bureaucratic Caring, Unpleasant Symptoms, Self-Efficacy, Symptom Management, Cultural Marginality, Transitions, Moral Reckoning, and Self-Care of Chronic Illness, are rooted primarily in the social sciences and relate to a multidimensional and contextual reality. These nine theories have links to the interactive–integrative paradigm. The middle range theories of Story, Meaning, Self-Transcendence, and Self-Reliance are primarily rooted in the human sciences encompassing a process of mutual and creative unfolding. These four theories describe values consistent with the unitary–transformative paradigm. There is usefulness in understanding the paradigmatic perspective of a theory because it helps to lay out a starting point by establishing the philosophical foundation.

**THEORETICAL LEVEL**

Ideas are languaged to explain and describe their essence. Ideas at the theoretical level are concepts specific to a theory. Concepts are the essential ideas that build a theory; concepts characterize properties that describe and explain the theory at a middle range level of discourse. Levels of discourse are differing ways of expressing, defining, and specifying an idea. If one idea is more abstract than another, then it is more encompassing, enveloping a broader scope. On the other hand, if an idea is less abstract it is more concrete. This notion of the relationship between levels of abstraction is key to understanding and making sense of the theoretical. Levels of abstraction apply to each rung of the ladder in relation to the other rungs. That is to say, the philosophical is at a higher level than the theoretical rung of the ladder. When one is grappling with understanding the theoretical or middle level on the ladder, the process is to move the idea up to evaluate the philosophical premise and move down to empirical indicators, where the theory connects to the world of practice and research. To have a complete understanding one moves the theoretical idea back and forth, along the rungs of the ladder and within the rungs of the ladder. For example, if trying to understand a theory, a start at the middle rung of the ladder would lead to the question: How is the theory defined conceptually? What are the concepts, and what do the concepts mean? Then given the answers to the first set of questions, move to a lower ladder rung and ask: What does this mean to me and how does it connect with what I already know, namely my experience? Then one might look at how personal experience fits with the description of the theory. One might also question what values and
beliefs are included in the assumptions of the theory, thus moving the theory up the ladder of abstraction. The point is that in coming to know the realm of the theoretical, one thinks through the theory by moving up and down the rungs of the ladder. The theory becomes understandable through personal reflection and discourse with others; processes that include reading, thinking, and dialogue. Coming to understand a theory requires both tacit and explicit knowing. This means that a person can begin to describe in words the meaning of an abstract idea and at the same time hold tacitly more knowledge about the idea than can be made explicit. Each time the idea is described through talking, writing, and discussion, a greater grasp of the theoretical is achieved.

The theoretical is in the realm of the abstract, consisting of symbols, ideas, and concepts. Many of the theories in this book are known by a central abstraction. For instance, uncertainty, meaning, and self-transcendence are some of the theoretically abstract ideas that will be discussed in this book. Implicit in abstraction is an outer shadow of vagueness that enables the ongoing development of the idea. This bit of vagueness can throw a person off guard and engender confusion about the meaning of an idea. However, the abstract nature of theory is not intended to be confusing or abstruse. In deciphering the abstract and differentiating ideas according to the philosophical, theoretical, and empirical, one figures out meaning and comes to know what is explicit about an abstract idea.

The theoretical rung on the ladder of abstraction includes concepts, frameworks, and theories. A theoretical concept is different from an everyday concept because it is a mental image of an aspect of reality that is put into words to describe and explain the meaning of a phenomenon significant to the discipline of nursing. A theoretical framework is a structure of interrelating concepts that describe and explain the meaning of a phenomenon. What then is a theory? Theory is described in the literature at all levels of abstraction. The accepted definition of a theory rests in the eye of the beholder. Chinn and Kramer (1999, p. 258) define theory as “a creative and rigorous structuring of ideas that project a tentative, purposeful and systematic view of phenomena.” Im and Meleis (1999, p. 11) define theory as “an organized, coherent and systematic articulation of a set of statements related to significant questions in a discipline that are communicated in a meaningful whole to describe or explain a phenomenon or set of phenomena.” McKay (1969), on the other hand, describes theory as a logically interrelated set of confirmed hypotheses. Chinn and Kramer’s definition of theory is at the highest level of abstraction, next is Im and Meleis, and at the lowest level is McKay. Given this array of theory definitions it is easy to understand why one could argue several ways about whether a particular theory is indeed a theory: it all depends on the way theory is defined.

Furthermore, there are levels of theory within the theoretical rung of the ladder. At the most abstract level, there are the grand theories. These are theories that have a very broad scope. The conceptual focus of some of these grand
theories includes goal attainment (King, 1996), self-care (Orem, 1971), adaptation (Roy & Andrews, 1991), becoming (Parse, 1992), and unitary human field process (Rogers, 1994). Each of these grand theories shares the common ground of offering a structure that enables description and explanation of essential conceptualizations of nursing. However, even on the common ground of grand theory, some are more abstract than others. For instance, becoming is more abstract than goal attainment.

Middle range theories, the subject of this book, are described by Merton (1968, p. 9) as those “that lie between the minor but necessary working hypotheses that evolve in abundance during day-to-day research and the all-inclusive systematic efforts to develop unified theory.” He goes on to say that the principal ideas of middle range theories are relatively simple. Simple, here, means rudimentary straightforward ideas that stem from the focus of the discipline. Thus, middle range theory is a basic, usable structure of ideas, less abstract than grand theory and more abstract than empirical generalizations or microrange theory.

Microrange theories, described as situation-specific by Im and Meleis (1999, p. 13), are theories that focus on “specific nursing phenomena that reflect clinical practice and that are limited to specific populations or to particular fields of practice.” These theories “offer a blue print that is more readily operational and/or has more accessible utility in clinical situations” (p. 19). Microrange theory is lower on the ladder of abstraction than middle range theory. While Im’s Theory of Transitions (see Chapter 11) is at the middle range level of abstraction, the population-specific theories that emerge from it are at a lower level of abstraction and identified as situation-specific theories. Examples of situation-specific theories are menopausal transition of Korean immigrant women, learned response to chronic illness of patients with rheumatoid arthritis, and women’s responses when dealing with their multiple roles (Im & Meleis, 1999). In this case, a middle range theory has spawned situation-specific theories that have direct application to particular nursing practice situations.

The ladder of abstraction depicts microrange theory, middle range theory, and grand theory on ascending levels of discourse (Figure 2.1). The ladders for each theory presented in this book show a description of the philosophical, conceptual, and empirical connections. Each chapter’s author has specifically identified theory concepts, so the inclusion of concepts on the ladder was a straightforward process. This may not always be true; sometimes the authors of published articles on middle range theory do not clearly identify concepts. In that instance, the reader is left to decipher what the concepts of the theory are and how they are defined. For some middle range theories it may be necessary to differentiate concepts by a very careful reading of the manuscript and examination of the model. When this interpretative process is needed, there is always a risk that the concepts identified by the reader are not exactly what the author of the theory intended.
EMPIRICAL LEVEL

The empirical level represents discourse that brings a theory to research and practice. Empirics include physiologic indicators, questionnaires, observation, interview, and narrative (Figure 2.1). Like other rungs on the ladder, the empirical level of discourse moves from the most concrete (physiologic indicators) to the most abstract (narrative). Even at this lowest level of discourse there is a range of abstraction. The empirical is the lowest rung on the ladder, at a concrete level of discourse. The empirical represents what can be observed through the senses and moves beyond to include perceptions, symbolic meanings, self-reports, observable behavior, biological indicators, and personal stories (Ford-Gilboe, Campbell, & Berman, 1995; Reed, 1995).

Whether practicing or doing research, the nurse connects with the empirical level. The advanced practice nurse may use physiologic indicators, interview, and observation while applying theory to caring in the human health experience. The nurse researcher may use observation and narrative in a single study while applying theory to examine caring in the human health experience. Decisions about empirics are guided by philosophy and theory. It is important that the nurse choose empirics that fit with philosophical and theoretical perspectives, thus providing a match between all levels of abstraction.

CARING IN THE HUMAN HEALTH EXPERIENCE

All theories in the book comply with the focus of nursing as presented by Newman et al. (1991), who say that nursing “is the study of caring in the human health experience” (p. 3). They go on to say “A body of knowledge that does not include caring and human health experience is not nursing knowledge” (p. 3). Caring is described as a moral imperative having a service identity. All 13 middle range theories described in this work have a focus of caring in the human health experience. Application of any one of these theories in practice or in research aims at facilitating change in the human health experience.

The human health experience is explicit in each of the theories as experiencing: uncertainty, suffering, spiritual–ethical caring, vulnerability, symptoms, decisions to make behavioral change, a health challenge that complicates everyday living, life transitions, being responsible, disciplined and confident, living at the margin of cultures, caring for self, and situational binds that demand moral reckoning. It is noteworthy that two of the middle range theories, Unpleasant Symptoms and Symptom Management, share the common human experience of symptoms. There is also common ground for the theories of meaning and self-transcendence through their respective focus on suffering and vulnerability, which are intricately connected human health experiences. Furthermore, the theories of Cultural Marginality and Self-Reliance are
rooted in unique cultural perspectives. It should also be noted that Self-Care of Chronic Illness and Bureaucratic Caring hold caring as a central focus.

Caring in the human health experience requires consideration of how the nurse lives relationships with people regarding health. Based on these theories, some of the ways that caring transpires in the context of nursing are through: promoting structure and order in uncertain circumstances; intentionally engaging in dialogue to address what matters most; supporting inner resources to move beyond vulnerability; exploring symptom experience; and discussing situational binds with practicing nurses.

The middle range theories in this book add to the body of knowledge about nursing regardless of their discipline of origin. All of the theories have been applied in nursing practice and research to enhance caring in the human health experience. Theories belong to many disciplines. What is important to nursing science is that the research and practice based on a theory can be grounded in the focus and paradigmatic perspective of the discipline of nursing.

**MIDDLE RANGE THEORIES ON THE LADDER OF ABSTRACTION**

There are 13 middle range theories in the book, presented in chronological order according to when the chapter author introduced the idea in a refereed publication. This approach to ordering the chapters places explicit emphasis on the continued work necessary to grow ideas over time. Nursing scholars must be willing to persist with the sometimes tedious work of theory building that often occurs with spurts and stalls over decades.

The first middle range theory is Uncertainty in Illness and conceptualized for both acute and chronic illness. Mishel and Clayton coauthored the chapter on uncertainty in the first and second editions of this book. The chapter in this fourth edition was coauthored by Clayton and Dean. Clayton was a student of Mishel and Dean has published on uncertainty. The original uncertainty theory pertains to acute illness while the reconceptualized theory pertains to the continual uncertainty experienced in chronic illness. On the ladder, the reconceptualization is represented in bold print at the philosophical and theoretical level. The theories are consistent with beliefs associated with the interactive–integrative paradigm.

Persons experience uncertainty during diagnosis and treatment and when illness has a downward trajectory, and persons experience continual uncertainty in ongoing chronic illness and also with the possibility of recurrence of an illness. Concepts at the theoretical level in both theories are antecedents of uncertainty, appraisal of uncertainty, and coping with uncertainty. Concepts added in the reconceptualized theory include self-organization and probabilistic thinking. Moving to the empirical level with practice is offering information and explanation, providing structure and order, and focusing on choices and alternatives. An instrument has been developed that is directly related to the theory, the uncertainty in illness scale (see Figure 2.2).
The second middle range theory is the Theory of Meaning, based on the work of Viktor Frankl. The theory was authored by Patricia Starck in all three of the previous editions of this book. When Dr. Starck was invited to revise the chapter for this edition, she graciously requested that authors be found who were interested in the theory. Teresa Ritchie and Suzy Walter, the coauthors of the theory in this fourth edition, have been teaching and applying the theory to their advanced practice. This theory is grounded in the unitary–transformative paradigm. It is assumed that through a transformative process, persons find meaning. When confronted with a hopeless situation, meaning can be freely and responsibly realized in every moment. Concepts at the theoretical level are life purpose, freedom to choose, and suffering. Practice approaches at the empirical level include dereflection, paradoxical intention, and Socratic dialogue. Empirical indicators for research are questionnaires, interviews, and other narrative approaches (see Figure 2.3).

The third middle range theory of Bureaucratic Caring developed by Ray is a new theory in the fourth edition and is supported by assumptions of the interactive–integrative paradigm. Caring is humanistic, spiritual, and ethical; and bureaucratic systems are political, economic, technological, legal, and sociocultural. The merger of caring and bureaucratic values distinguishes this theory. Concepts include the social–cultural, legal, technological, economic, political, educational, and physical dimensions of spiritual–ethical caring. It allows for both quantitative and qualitative approaches to research. The theory has been used in Magnet® hospital designation processes. Most recently, it has been adopted by the U.S. Air Force to serve as a foundation for an interdisciplinary practice model (see Figure 2.4).
FIGURE 2.3  Ladder of abstraction: Meaning.

The fourth middle range theory, Self-Transcendence developed by Reed, is grounded in assumptions of the unitary–transformative paradigm. Self-transcendence is a unitary process. The theory assumes that persons are integral and coextensive with their environment and capable of an awareness that extends beyond physical and temporal dimensions. Concepts at the theoretical
level of discourse include vulnerability, self-transcendence, and well-being. Taking the theory to the empirical level with practice includes integrative spiritual care, support of inner resources, and expansion of intrapersonal, interpersonal, temporal, and transpersonal boundaries. Like the Theory of Uncertainty, a research instrument has been developed that is directly related to the theory, the self-transcendence scale (see Figure 2.5).

The fifth theory presented in the book is Symptom Management Theory by Bender, Janson, Franck, and Lee. These four authors, like the author group in the third edition, are members of the University of California, San Francisco Symptom Management Faculty Group. The theory is grounded in assumptions of the interactive–integrative paradigm, in which persons manage their symptoms in interaction with the environment. The specific assumptions of the theory are that: health and illness affect symptom management, improvement in symptoms extends beyond personal health, and symptoms are subjective and experienced in clusters. There are three concepts at the middle range level of discourse. The concepts are symptom experience, symptom management strategies, and symptom status outcomes. At the empirical level, practice application occurs with patient–provider communication marked by an understanding of the symptom experience and implementation of effective strategies. Research application includes measurement of symptom-specific outcomes and contextual factors related to the symptom under study (see Figure 2.6).

The sixth middle range theory is Unpleasant Symptoms by Lenz and Pugh. The theory is grounded in the beliefs and assumptions associated with the interactive–integrative paradigm. Specific beliefs of the theory are that there

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**FIGURE 2.5** Ladder of abstraction: Self-Transcendence.
are commonalities across different symptoms experienced by persons in varied situations, and that symptoms are subjective phenomena occurring in family and community contexts. Concepts at the theoretical level include symptoms, influencing factors, and performance. Practice application at the empirical level includes assessment of the symptom, symptom management, and relief intervention. Empirical measurements are gathered through scales and observations that capture the symptom experience (see Figure 2.7).

The seventh middle range theory is Self-Efficacy by Resnick, grounded in the assumptions of the interactive–integrative paradigm. Persons change in a reciprocal interactive process when they exercise influence over what they do and decide how to behave. Concepts at the theoretical level include self-efficacy expectations and self-efficacy outcomes. Examples of practice applications at the empirical level include learning about exercise, addressing unpleasant sensations, and cueing to exercise. Research based on this middle range theory uses self-efficacy scales (see Figure 2.8).

The eighth middle range theory presented is Liehr and Smith’s Story Theory, which is grounded in the assumptions of the unitary–transformative paradigm where change is viewed as creative and unpredictable. Story is a narrative happening in the unitary nurse–person process. The specific assumptions of the theory are that persons change in interrelationship with their world as they live in an expanded present and experience meaning. There are three concepts at the theoretical level: intentional dialogue, connecting with self-in-relation, and creating ease. At the empirical level the health story is the basis for both
practice and research. Examples of empirical approaches in practice include creation of a story path and family tree. Health story data may be analyzed using phenomenological, linguistic, case study, or story inquiry methods (see Figure 2.9).

The ninth theory found in the book is the Theory of Transitions presented by Im. This theory is in keeping with the assumptions of the interactive–integrative paradigm and describes circumstances related to change in health/illness,
life situations, and developmental stages. Assumptions include the centrality of transitions to nursing practice, reciprocity of the nurse/client relationship, and the complexity of patterns and processes of transitions. Nursing therapeutics incorporate the phases of assessment of readiness, preparation for transition, and role supplementation. Research studies have produced situation-specific theories on the pain experience of Caucasian and Asian American cancer patients and the menopausal experience of Asian women (see Figure 2.10).

The tenth theory is the Theory of Self-Reliance developed by Lowe. This theory is in keeping with the unitary–transformative paradigm and is rooted in the author’s Native American Cherokee values. Assumptions specific to the theory are the value of being true to oneself and being connected with others. Concepts of the theory are being responsible, disciplined, and confident. This theory articulates a process for promoting well-being with attention to appreciation of one’s culture. The Talking Circle offers an approach to nursing practice through honoring the process of life and growth. A 24-item self-reliance instrument has been developed and used in research, including intervention studies (see Figure 2.11).

The eleventh theory presented in this book is the Theory of Cultural Marginality developed by Choi. This theory is embedded in the interactive–integrative paradigm and describes the experience of people who are caught between two cultures. Concepts specific to the theory include marginal living, across-cultural conflict recognition, and easing cultural tension. Examples of practice applications include promoting parent–child engagement through across-cultural understanding and being sensitive to the struggle of
Interactive-integrative paradigm

Assumption of the theory
Developmental, situational, health and illness, and organizational transitions are central to nursing practice.
Transitions are characterized by dynamic patterns and complex processes.
Meanings attached to health and illness situations are influenced by and in turn, influence transition conditions.
The reciprocal relationship between nurse and client shapes transitions.

FIGURE 2.10  Ladder of abstraction: Transitions.

immigration. Research activities are aimed at developing an instrument to measure cultural marginality and studying mental health outcomes of persons living through across-culture conflict (see Figure 2.12).
The twelfth theory is Nathaniel’s Theory of Moral Reckoning, grounded in the interactive–integrative paradigm. According to this theory persons engage in a social process of deliberating when faced with a moral dilemma.

FIGURE 2.11  Ladder of abstraction: Self-Reliance.

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Assumptions supporting the theory include facing a moral dilemma where no one choice is right or wrong and experiencing situational binds that are inherent to being human. Concepts in the theory are ease, situational bind, resolution, and reflection. Practice based on the theory includes providing structured discussion with nurses about situational binds and introduction of moral reckoning in nursing education courses. Research guided by the theory includes study of moral reckoning with other professionals. Because moral reckoning is a human experience that is increasingly common in this day and age, it warrants consideration for guiding nursing practice and structuring study for people who are in a moral bind (see Figure 2.13).

The thirteenth theory is Self-Care of Chronic Illness by Riegel, Jaarsma, and Stromberg. The theory is aligned with the interactive–integrative paradigm. Assumptions are in keeping with a holistic view, and the unique perspective required for multiple chronic conditions with an understanding that similar self-care behaviors occur across varying chronic illnesses. Concepts are self-care monitoring, maintenance, and management. Practice includes applying self-care approaches with persons experiencing multiple chronic conditions. Research studies center on self-care (see Figure 2.14).

There is one final ladder of abstraction in this book in the evaluation chapter (see Chapter 3) by Smith. In this chapter, Smith offers a process for understanding and evaluating middle range theories based on postmodern beliefs (see Figure 2.15). Overall, the ladders of abstraction provide a structure to guide the student in deciphering theory so that it can be used productively in advanced nursing practice and research. So, we urge you to...
begin climbing the ladders . . . stay long enough on each rung to get comfortable, and spend enough time on all three rungs to get the whole picture of any theory. Also, expect to be uncomfortable when a rung is new to you. Discomfort is a space for growing and connecting what you know with what you are learning.
It should be pointed out that failure to move around all the rungs of the ladder deters understanding and limits ability to use the theory in practice or research. Sometimes scholars may choose to stay on the rung that is most comfortable. For example, theorists may stay on the theoretical rung, and researchers may stay on the empirical rung, while meta-theorists may be more comfortable on the philosophical rung. It is a premise of this work on middle range theory that in order to move nursing science to the front lines of practice and research, nurses must be skilled in moving up and down and back and forth on the ladder of abstraction when studying, practicing, and researching the science of nursing.

When all levels of an idea can be mapped on the ladder of abstraction and the levels cohere with each other, theory is guided by a logical process that provides clarity and facilitates understanding and use of the theory in research and practice. To understand a theory at all levels of abstraction requires a process of reasoning. By moving from the lower rung of the ladder to the middle and then the upper rung, one is making sense of phenomena through inductive reasoning. And conversely, movement from the upper philosophical rung to the theoretical and then to the empirical requires deductive reasoning. The substantive knowledge of the discipline structured by logic guides thinking through nursing research and advanced nursing practice. This point flies in the face of the notion that theory is bewildering logic, abstruse, and rather incomprehensible. There is logic to the abstract that can be reasoned through with the ladder of abstraction.

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