ROUTLEDGE HANDBOOKS

Routledge International Handbook of Qualitative Nursing Research

Edited by Cheryl Tatano Beck

Routledge International Handbook of Qualitative Nursing Research

Qualitative research, once on the fringes, now plays a central part in advancing nursing and midwifery knowledge, contributing to the development of the evidence base for health care practice. Divided into four parts, this authoritative handbook contains over forty chapters on the state of the art and science of qualitative research in nursing.

The first part begins by addressing the significance of qualitative inquiry to the development of nursing knowledge, and then goes on to explore in depth programs of qualitative nursing research. The second section focuses on a wide range of core qualitative methods, from descriptive phenomenology, through to grounded theory and to ethnography, and narrative research. Part III highlights key issues and controversies in contemporary qualitative nursing research, including discussion of ethical and political issues, evidence-based practice and Internet research. Finally, Part IV takes a unique look at qualitative nursing research as it is practiced throughout the world with chapters on countries and regions from the UK and Europe, North America, Australasia, Latin America, to Japan, China, and Korea.

With an international selection of established scholars contributing, the *Routledge International Handbook of Qualitative Nursing Research* is an essential overview and will help to propel qualitative research in nursing well into the twenty-first century. It is an invaluable reference for all nursing researchers.

Cheryl Tatano Beck is Distinguished Professor in the School of Nursing at the University of Connecticut, USA.

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To my family:
my husband Chuck, son Curt and daughter Lisa for all
their understanding and support of my professional career

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About the editor

Dr Beck is a Distinguished Professor at the University of Connecticut, School of Nursing. She also has a joint appointment in the Department of Obstetrics and Gynecology at the School of Medicine. Her Bachelor of Science degree in Nursing is from Western Connecticut State University. She received her Master's degree in maternal-newborn nursing from Yale University. Cheryl is a certified nurse-midwife. She received her certificate in nurse-midwifery also from Yale University. Her Doctor of Nursing Science degree is from Boston University. She is a fellow in the American Academy of Nursing. She has received numerous awards, such as the Association of Women's Health, Obstetric, and Neonatal Nursing's Distinguished Professional Service Award, Eastern Nursing Research Society's Distinguished Researcher Award, the Distinguished Alumna Award from Yale University and the Connecticut Nurses' Association's Diamond Jubilee Award for her contribution to nursing research. She has been appointed to the President's Advisory Council of Postpartum Support International.

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Karin Olson PhD, RN is a Professor in the Faculty of Nursing at the University of Alberta. She holds certification in palliative care nursing from the Canadian Nurses Association and is the author of *Essentials of Qualitative Interviewing* (2011). Dr. Olson's program of research focuses on fatigue, primarily in individuals with cancer.

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Barbara Paterson PhD, RN, 3M Fellow was the lead author of a 2001 text about metastudy, a metasynthesis method. Since that time, she has participated in several metasynthesis research projects, including a multimillion-dollar-funded project to investigate inquiry learning in science education. She is the author of more than a dozen articles or book chapters about metasynthesis

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Janet M. Rankin PhD, RN is an Assistant Professor in the Faculty of Nursing at the University of Calgary. She has been working in a variety of nursing specialties since 1979. Her doctoral work used institutional ethnography to study nurses' work in contemporary hospitals. Published as *Managing to Nurse: Inside Canada's Health Care Reform*, the research explicated tensions embedded in managerial technologies being used to streamline and coordinate nurses' work. Currently Dr. Rankin is chair of the Institutional Ethnography Division of the Society for the Study of Social Problems. She is supporting a number of graduate students using institutional ethnography and is lead facilitator of an "IE Working Group" that uses free electronic media to meet once a month. Her own program of institutional ethnographic research rests at the intersections of nursing practice and nursing education.

Marilyn A. Ray PhD, MSN, MA (Anthro), RN, CTN-A, Fellow, SfAA is a Professor Emerita at Florida Atlantic University, Christine E. Lynn College of Nursing, Boca Raton, Florida, holds a diploma from St. Joseph Hospital, Hamilton, Canada, BSN and MSN degrees from the University of Colorado, an MA degree in cultural anthropology from McMaster University, a PhD in transcultural nursing from the University of Utah, and an honorary degree from Nevada State College. As a certified transcultural nurse and scholar of the Transcultural Nursing Society, Ray was mentored by Dr. Madeleine Leininger. She is a Fellow of the Society for Applied Anthropology. Ray held faculty positions at the Florida Atlantic University, University of Colorado, McMaster University, University of California San Francisco, and University of San Francisco. Ray retired as a Colonel in 1999 from the United States Air Force Reserve Nurse Corps after a 30-year career in aerospace nursing. As one of the first nursing researchers to advance the study of caring in complex cultural organizational systems, she was awarded charter membership in the International Association for Human Caring. She is committed to transcultural nursing and caring as the essence of nursing. Throughout her career Ray has researched and published on the subjects of caring in organizational cultures developing the Theory of Bureaucratic Caring, caring methodology, technological and economic caring, transcultural caring and ethics, complex caring dynamics, and complexity sciences, and military health care. She received the Federal Nursing Award for excellence in research. Her books include: *Transcultural Caring Dynamics in Nursing and Health Care: A Study of Caring within an Institutional Culture*, *The Discovery of the Theory of Bureaucratic Caring* and with her colleagues Davidson and Turkel, *Nursing, Caring, and Complexity Science: For Human-Environment Well Being*.

Shigeko Saiki-Craighill PhD, RN is Professor of Pediatric Nursing at Keio University. She received her doctorate in nursing sciences from the University of California, San Francisco, in 1994. For her doctoral dissertation, she interviewed mothers who had recently lost a child to cancer to find what their coping strategies are and how the journey from diagnosis to grieving had transformed them. Since then she has been exploring various aspects of the medical culture surrounding pediatric oncology, including its effect on other members of the family, the community, and the health professionals themselves. Earlier, she worked on establishing focused and well-organized support groups for grieving mothers. This led to a research focus on issues of disclosure and communication as it applies to children and their families, and more recently how notions of professionalism incorporate the emotional labor of extremely stressful situations.

She also frequently gives seminars and workshops on qualitative research, and has published several books on grounded theory techniques for Japanese researchers.

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Phyllis Noerager Stern PhD, LLD (hon.), FAAN, Professor Emerita of Indiana Perdue University at Indianapolis School of Nursing, learned grounded theory during her doctoral work in the mid-1970s from its originators, Barney Glaser and Anselm Strauss, and has been explaining the method to her colleagues and students ever since. She edited the journal *Health Care for Women International* for 20 years and moved it from a maternity focus to an international status with the broader lens of overall health conditions for women. In 1983, she accepted the position of Director of the School of Nursing at Dalhousie University in Halifax, Canada. From that base, she established the International Council on Women's Health Issues in 1984. This society holds Congresses all over the world. In 2003 she received an honorary doctorate from Dalhousie, for "Changing the face of nursing in Eastern Canada." In 2008, she was named a "Living Legend" by the American Academy of Nursing for her research using grounded theory and her work pertaining to women's health.

Sally Thorne PhD, RN, FAAN, FCAHS is Professor of Nursing at the University of British Columbia. Her program of substantive research has been in the field of chronic illness and cancer experience, with a particular focus on the human interface of care delivery processes. She holds leadership positions and serves on policy boards related to cancer care, nursing advocacy, and research development. A widely published author, including scholarly papers and books on qualitative research methodology, she serves as Editor-in-Chief for the journal *Nursing Inquiry*.

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Judith Wuest PhD, RN is Professor Emerita at the University of New Brunswick, Faculty of Nursing in Fredericton, New Brunswick, Canada. Her research interests are in the field of women's health, particularly intimate partner violence and women's caregiving. She is internationally known as a qualitative grounded theorist; however, research questions emerging from her grounded theory analysis have led to quantitative theory testing and intervention development. She is currently leading a feasibility study on implementing the grounded theory-based Intervention for Health Enhancement after Leaving with existing domestic violence outreach services in New Brunswick.

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1

Introduction to qualitative nursing research

Cheryl Tatano Beck

Qualitative nursing research: a subdiscipline

Morse (2010) asked: "How different is qualitative health research from qualitative research? Do we have a subdiscipline?" (p. 1459). Her answer was yes. Morse (2012) defined qualitative health research "as a research approach to exploring health and illness as they are perceived by the people themselves, rather than from the researcher's perspective" (p. 21). Morse argued that the context, the participants in the research, and the nature of the research questions investigated in qualitative health research are distinct. She made the case (p. 1463) that researchers who conduct qualitative health research required special skills and qualifications as "insiders":

- Health professionals are "street smart," knowing the rules, regulations, and norms for working in a hospital or other health care contexts.
- Health professionals, with some working knowledge of the patient population, can recognize appropriate research questions.
- Because of their knowledge of the signs of fatigue and experience with illness, health professionals can monitor their patient participants throughout data collection.
- From their completed projects, health professionals can more readily make realistic recommendations for practice.

When conducting qualitative health research, a variety of health care professionals can be considered "insiders," such as nurses, physicians, respiratory therapists, social workers, dieticians, and physical therapists, to name but a few. Each of these qualitative health researchers can make a unique contribution to their respective disciplines and to health care, providing understanding and meaning to our research agendas.

Kuzel (2010) agreed with Morse that "insiders" are generally better than "outsiders" to conduct believable qualitative research. Eisner (1998, p. 39) stressed that "qualitative research becomes believable because of its coherence, insight, and instrumental utility." He called on qualitative researchers to have an enlightened eye, that is, "the ability to see what counts is what distinguishes novices from experts" (p. 34). Kuzel believed that experts in their respective fields are better suited to deliver these qualities that Eisner highlighted.

To begin this first ever *International Handbook of Qualitative Nursing Research*, I will ask the question: Is qualitative nursing research a subdiscipline of qualitative health research? Following

Morse's line of argument that qualitative health research is a subdiscipline of qualitative research, I believe qualitative nursing research *is* a subdiscipline of qualitative health research, and is particularly important for the advancement of nursing science. Many of Morse's arguments for why qualitative health research is a subdiscipline are pertinent to making the case for narrowing again the focus of qualitative research, this time to qualitative research in the discipline of nursing (Figure 1.1).

Qualitative health researchers need to be connoisseurs of the phenomena they are studying. These researchers are not connoisseurs in all health care-related disciplines. Phenomena studied in nutritional sciences, for example, are different than phenomena in medicine or social work or occupational therapy, including human behaviors associated with the physical phenomena. Nutrition, for instance, focuses on eating behaviors; medicine with symptom responses, compliance, and responses to therapy; occupational therapy to coping, and so forth. Each health care discipline can be considered a culture unto itself, with its own norms and perspectives. Medicine and these other disciplines do not have a subdiscipline of qualitative research yet but nursing does.

Members of each health care discipline can be considered as "insiders" while members of the other disciplines can be viewed as "outsiders." Nursing is a culture different from the other "cultures" in health care. Nurse researchers are the "insiders" who have the required special skills and qualifications: (1) to conduct qualitative research on phenomena in the discipline of nursing; and (2) to develop a specific body of knowledge known as qualitative nursing research.

In this introductory chapter, the emergence of qualitative inquiry in nursing is described. The remainder of the chapter describes the four parts of this handbook: Part I: What does qualitative nursing research do?, Part II: Qualitative research methods, Part III: Contemporary issues in qualitative nursing research methods, and Part IV: International qualitative nursing research: State of the science.

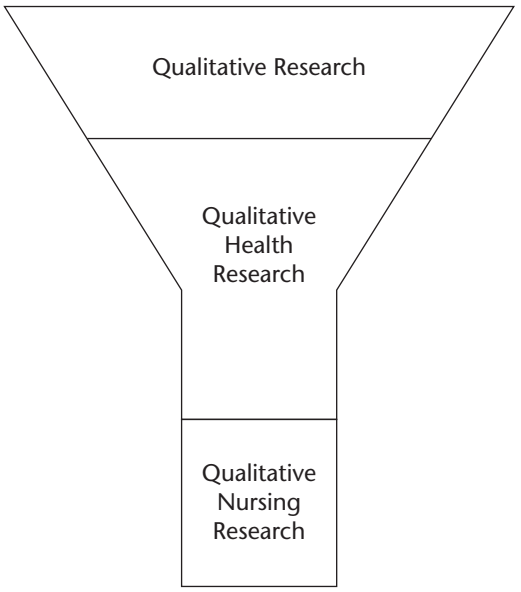

Figure 1.1 Narrowing the focus of qualitative research

Emergence of qualitative nursing research

In the 1960s, the federal nurse scientist program started and provided nurses opportunities to obtain doctoral degrees in the social sciences. Methods courses in anthropology and sociology were available for nurses to enroll in. Nurses studied with qualitative scholars such as Barney Glaser, Anselm Strauss, and Leonard Schatzman, to name but a few. At universities such as the University of California at San Francisco and Columbia University, nurses were educated in qualitative research methods. Jeanne Quint Benoliel, one of nursing's first qualitative scientists, was educated in this first wave. Until that time many nurses who had undertaken doctoral studies obtained their degrees in education and psychology where quantitative research was the prevailing method.

In the 1970s and early 1980s, tensions occurred in the discipline of nursing between the predominant quantitative researchers and the qualitative researchers who were in the minority. Qualitative research was viewed as "soft science." Hutchinson (2001) recounted how in the mid-1980s she and a few other qualitative nurse researchers who were members of the Council of Nursing and Anthropology met every year at the American Anthropology Association where they would present their qualitative papers. They would share with each other the high rejection rate of their qualitative manuscripts from journals that had rejected them for the wrong reasons. Reviewers not educated in qualitative methods would reject their manuscripts for reasons, such as small sample size and lack of random sampling. Hutchinson went on to tell how she and those few qualitative colleagues started on a mission to contact editors of journals to request that they add qualitative reviewers. Their efforts met with success in such journals as *Western Journal of Nursing Research*, *Advances in Nursing Science*, and *Image: Journal of Nursing Scholarship*. In the mid-1980s qualitative research textbooks in nursing were beginning to be published. Examples of these textbooks include Field and Morse's (1985) *Nursing Research: The Application of Qualitative Approaches*, Parse, Coyne, and Smith's (1985) *Nursing Research: Qualitative Methods*, Leininger's (1985) *Qualitative Research Methods in Nursing*, and Munhall and Oiler's (1986) *Nursing Research: A Qualitative Perspective*.

In 1986, Munhall astutely asked why had our nursing scholarship "evolved into a search for structural truth rather than dynamic meaning?" (p. 1). Why must nursing scholarship be polarized into two distinct positions of quantitative and qualitative research? Munhall argued (p. 5) that:

- our different angles enlarge our promise;
- are to be summative not negating;
- but engaging us in our community of endeavors.

Janice Morse in 1988 held a think tank for nurse leaders in qualitative research. Issues relevant to qualitative research were discussed. Morse published four edited volumes on qualitative research issues that were an outgrowth of these series of think tanks. The first volume was entitled *Qualitative Nursing Research: A Contemporary Dialogue* (Morse, 1991), followed by *Critical Issues in Qualitative Research Methods* (Morse, 1994). The third and fourth volumes were entitled *Completing a Qualitative Project* (Morse, 1997) and *The Nature of Qualitative Evidence* (Morse, Swanson, & Kuzel, 2001), respectively.

As the decade of the 1980s was coming to a close, the numbers of qualitative research manuscripts being published increased. Though progress was being made in the acceptance of qualitative research in our discipline, this was accompanied by a potential problem. There were not enough qualitative reviewers with expertise in different qualitative methods to review the influx of manuscripts. As a result, some sloppy qualitative research was being published. Research

which included "method slurring" (Baker, Wuest, & Stern, 1992) of qualitative methods in a study was being published in top tier nursing journals. Reviewers, lacking substantive understanding of qualitative methods, used rule-bound checklists as criteria for reviews, whether the criteria were appropriate for the methods they were reviewing or not.

In 1991, Janice Morse launched the first issue of the journal *Qualitative Health Research*. At that time the journal had four issues per year with six articles in each issue. It took six years for *Qualitative Health Research* to be referenced in Medline. Its niche market and readership have grown tremendously so much so that 22 years later there are now 12 issues a year with about 12 articles in each issue.

Next in this introductory chapter the four parts of this first ever international handbook of qualitative nursing research are introduced.

Part I: What does qualitative nursing research do?

Part I consists of eight chapters. This first section of the handbook will feature the "so what" of qualitative nursing research. In Chapter 2, Janice Morse addresses the significance of qualitative inquiry to the development of nursing knowledge. The other seven chapters in Part I feature exemplars of qualitative nursing research programs.

In Chapter 3, Judith Wuest, Marilyn Ford-Gilboe, Marilyn Merritt-Gray, and Colleen Varcoe discuss the processes, challenges, and advantages of translating their grounded theory, "Strengthening Capacity to Limit Intrusion," into a primary health care intervention for women who have left their abusive partners. Translation of grounded theories by researchers is crucial to facilitating their utilization in the clinical area.

In Chapter 4 the power of a program of qualitative research is clearly illustrated by Joanne Hall with her studies on traumatic experiences of marginalized groups. She examines the complex interrelated experiences, such as interpersonal violence, substance misuse, and racism in traumatized women.

Karin Olson in Chapter 5 describes her program of research on fatigue using qualitative research in conjunction with quantitative approaches. She and her team used their qualitative findings to reconceptualize fatigue, explore the social construction of fatigue, and develop the Edmonton Fatigue Framework.

In Chapter 6, Siv Söderberg presents her program of research on experiences of living with chronic pain syndrome that emerged from personal narrative interviews. By means of her research Söderberg illustrates that in order to preserve people's dignity within the health care system, clinicians need to be aware of the vulnerability of persons with chronic pain and their dependence on the power of health care providers to meet their individual needs.

Mary Beth Happ's qualitative research program in the care of ventilator-dependent ICU patients is highlighted in Chapter 7. Using a variety of qualitative and mixed methods Happ's research helped to explicate the social and cultural context and processes of interaction during critical care treatment of ventilator-dependent patients. Her research trajectory moved from descriptive theory building to intervention development and testing and then on to qualitative program evaluation.

In Chapter 8, Lauren Clark, Susan Johnson, Mary O'Connor, and Jane Lassetter describe their series of qualitative studies aimed at filling in the gaps of clinicians' understanding of Latino families' cultural values and patterns of infant feeding that result in normal weight or childhood obesity. Their focused ethnography helped to identify the mismatch between Latino parents and clinicians' cultural construction of childhood obesity, and in turn to develop effective childhood obesity prevention with Latino families.

In Chapter 9, Cheryl Tatano Beck's program of research on postpartum depression illustrates a line of scientific inquiry that was knowledge-driven and not limited to either qualitative or quantitative research methods. Her series of qualitative studies using phenomenology and grounded theory provided the conceptual basis for the development of her instrument, the Postpartum Depression Screening Scale (PDSS). All the items on the PDSS were developed from her qualitative findings.

Part II: Qualitative research methods

Seventeen chapters comprise Part II of the handbook which concentrates on various qualitative research methods. Some of these chapters on different qualitative research methods start with a brief history of that method's use in nursing research. Philosophical or theoretical underpinnings of the qualitative research method are discussed when appropriate. An advanced level discussion of the method and any various approaches to that method are addressed as well as any current debates or controversies regarding the method. A review of published studies over the past 20 years in which nurse researchers used that particular qualitative research method is included which leads to presentation of the state of the science of qualitative nursing research in regards to the method. Highlights of particular nursing research studies using that method and their analyses are included. Chapters end with a summary of the contributions of qualitative nursing research using this method, and future directions of this qualitative research method in nursing.

The first two chapters in Part II focus on phenomenology. In Chapter 10, Cheryl Tatano Beck describes the state of the science of descriptive phenomenology in nursing research. Published descriptive phenomenological studies conducted by nurse researchers across the globe over the past 20 years are reviewed. Trends in the methods used by nurse researchers and also the phenomena studied are identified.

Next, in Chapter 11, Patricia Munhall addresses interpretive phenomenology not only as a research method but also as a way of being-in-the-world. She helps the reader inquire how one should use an interpretive phenomenological philosophy as a research approach. Munhall describes her own approach to interpretive phenomenological inquiry. Exemplars of international interpretive phenomenological studies are identified.

Grounded theory is the focus of the next three chapters. In Chapter 12, Phyllis Noerager Stern presents classic Glaserian grounded theory supplemented with excellent examples from her own grounded theory studies. Next in Chapter 13 Juliet Corbin addresses Strauss' grounded theory method. The philosophy underlying Strauss' method and some of the criticisms directed at his method are described. A summary of studies using Strauss' method conducted by nurse researchers over the past 20 years is presented.

New directions in grounded theory are presented in Chapter 14 by Rita Schreiber and Wanda Martin. Some of the areas where grounded theorists are currently pushing the boundaries of the method are described, such as constructivist grounded theory, situational analysis, and complex adaptive systems perspective to ground theory. Examples from nursing research of each of these methods are highlighted.

The next four chapters concentrate on ethnography. First, in Chapter 15, Pamela Brink addresses traditional ethnography. She begins with the history of traditional ethnography in both anthropology and nursing, following this with a discussion of the basic requirements of this method. Some of the misunderstandings found in nursing literature regarding ethnography are identified. Her chapter ends with a review of some traditional ethnography nursing publications over the past 20 years.

In Chapter 16, Leininger's ethnonursing method is presented by Marilyn Ray, Edith Morris, and Marilyn McFarland. These authors address the philosophical and human science foundations of Leininger's ethnonursing method and the progression of her transcultural theory of culture care diversity and universality. Leininger's method is outlined and highlighted in terms of complexity science, complex caring dynamics, and translational science. Nursing research studies incorporating the ethnonursing method are highlighted. The chapter concludes with a description of the new meta-ethnonursing research method.

Karen Breda in Chapter 17 describes the historical evolution, value and relevance of critical ethnography within the family of critical qualitative research methodologies. She analyzes the nursing literature using critical ethnography, including controversial applications of this research method. Breda's chapter concludes with a discussion of the future directions of critical ethnography in nursing.

Institutional ethnography is the topic of Chapter 18 by Janet Rankin. This chapter includes a discussion of the philosophical and theoretical underpinnings of institutional ethnography and its methodological fit for nursing research. Selected examples of this type of ethnography conducted by nurse researchers are described in addition to examples from Rankin's own research which are presented to demonstrate the pragmatics of formulating an institutional ethnographic project.

Historical research in nursing is the focus of Chapter 19 by Sandra Lewenson. In this chapter the meaning and significance of historical research, and the impact various organizations, centers, and archives have had on the advancement of research on nursing history are addressed.

In Chapter 20, Patricia Hill Bailey, Phyllis Montgomery, and Sharolyn Mossey discuss narrative inquiry in nursing. The chapter begins by describing this method from the perspective of the major authors in this area. Next common classifications and features of stories and models of narrative analysis are presented. The authors discuss the ongoing controversy of the legitimacy of narrative as a research method. The state of narrative inquiry in nursing research concludes the chapter, along with an example of this method.

Discourse analysis is the featured topic of Chapter 21 by Michael Traynor. There are three main components of this chapter: (1) the range of practices that come under the title of discourse analysis and some of these differing assumptions about human subjectivity; (2) the different focus of discourse analysis by nurse researchers; and (3) the relationship between subjectivity and language.

In Chapter 22, Sally Thorne presents the interpretive description approach she has developed. The origins and development of this applied methodological approach that capitalizes on the perspective that nursing brings to rigorous qualitative inquiry are described. An exemplar of a nursing research study using the interpretive description is included to illustrate the method.

Denise Côté-Arsenault addresses focus groups in Chapter 23 where she provides a brief history of this method along with its use in nursing. Key aspects and considerations when using focus groups are described to help avoid common misuse of focus groups. Also included in this chapter are current controversies with focus groups. The chapter concludes with a review of published nursing research using focus groups from 2000 to 2010.

Participatory Action Research (PAR) is the focus of Chapter 24 by Lynne Young. She begins with defining PAR as a moving target as she differentiates it from Action Research. With PAR's roots in the social and political sciences and in organizational change literature, Young discusses how it is well suited to questions relevant to nursing. She provides examples of research that align with the principles of PAR to illustrate how these designs have been used by nurse researchers. Challenges and issues facing PAR researchers along with future directions are addressed in this chapter.

In Chapter 25, Barbara Paterson provides a historical and methodological overview of metasynthesis as a research approach. She highlights the major schools of thought in the field. Some of the most commonly used metasynthesis methods are described while comparing and contrasting their epistemological and methodological underpinnings. The chapter also includes critiques of metasyntheses that are identified in the literature and the challenges facing nurse researchers conducting metasyntheses.

In Chapter 26, the final chapter in Part II of this handbook, Margarete Sandelowski, Corrine Voils, Jamie Crandell, and Jennifer Leeman address mixed research synthesis. An overview is presented of the challenges of and approaches to conducting an integration of results from primary qualitative, quantitative, and mixed methods studies in a specific domain of research.

Part III: Contemporary issues in qualitative nursing research methods

Part III of the *Routledge International Handbook of Qualitative Nursing Research* targets some contemporary issues in the field. This third part consists of five chapters.

Chapter 27 focuses on ethical issues in qualitative nursing research and is authored by Wendy Austin. The more subtle risks in qualitative research, such as the emotional and social risks, are highlighted, along with particular ethical issues that can arise in dynamic and emergent qualitative research designs and that cannot be predicted with certainty. In this chapter, current policies and practices of research ethics are also addressed. Austin's approach of relational ethics is key in this chapter.

Joy Johnson considers the overlapping spheres of politics and qualitative nursing research in Chapter 28. Five related areas are addressed: the politics of evidence, the politics of research funding, the politics of grant writing and peer review, the politics of policy-making, and the politic of partnerships. Johnson draws on examples from her experiences in relation to her work with the Canadian Institutes of Health Research.

In Chapter 29, issues of Internet qualitative research are explored by Eun-Ok Im and Wonshik Chee. Characteristics of Internet research are reviewed, followed by general types of Internet qualitative research. A review of literature related to issues in Internet qualitative research in nursing is presented.

Sally Thorne considers secondary qualitative data analysis as it is currently applied within nursing in Chapter 30. She first presents its history and tradition in the qualitative nursing research context. Significant issues are addressed that nurse researchers must wrestle with and work out before a viable qualitative secondary analysis can be undertaken. Thorne describes five secondary research approaches: analytic expansion, retrospective interpretation, armchair induction, cross-validation, and amplified sampling. Issues in writing and reporting results from a qualitative secondary analysis are discussed in this chapter.

In the final chapter in Part III of the handbook, Chapter 31, Barbara Bowers explores the contributions and possibilities for qualitative nursing research in evidence-based practice. Questions are raised regarding what qualitative methodologies have to offer as nurse researchers develop evidence to support clinical practice. Challenges facing qualitative nurse researchers and the unrealized potential of qualitative research for our discipline are addressed.

Part IV: International qualitative nursing research: state of the science

In each of the 14 chapters in Part IV the focus is on the state of the science of qualitative nursing research in a particular country. Based on a review of literature of studies conducted in that country for the past 20 years, each chapter includes a brief history of qualitative nursing research

in that country and describes what qualitative research methods are used most frequently by nurse researchers in that country. Specific contributions of qualitative nursing research in that country and to the nursing profession as a whole are addressed, along with highlights of some exemplars of the country's qualitative nursing research. The chapters end with a discussion of future directions of qualitative nursing research in that specific country. This fourth part of the handbook is the most unique and valuable addition to qualitative nursing research as nursing scholars from across the globe can see the state of the science of qualitative nursing research internationally.

In Chapter 32, Dawn Freshwater and Jane Cahill provide a state of the science of qualitative nursing research in England, Wales, and Scotland. The chapter begins with the historical context of nursing research in these three countries. Based on their literature review, these two authors describe the most frequent qualitative methods used in these countries by nurse researchers. Also research centers of excellence that focus on qualitative approaches in these countries are identified, along with their contributions to the field. Exemplars of cutting-edge qualitative nursing research are highlighted.

Qualitative nursing research in Ireland is the focus of Chapter 33, written by Carolyn Tobin. A history of nursing research in the Irish Republic in which the fundamental innovations that provided the building blocks for the increased research productivity over the past 15 years is described. Results of a literature review of qualitative nursing research conducted in the Irish Republic identify trends, research productivity, and focus over the past 15 years. Exemplars of qualitative research conducted by nurse researchers in Ireland are presented.

In Chapter 34, Joan Anderson considers the state of the science of qualitative nursing research in Canada. She begins by presenting the context of the development of qualitative research in Canada. Following this, she presents her interpretation of the intersecting factors influencing the development of qualitative nursing research by means of exemplars from Canadian nurse scholars, who have used different qualitative perspectives, in order to highlight the breadth of the theories and methodologies being used in Canada. Anderson concludes the chapter with a reflection on some broader questions based on her experience conducting qualitative research for 30 years.

Jennieffer Barr considers the state of qualitative nursing research in the countries of Australia and New Zealand in Chapter 35. She begins with the history of research development of Australasian nurses. The qualitative research methods most frequently used by nurse researchers are discussed, followed by the contribution that Australasian nurse researchers have made to the discipline of nursing. Suggestions for future research endeavors are included.

In Chapter 36, qualitative nursing research in four countries in Latin America (Brazil, Chile, Colombia, and Mexico) is presented. The authors of this chapter are María Claudia Duque-Páramo, Maria Itayra Padilha, Olivia Inés Sanhueza-Alvarado, María Magdalena Alonso Castillo, Fabiola Castellanos Soriano, Karla Selene López-García, and Yolanda Flores Peña. Their analysis reflects the different processes and characteristics of qualitative nursing research in these four countries. An in-depth literature review is also supplemented by interviews with researchers. For each Latin American country the following questions are addressed: the historical context; current purposes and contributions; methods, perspectives, approaches, tools; challenges and limitations; and future directions.

Qualitative nursing research in Spain is the focus of Chapter 37 written by Andreu Bover Bover, Denise Gastaldo, Margalida Miró and Concha Zaforteza. In this chapter the authors describe the movement that led to an increase in Spanish qualitative nursing research. Major trends in qualitative nursing research in Spain over the past decade are identified by means of a review of studies published by Spanish scholars in nursing. Qualitative nursing research in Spain represents a political opportunity to re-position nursing as a profession that produces scientific

knowledge and engages with research in both academic and health care settings. Challenges facing qualitative nurse researchers in Spain are addressed.

Portugal is the focus of Chapter 38 which is authored by Marta Lima-Basto. The chapter begins with a historical background highlighting landmarks in the development of nursing research. Included is an analysis of doctoral theses conducted by Portuguese nurse researchers. The impact that qualitative studies have had in Portugal is reflected on.

In Chapter 39, Terese Bondas considers the qualitative methodological developments over the past two decades in nursing and caring science in Finland and Sweden. On the basis of an extensive literature review, Bondas classifies qualitative nursing research in these two countries in three eras: the trembling years, years of steady growth, and coming of age.

Qualitative nursing research in Norway, Denmark, and Iceland is addressed in Chapter 40 by Marit Kirkevold. After a brief historical overview of nursing research in these three countries, Kirkevold uses Kim's description of the structure of nursing knowledge to reveal how qualitative research in these countries has contributed to nursing in the areas of normative/ethical knowledge, situated/hermeneutical knowledge, transformative/critical hermeneutical understanding knowledge, aesthetic knowledge, and inferential/generalized knowledge.

Maria Grypdonck, Marijke Kars, Ann Van Hecke, and Sofie Verhaeghe consider qualitative nursing research in the Netherlands and Flanders in Chapter 41. The similarities and differences in the history of nursing research in these two countries are presented in the first section of the chapter. Qualitative methodologies used by nurse researchers in the Netherlands and Flanders are described with supporting examples of published studies.

In Chapter 42, qualitative nursing research in Korea is addressed by Kyung Rim Shin, Miyoung Kim, and Seung Eun Chung. The historical background of qualitative nursing research in Korea for the past 20 years is briefly examined. Published qualitative studies by Korean nurse researchers are reviewed from 1991 to 2010 and analyzed for trends and suggested future research directions.

Shigeko Saiki-Craighill presents the state of the science of qualitative nursing research in Japan in Chapter 43. Framed by the historical context, she provides an overview of both the quantity and quality of qualitative research conducted by nurse researchers in Japan. An in-depth analysis of one particular representative method, grounded theory, is performed.

In Chapter 44, David Arthur considers qualitative nursing research in South-East Asia, China, and Taiwan. He describes the development of qualitative research by nursing scholars in these countries. Next, the quantity and quality of qualitative research in these countries are addressed followed by some exemplars. Arthur highlights some methodological issues in these countries and the future of qualitative research in nursing.

The final chapter, by Cheryl Tatano Beck, looks at the future directions in international qualitative nursing research. Chapter 45 is a compilation of the directions for future qualitative research around the globe that the nursing contributors of this handbook have identified and merit our attention in order to advance qualitative research in our discipline.

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Part I

What does qualitative nursing research do?

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2

The development of qualitative nursing research

Janice M. Morse

Nursing care is neither easily taught, nor easily learned. Most difficult, is researching nursing care: documenting the art of nursing, describing and eliciting the nurse–patient interaction, the meaning of care to the patient, and the effects and outcomes of such care. Such description requires introspective understanding, interpretative insight, and the creation of theories; it requires identification of interventions, the production of evidence that reveals effectiveness, and it thereby furthers the development of nursing practice. This is what we call qualitative nursing research.

People say, "soft science is harder," meaning that engaging in the science of an art is more difficult than bench science or quantitative research. It is more difficult because qualitative researchers study subjective experiences rather than hard concrete facts. We are using humanistic methods, examining subjectively, inductively and inferentially, rather than using discrete measures. And as nurses, our participants are those who are suffering, who are at the edge of what they know and understand, and facing their greatest fears and losses. They are vulnerable in the extreme.

Qualitative methods provide researchers with a way of seeing, and a way to understand; a way of listening, and a way to hear; ways of accessing and empathetically knowing the most intimate parts of the other. Our methods are humanistic, gentle and kind, in our empathetic interaction with our participants. Our nursing selves—with the skills that nurses have learned clinically, working with those in pain, ill or dying—facilitate our ability to collect data, to observe, to interview, to know, and to subsequently analyze and disseminate the research and identify interventions.

Qualitative researchers have no concrete measures, no yardsticks to verify what people feel, no monitors to quantify their agonies and to add credence to our research. The quality of qualitative inquiry can only be shown in the quality of the results, in the richness and accuracy of the description, in the essence of the interpretation, in the recognition of the situation or what it implies, and in the elegance of the theory and its ramifications. And when qualitative researchers reveal the experiences of such suffering or the struggles to regain health, such disclosure is often not very pleasant. Many people find it so painful read that it is easier to ignore, than to face what we write.

In this chapter, I will describe the development of qualitative nursing research, both as a method and in the substantive areas that we study; I will also discuss the global dissemination of

this method. In doing so, I will explain why qualitative research is so essential to molding our profession, and to improving health and health care to society in general.

What is qualitative nursing research?

Qualitative nursing research is a recent research paradigm in nursing—so new, in fact, that many established nurse researchers may have never taken a course in qualitative inquiry, and know little of its various methods and strategies, assumptions, principles, and contributions. In fact, as with all innovations, qualitative methods are not uniformly distributed, accepted or equally incorporated into the curriculum. In some nursing programs they are standard and accepted, but in others—and sometimes in quite influential schools of nursing—they are absent. These schools argue that qualitative inquiry is not justified in their program because it may be considered "unfundable" by our national granting agencies (that is, unsuited for funding because of its unorthodox methods and different standards), and their goal is to train career nurse researchers, whose quantitative skills will be fundable. Thus, these schools do not offer qualitative courses and no qualitative research is conducted in these programs. This position, of course, will change dramatically in the future, as qualitative nurse researchers increase in number, as the number of publications using qualitative methods increase, and as the number of qualitative researchers on national funding boards balance the present quantitative researcher majority. It is now inevitable that qualitative nursing research will become an essential component of nursing programs at the doctoral level (or earlier), and that qualitative inquiry will become critical for the development of nursing knowledge. This volume gives credence to this position, in helping move qualitative nursing research one step forward.

The development of qualitative research

In this section, I will provide an overview of the development of qualitative methods in general, and then discuss the later development of qualitative inquiry in nursing.

The first phase (1900–1960): The development of qualitative methods

Observation and interviewing have always contributed to the development of knowledge. For instance, in medicine, there was the development of the compendia of signs and symptoms and basic anatomy, as developed from observation and pattern recognition over the past several centuries. In the early 1900s, qualitative methods developed in the "modern" form, from several disciplines, in different ways. In anthropology, Malinowski developed methods of fieldwork and ethnography—methods that were further developed by his students, including Margaret Mead, Ruth Benedict, and Evans-Pritchard. With other early anthropologists, ethnography was established, and the normative way to study culture was by living with the group being studied, learning their languages, and observing, interviewing, and recording field notes.

A second strand of inquiry emerged from the European phenomenological philosophers, mainly Husserl (1859–1938) who worked through phenomenological reductionism, intentionality, consciousness and "bracketing" and Heidegger (1889–1976), related to the essence of "being in the world" and the experiences associated with being. In psychology, the phenomenologist Merleau-Ponty (1908–1961), a student of both Husserl and Heidegger, developed the notion of "consciousness as the source of all knowledge," of perception, and embodiment. Also from psychology is also the work of Jean Piaget (1896–1980), who used microanalytic observational methods, observing his own two infants, and developing a theory of cognitive development.

The work of these early researchers formed the basis of qualitative methods as we know them today. Although the number of strategies have increased and been formalized within each method, and different forms (or styles) of each method have emerged, these early researchers must be credited with the development of qualitative research.

During this period in nursing, apart from the epidemiological efforts of Florence Nightingale, research was virtually absent. Without qualitative research methods, early nursing theorists used their own experiences of nursing to develop nursing frameworks for practice, writing from what they already knew or had learned themselves in the process of providing care. This is the case for our greatest early nurses, such as: Florence Nightingale's *Notes on Nursing* (1859/1960), Virginia Henderson's collaborative work with Harmer and Henderson (1939) and Henderson's (1966), *The Nature of Nursing*; Hildegard Papleau's (1952) *The Interpersonal Relations in Nursing*; and Dorothea Orem's (1971) *Nursing: Concepts of Practice*. Their nursing "theories" were not actually theories, but rather conceptualizations of practice. Using their own knowledge of nursing practice, they described ways to organize care and to give it a particular perspective. These nurses made a tremendous contribution to nursing, considering they did not have the research tools and supports that we now have in the twenty-first century.

The second phase: Recognition of the essentialness of nursing concepts, 1950–present

After these "framework theorists," beginning about the 1950s, it was realized that new concepts were essential if we were to describe nursing practice. Hildegard Papleau invited Carl Rogers to Keynote at the America Nurses Association Annual Convention in 1957. He described empathy in his address, and this concept was immediately adopted into nursing (Morse, Anderson, Bottorff, et al., 1992). But borrowing concepts from other disciplines was only a partial solution (and often an unsatisfactory solution) for nursing. Often concepts developed for another discipline were not always a good fit for nursing phenomena. Subsequently, in 1973, a group of 11 nurses formed the Committee of the Whole of the Nursing Development Conference Group (NDCG, 1973) to discuss concepts and their development. About this time, several edited books appeared, with each chapter written about a particular concept of interest to nurses and nursing education (Carlson, 1970; Norris, 1982). Note that while nursing was struggling with these efforts, other disciplines, particularly anthropology and sociology, were conducting qualitative research and publishing monographs to develop their concepts.

The demand for *nursing concepts* continues to this time, with several approaches to concepts development available to nurses (e.g. Walker & Avant, 1983; Knafl & Rodgers, 2000). Unfortunately, this important task is conducted by students as a part of their first doctoral class, rather than being approached seriously by competent nurse researchers, so progress in developing our profession has been hobbled.

The third phase (1960–1985): The emergence of qualitative health research

In the third phase, qualitative methods began to cluster in various university departments by types of methods. In these units, a professor with a particular type of methodological expertise, with a group of students, formed a *cluster*, a team investigating particular topics. The earliest example was at the University of California at San Francisco, where Barney Glaser and Anselm Strauss, sociologists hired by the University of California School of Nursing, wrote their classic methods book, *The Discovery of Grounded Theory* (Glaser & Strauss, 1967). In addition to developing grounded theory, they conducted studies on dying in hospitals (Glaser & Strauss, 1965, 1968),

and later, collaborating with their students, studies on the comfort work of nurses (Corbin & Strauss, 1988). These were strong studies with mid-range theory, and clinical application to nursing and health care. As Glaser and Strauss' students graduated, they continued to conduct research in health care, to mentor students of their own, and to publish both methods texts and studies of health illness, thus promulgating grounded theory across the United States and beyond.

In the1960s, recognizing the importance of nursing research and the need for doctorally prepared nurses, the NCNR NIH Nurse Scientist Program provided funding to support nurses to attend doctoral programs in disciplines outside of nursing. Many selected bench science programs, but a few chose anthropology and sociology. Nurses who selected sociology and anthropology learned qualitative methods, and brought them back into nursing, primarily through the study of culture and health—and later to develop transcultural nursing (Leininger, 1978). Through the American Anthropological Association, they developed an interest group, the Council of Nursing and Anthropology (CONAA), supporting the development of transcultural nursing and qualitative inquiry nationally. Although transcultural nursing remained the primary vehicle for qualitative methods for some time, eventually qualitative inquiry moved beyond "culture" to explore the subjective domains of nursing. In 1985, Leininger published the first qualitative methods book, applying qualitative inquiry from culture and health to nursing in general.

We owe a tremendous debt to this cadre of nurses who fought for the introduction of qualitative research into nursing. Margarita Kay, Eleanor Bowen, Pam Brink, Noel Chrisman, and Melanie Dreher prepared course outlines, and taught the first courses. They monitored journal editors, insisting on fair reviews by qualified reviewers. And by their presence they provided an appreciative audience for our meetings, which was mentorship *par excellence*!

The fourth phase: qualitative nursing methods: Coming of age, 1990–present

In the mid-1990s, qualitative research "came of age." Qualitative researchers received NIH funding. They examined nursing phenomena, both micro- and macroanalytically, and it is these topics that are combining with ongoing work to form the theoretical foundation of nursing.

Etching a new and different research approach into academia and into nursing was a relatively slow and arduous process. Despite resistance, qualitative inquiry is now making a distinct contribution to nursing and to health care, filling a necessary void that cannot be filled by quantitative research. Articles describing methods added to our understanding of qualitative inquiry, albeit in short "bites" given the limitations of the 15-page article, and these become increasingly common from the 1990s. Presently, *Qualitative Health Research* is the primary venue for qualitative nursing research, with many supporting journals such as *Nursing Inquiry*, *Journal of Advanced Nursing*, *Western Journal of Nursing Research*, and *Research in Nursing and in Health*. A journal, *Global Qualitative Nursing Research*, is planned for 2013 (Sage, online), and other nursing journals routinely publish qualitative inquiry. The International Institute for Qualitative Methodology (IIQM) holds annual Qualitative Health Research conferences. The recently established Global Congress for Qualitative Health Research will present its third convention in Thailand, in 2013. Qualitative nurse researchers also attend multidisciplinary qualitative conferences (such as the International Congress for Qualitative Inquiry (ICQI)) where they stand shoulder-to-shoulder with researchers from other disciplines.

In 1985, the first qualitative research texts written especially for nursing appeared (Leininger; Field & Morse; Morse & Field; Parse, Coyne, & Smith) (see Table 2.1). Shortly afterwards, the first edition of Munhall's classic series appeared (Munhall & Boyd, 1987), and this edited book has been continuously in print since that time; it is now in its fifth edition (Munhall, 2012). These

"overview" books were generally used in introductory courses, and are detailed and comprehensive; much of the content is specific to the context of nursing, illustrating how qualitative inquiry may enhance care. The publication dates of these books closely resemble the establishment of doctoral programs internationally, and it is probable that the demand for such texts by doctoral students was a factor in their publication.

A proliferation of single method books closely trailed the overview texts, with grounded theory forming the strongest and earliest cadre of collaborators (Table 2.1). The single method books tend to be used for more advanced courses or by researchers needing more detailed information.

There are also "special topics" books, which address particularly difficult aspects of qualitative inquiry. The appearance of these books indicates that nurse researchers have something useful, and even insightful, to add to the growing debates in qualitative inquiry, and attacking special problems—certainly a sign of qualitative maturity.

Table 2.1 Qualitative nursing research methods books, by type, date and country

Title	*Author(s)*	*Date*	*Country*
General			
Nursing research: The application of qualitative approaches (trans. Finnish, Korean, German, Japanese)	Field & Morse Morse & Field	1st ed. 1985 2nd ed. 1995	Canada
Qualitative research methods in nursing	Leininger	1985	USA
Nursing research: Qualitative methods	Parse, Coyne, & Smith	1985	USA
Qualitative health research	Morse	1992	Canada
Nursing research: A qualitative perspective	Munhall & Boyd Munhall	1st ed. 1987 2nd ed. 1993 3rd ed. 2000a 4th ed. 2006 5th ed. 2012	USA
Qualitative research for nurses *Qualitative research for nurses* *Qualitative research for nursing and health care*	Holloway & Wheeler	1st ed. 1996 2nd ed. 2002 3rd ed. 2010	Great Britain
Qualitative research in nursing: Advancing the humanistic perspective	Streubert & Carpenter Streubert & Carpenter Speziale & Carpenter Speziale & Carpenter Streubert & Carpenter	1st ed. 1995 2nd ed. 1999 3rd ed. 2003 4th ed. 2007 5th ed. 2011	USA
Pesquisa em Enfermagem: Novas Metodologias Aplicadas [Nursing research: New methods]	Gauthier, Santos, Cabral, & Tavares	1998	Brazil
Readme first for a user's guide to qualitative research (trans. Korean, Italian, Japanese)	Morse & Richards Richards & Morse Richards & Morse	1st ed. 2002 2nd ed. 2007 3rd ed. 2012	Canada/ Australia

Table 2.1 Continued

Title	*Author(s)*	*Date*	*Country*
Qualitative Gesundheits- und Pflegeforschung [Qualitative health research and care]	Schaeffer & Müller-Mundt	2002	Germany
Advanced qualitative research for nursing	Latimer	2003	Great Britain
ศิริพร จิรวัฒน์กุล. การวิจัยเชิงคุณภาพในวิชาชีพการพยาบาล. ขอนแก่น: ศิริภัณฑ์ออฟเซท. จำนวน หน้า *[Qualitative research in nursing] [Qualitative research in nursing] [Qualitative research in nursing*]	Chirawatkul	1st ed. 2003 2nd ed. 2005 3rd ed. 2012	Thailand
질적연구 용어사전 *[Qualitative research methodology]*	Shin, Kim, Kim, et al.	2003	South Korea
질적연구방법론 *[Qualitative research methodology]*	Shin, Cho, & Yang	2004	South Korea
Pesquisa Qualitativa em Enfermagem [Qualitative research in nursing]	Matheus & Fustinoni	2006	Brazil
护理质性研究 [*Qualitative research in nursing*]	Liu	2008	China
Abordagens Qualitativas: trilhas para pesquisadores em saúde e enfermagem [Qualitative approach: Path for researchers in health and nursing]	Teixeira	2008	Brazil
Grounded theory			
From practice to grounded theory	Chenitz & Swanson	1986	USA
Basics of qualitative research (trans. Chinese, Japanese, Arabic)	Strauss & Corbin Strauss & Corbin Corbin & Strauss	1st ed. 1990 2nd ed. 1998 3rd ed. 2007	USA
Grounded theory in practice	Strauss & Corbin	1997	USA
Using grounded theory in nursing	Schrieber & Stern	2001	Canada/USA
Developing grounded theory: The second generation	Morse, Stern, Corbin, Charmaz, & Clarke	2009	USA
Essentials of accessible grounded theory	Stern & Porr	2011	USA/Canada
Ethnography			
Ethnography in nursing research	Roper & Shapira	2000	USA
Interpretative description			
Interpretive description	Thorne	2008	USA

Table 2.1 Continued

Title	*Author(s)*	*Date*	*Country*
Phenomenology			
Interpretative phenomenology	Benner	1994	USA
Revisioning phenomenology: Nursing and health science research	Munhall	1994	USA
Hermeneutic phenomenological research	Cohen, Steeves, & Kahn	2000	USA
현상학적 연구 *[Phenomenological research]*	Shin & Kong	2001	Korea
Å forske i sykdoms- og pleieerfaringer: Livsfenomenologisk bidrag [Research in sickness- and caring experiences: A life world phenomenological contribution]	Bengtsson	2006	Norway
Reflexive lifeworld research	Dahlberg, Dahlberg, & Nyström	2008	Sweden
Mixed-method			
Mixed-method design: Principles and procedures	Morse & Niehaus	2007	Canada
Special topics			
Qualitative nursing research: A contemporary dialogue	Morse (Ed.)	1989	Canada
Qualitative health research	Morse (Ed.)	1992	Canada
Critical issues in qualitative research methods (trans. Spanish)	Morse (Ed.)	1994	Canada
Completing a qualitative project: Details and dialogue	Morse (Ed.)	1997	Canada
Qualitative research proposals and reports	Munhall	1st ed. 1991 2nd ed. 2000b 3rd ed. 2010	USA
The nature of qualitative evidence	Morse, Swanson, & Kuzel	2001	Canada/USA
O método de análise de conteúdo: uma versão para enfermeiros [Content analysis: Nurses approach]	Rodrigues & Leopardi	1999	Brazil
Handbook for synthesizing qualitative research	Sandelowski & Barroso	2007	USA
Essentials of a qualitative doctorate	Holloway & Brown	2012	Great Britain
Essentials of qualitative interviewing	Olson	2011	Canada
Focus group research	Carey & Ashbury	2012	USA

Global dissemination for qualitative methods for nursing

Compared with the slow and rocky introduction of qualitative research into nursing, the spread of qualitative methods internationally was relatively rapid. New methods were disseminated first by foreign students learning qualitative methods during the course of their doctoral programs in the United States. As these students returned to their own countries to teach qualitative methods and to offer workshops, and supervise students, they published articles and chapters using the particular methods with which they were familiar, and, in time mentored a new generation of qualitative researchers. The original mentor may also have translated the methods book written in English into his or her own language. The final step is the writing of a new qualitative methods book for nursing for their own context, and in their own language.

The international dispersal of qualitative methods in nursing

The introduction of qualitative methods in chapters, written by nurses, in edited books prepared for a larger market, appears before foreign language books; they are more difficult to trace, and I have not cited them here. However, they do provide some evidence of the growth of qualitative inquiry within a particular region. For instance, I could not find a single book written by nurses in Spanish, but Denise Gastaldo has contributed a chapter in a more general text (Mercado, Gastaldo, & Calderón, 2002).

The dispersal of qualitative methods internationally typically follows the publication of books in the United States. First, books published by authors in North America were translated into other languages. These books, written in foreign languages for nurses of a particular country, appeared to be an indicator of "readiness" to learn about and to do qualitative inquiry in schools of nursing.

These translated books were then followed by qualitative methods books, both general and specialist methods, authored by nurses internationally (see Table 2.1). The publication dates of these books provide one indicator of the dissemination of qualitative research methods internationally. They form a pattern of dissemination and indicate the introduction, demand and even the utilization of qualitative methods globally. The list in Table 2.1 contains those books with an author or co-author who is a nurse, and who was writing qualitative methods for nursing students and nurse researchers. The list is probably not complete, and I apologize to those whose books have been omitted. The list also does not reflect the distribution of books in qualitative inquiry written in English (and that were later translated) or, for instance, of books such as Morse and Field's (1995) that was simultaneously published in the US and Great Britain. Note that while the first general qualitative books emerged from the US and Canada in 1985, the first in Great Britain was not until 1995; Sweden, Germany and Australia in 2002; South Korea in 2003; China in 2008; and Thailand in 2011.

Grounded theory made its mark quite early internationally, and the early Strauss and Corbin works have been translated into ten languages. The other major method is phenomenology, and research groups using van Manen's (1990) text are found in Scandinavia, Australia, China, and South Korea, as well as the US.

Nurses' contributions to the development of qualitative methods

As noted in the first part of this chapter, methods of qualitative inquiry developed rapidly, and this trend continues as nurses become major players in the areas of synthesis, qualitative evidence, and qualitatively driven mixed methods design. In nursing, we are expanding beyond our

30-year preoccupation with the development of concepts and theory, to application and the integration of research in two ways: (1) by making our research stronger by synthesizing several similar projects; and (2) in mixed methods, we are becoming stronger by forming a foundation that is then enhanced by quantitative findings or provides a springboard for quantitative inquiry. Qualitative inquiry is becoming essential to knowledge development.

Qualitative methods continue to evolve and be modified, and new methods develop. In nursing we realize that when collecting data in the clinical area, there are constraints to data collection imposed by the hospital environment and by the patients' condition that often require modifications to standard qualitative methods. For instance, in the hospital environment, it may be difficult to find a private, quiet place to conduct an interview. Patients often share rooms, other staff interrupt to check on the patient or to give medications, and the patient has a host of scheduled appointments: X-rays, blood tests, doctors' visits, housekeeping, meals, and relatives' visits all intrude. Recordings may prove difficult—the patient may have a dry mouth, or be fatigued; once, when I placed the recorder on the patient's chest, I found I had recorded the click of artificial heart valves, rather than the interview. Patients may be too shocked, or enduring events or pain, to be able to express themselves; they may be on a ventilator and unable to speak. They may be confused, be cognitively impaired or have amnesia, or feel drowsy from drugs, and thus not be able to be interviewed. In these cases, observational research becomes more important, i.e., "retrospective" interviews conducted once the patient is able to be interviewed, or interviews with the vigilant significant others (Morse, 2012). Shorter hospital stays, and patients being discharged before they are well, transfer some data collection into the home or rehabilitation hospital. There is no doubt that qualitative nurse researchers must be versatile and resourceful.

What do these conditions do to the application of the method? If only inadequate data can be collected by the method planned—for instance, only one, not two of the planned interviews may be obtained from each patient—then the researcher must either increase the sample size or interview observers, that is, other patients, significant others or nurses. Sometimes multiple indicators have to be used to examine the same phenomena. For instance, Kayser-Jones, Kris, Miaskowski, Lyons, and Steve (2006), when needing an indicator of pain intensity experienced by elderly demented nursing home residents, used posturing and grimacing, vocalizations, and the assessment of relatives and nurses.

Have nurses developed qualitative methods? To date, only Leininger has attempted to develop a separate method for nursing, an adaptation of ethnography for nursing, which she called ethnonursing (Leininger, 1997). However, it is not used extensively, and a recent metasynthesis of the findings from these studies revealed only 24 dissertations (McFarland, Wehbe-Alamah, Wilson, & Vossos, 2011).

Other nurses have made contributions to qualitative nursing research. Sandelowski and Barroso (2007) refined methods of synthesizing qualitative findings. Morse and Niehaus (2009) introduced some strategies to refine mixed method design. The latest complete method book was Thorne's (2008) *Interpretative Description*, moving description another step forward by adding methods to eliciting meaning.

The implementation failure of qualitative nursing research?

Qualitative inquiry is still somewhat ignored in the areas of evidence-based practice. Yet qualitative projects are being conducted with greater intensity. What happens to these projects?

These articles fill our journals, and, in turn, are primarily cited by other researchers and students. Not clinicians? I do not think they know what to do with the information at the bedside.

If these studies provide information that assists them to recognize "what is going on" with their patients, it is not making its way back to our conferences or to our literature.

Are the qualitative studies too small, too local? Perhaps they need to be amalgamated. Metasynthesis will facilitate this process, and these are appearing with greater frequency for our more common topics. The recent funding of a five-year project by Kathy Knafl and Margarete Sandelowski to synthesize literature on child health (Anon, 2011) will be a major milestone in this area. The utilization of methods of synthesis will have importance for clinical research, including incorporation of qualitative findings into the Cochrane Database.

Perhaps there is a lack of useful qualitative inquiry because most qualitative researchers are focused on inferential methods, rather than on "harder" data, such as methods of microanalytic description. I made the argument that methods of qualitative inquiry, such as microanalysis of video data, would enable evaluation of much clinical phenomena, such as assessing risk of fall while climbing out of bed (Morse, 2012).

Elsewhere I have argued that our methods of assessing evidence—and even considering the nature of evidence—are narrow and exclude qualitative contributions. Qualitative assessment enables evaluation for less monetary cost, and less risk of harm; and if one includes principles of logic and common sense, such inquiry may not even require data of the actual incident (Morse, 2012). For instance, such qualitative methods with potential may be the assessment of incident reports, with or without harm, and extrapolation of these patterns of causation to the introduction of policy to prevent future incidence. Such use of qualitative research is in aviation, where the human cost of an "incident" is too great to wait until it occurs, and policy changes are based upon near misses (Connell, 2004). It is the ethical, moral and economic way to proceed in many instances, and this approach has great potential for nursing and is already the basis for preventing errors in hospitals, such as medication errors.

What does qualitative research contribute to nursing knowledge?

The discipline of nursing is both a hard science and an art, concerned with both the objective and the subjective—concerned both with the physical body and with all aspects of the person. But qualitative nursing research focuses on the subjective: on health and illness, on birth and dying, on the person, their family, and the community. In nursing, the technical aspects of care are melded with the interpersonal, with the patient as a recipient of care and the attentions of the lay caregiver or the nurse. In nursing, the subjective experiences of illness, rehabilitation and attaining health is as important as the objective measurement inherent in physical assessment. Nursing is focused on the person, yet concerned with populations and, of course with dyads and families. These are areas in which qualitative inquiry should be a key player in research, making major contributions. Has it? Earlier I argued that qualitative research was poorly funded. Studies are small and criticized for their lack of significance. These questions remain: Has qualitative inquiry contributed to nursing knowledge? What has been contributed? And how?

The collectiveness of qualitative knowledge

One criticism of qualitative studies is that they are small and insignificant, because the investigator cannot "manage" large numbers of cases of in-depth data. Even when using a qualitative data program, there are limits to human conceptualization. As a result, qualitative studies tend to be limited in scope and number of participants—usually less than 50 for a study using interview data. While one could argue that such a study may produce significant insights, a single qualitative study, published as a 15-page article, usually has limited impact.

Generally, however, the development of qualitative knowledge does not depend upon one study at a time, but rather upon the accrual of results of many small studies on a similar topic. Despite problems with replication, these studies on diverse topics, on concepts, on changing phenomena, presenting different interpretations, eventually support each other and meld into consensus: knowledge becomes accepted, and extends to form theory. Of course, this does not happen by itself, nor by some magical emergence. It happens through our basic inquiry, our overlapping findings, our beginning inquiry on firm foundations from the research of others, from our metasynthesis, and eventually leading to the acceptance of our concepts and theories.

While patterns of inquiry and research programs differ, these studies are most often conducted by different authors, and are not exactly the same—not replications—but they are overlapping studies that in part endorse each other.

These studies develop general areas of knowledge, following a general trend. The pattern of development falls roughly into eight levels (Morse, 2012):

Level 1: Exploratory, descriptive studies, identifying the phenomenon.
Level 2: From the phenomenon, description and delineating, developing the concept(s).
Level 3: Examining the concept in different contexts or situations.
Level 4: Exploring the concept with other co-occurring concepts.
Level 5: Synthesizing studies about the concept.
Level 6: Model and theory development.
Level 7: Developing assessment and measurement.
Level 8: Clinical applications, evaluation and outcomes.

These levels do not indicate that studies at a higher level are more significant, or more rigorous, than those at a lower level. Although generally descriptive studies must precede inferential ones, and studies developing the concept should precede studies that develop theory, leveling is not associated with contribution nor sophistication of higher level studies (Sandelowski, 2008).

There are numerous broad topics that have been researched by many qualitative nurse researchers, and these have made major contributions following this general pattern of knowledge development. Examples of these topics are: caring, social support, empathy, and nurse–patient relationships. These areas are not inclusive—they are listed because they were primarily the first areas that qualitative researchers addressed, and have therefore a long history of inquiry and had the time to build a strong body of knowledge. These studies incrementally accrue to form a theoretical foundation for nursing science and nursing praxis.

Developing qualitative knowledge: the example of caring

Because it takes time and many, many studies to develop an area of inquiry, I will demonstrate the development of one of the earliest qualitative areas: caring. Paley (2001) noted in frustration that there has been "a small avalanche of publications" on this topic (p. 188), and that these descriptions of caring are "simply added to previous descriptions . . . and the space into which it expands has no effective boundaries" (p. 192). Thus, knowledge piles, often without any acknowledgment of previous work, or advance in knowledge. I disagree that researchers have no boundaries: such boundaries should be enforced by reviewers and editors. Since qualitative inquiry does not directly replicate, if a qualitative study does not contribute anything new, it should be rejected.

However, as Paley (2001) correctly indicates, we are in the midst of a vast collection of studies on caring. Therefore, the ones used in the example below are not especially seminal, but are typical of the studies of each general type for each level.

From the titles of studies listed in Table 2.2, one can clearly see the changes in the focus of the studies by each level. As knowledge is gained, the studies do change in focus, from basic description, to analyzing the concepts, to exploring different settings in which the concepts occur and allied (co-occurring) concepts. By Level 5, there are sufficiently rich and detailed to build a foundation for metasyntheses, then mid-range theories. At this point the research shifts to assessment and measurement, and to clinical application and caring interventions. The research area becomes "mature," and embodied into the discipline and into practice.

Table 2.2 Level of research developing nursing phenomenon: the example of caring

Level of research	*Examples of studies*
Level 1: Identifying caring	The experience of caring (Forrest, 1986) Noncaring and caring in the clinical setting: patients' descriptions (Reimen, 1986)
Level 2: Describing, delineating and developing the caring as a concept	Comparison of cancer patients' and professional nurses' perceptions of important caring behaviors (Larson, 1987) The caring concept and nurse-identified caring behaviors (Wolf, 1986)
Level 3: Examining caring in different contexts or situations	Importance of nurse caring behaviors as perceived by patients after myocardial infarction (Cronin & Harrison, 1988) Caring needs of women who miscarried (Swanson-Kauffman, 1988)
Level 4: Exploring caring with other co-occurring concepts	How well do family caregivers cope after caring for a relative with advanced disease and how can health professionals enhance their support? (Hudson, 2006) Patients' and nurses' experiences of the caring relationship in hospital: an aware striving for trust (Berg & Danielson, 2007)
Level 5: Synthesizing caring studies	Metasynthesis of qualitative analyses of caring: defining a therapeutic model of nursing (Sherwood, 1997) Metasynthesis of caring in nursing (Finfgeld-Connett, 2007)
Level 6: Developing models and theories of caring	Empirical development of a middle-range theory of caring (Swanson, 1991) The theory of human caring: retrospective and prospective (Watson, 1997)
Level 7: Assessing and measuring caring	Effects of nursing rounds on patients' call light use, satisfaction and safety (Meade, Bursell, & Ketelsen, 2006) Caring in patient-focused care: the relationship of patients' perceptions of holistic nurse caring to their levels of anxiety (Williams, 1997)
Level 8: Clinical application and caring interventions	Caring theory as ethical guide to administrative and clinical practices (Watson, 2005) Nursing as informed caring for the well-being of others (Swanson, 1993)

Patterns of researcher programs in qualitative nursing research

Not all qualitative nursing research is conducted in such an apparently disjointed manner as described above. Some researchers are working on a single problem or areas for large blocks of time—some even for their entire careers. And their research forms a logical sequence of studies, and creates a meaningful contribution. Some of these researchers have contributed review articles of this work to this volume, and other examples are summarized below.

Identifying phenomena (Level 1)

In the course of analyzing data on nurses' responses to patients in agonizing pain in the trauma room, we found data that did not fit empathy as it was presently described: as a feeling towards another's plight. Rather, these data described a physical response in the nurses towards the pain expression and observing injuries experienced in patients, which we labeled *compathy* (Morse & Mitcham, 1997; Morse, Mitcham, & van der Steen, 1998). Compathy was the shared, and therefore contagious, response. The response could mirror the response of the person in pain, be reflected to a lesser degree, or be converted to another somatic response (such as feeling nausea), or be blocked so that the person had no feelings at all and objectified the person.

The response would be triggered by seeing and/or hearing the person in pain, by reading about it, or even thinking about it.

Once compathy was identified from the descriptive data and developed into a concept, examples were evident, and examples were present in the literature—for instance, couvade, the husband's experience of his wife's labor pains, is an example of compathy.

Delineating the concept of fatigue (Level 2)

Karin Olson and her colleagues have been studying the concept of fatigue, concentrating on behavioral indices and ways to circumvent fatigue. First, they explored fatigue in different populations (in illness: cancer care, chronic fatigue syndrome; depressions; and in healthy persons: shift workers and athletes) (Olson & Morse, 2005). Once the symptoms of fatigue were identified in each group, the common characteristics (attributes) of fatigue were identified across groups, and delineated from tiredness and exhaustion.

Olson then extended her research program to explore fatigue in persons with different illness, for instance, lung and colorectal cancer (Olson, Tom, Hewitt et al., 2002); advanced cancer in active treatments and palliative care (Olson, Krawchuk, & Quddusi, 2007); multiple sclerosis and exercise (Smith, Hale, Olson, & Schneiders, 2009); and depression (Porr, Olson, & Hegadoren, 2010). Olson then collaborated with an international team to examine fatigue cross-culturally (Graffigna, Vegni, Barello Olson, & Bosiol, 2011). Finally Olson advanced her research program into measurement, developing the *Adaptive Capacity Index*, or the ability to adapt to multiple stressors that indicate risk for fatigue (Olson et al., 2011), extending her research program, firmly embedded in Level 2 to Levels 7 and 8.

Working horizontally in Levels 2–6

In a research program exploring the experiential and behavioral indices of suffering, Morse conducted a number of studies in various contexts for 20 years. These studies explored the suffering of pain (trauma room, and chronic pain), of dying, of relatives' response to illness and dying. The research delineates enduring, a state in which the emotions are deliberately suppressed

to prevent the person from panicking (and therefore not being able to help him or herself, or others). The second stage is emotionally suffering in which the emotions are released in the form of crying, weeping and sobbing, and the person demands to be comforted both behaviorally, by their vocalizations, and requests (Morse, 2010).

The model, the *praxis theory of suffering* (Morse & Carter, 1996; Morse 2001, 2010) is developed from many contexts—from trauma care, hospital care to dying, from the individual's perspective to the family and the community, and in a trajectory from impact to the resolution of suffering. It links the behaviors to the alleviations of suffering through nurse comforting. And comforting behaviors are described from the microanalytic touch (Morse, Solberg, & Edwards, 1993), to interpersonal strategies (Morse & Proctor, 1998).

Such a research program extends from examining suffering at many levels, contexts, and patient states. Yet it is useful to the clinician, for nursing is a profession in which clinicians must respond instantly, and the only indication that they may have is distress. They may not know what is causing the distress, but they must act immediately. Such is the usefulness of clinical frameworks provided by qualitative inquiry.

Metasynthesizing (Level 5)

In the context of developing methods for metasynthesis, Sandelowski and Barroso (2007) conducted metasyntheses on women with HIV/AIDS. These publications draw the work of many researchers together and solidify evidence. This research is one way to increase the scope and sample size in qualitative inquiry, while at the same time increasing the variation, and certainty in patterns identified in the individual studies. For example, exploring the trajectory of minority mothers, substance abuse and the events surrounding substance abuse, Barroso and Sandelowski (2004) were able to follow the course of substance abuse and on the onset of HIV, motherhood and recovery and beyond. In a second study, coping with motherhood in the context of HIV (Sandelowski & Barroso, 2003), they identified a "distinctive kind of maternal practice—virtual motherhood— to resist forces that disrupted their relationships with their children and their ability to care for them, as well as their identities as mothers" (p. 470). In virtual motherhood, there is a reciprocal relationship between the HIV "redefined motherhood"—the "redefining of treatment" and "eternal motherhood" and "protective motherhood"—"defensive motherhood" and virtual identify" (p. 475). From such examples we can see that metasynthesis is more than a summary of the findings of numerous studies—it is also a re-analysis and reconceptualization.

Identifying interventions (Level 8)

Identifying interventions in qualitative inquiry is difficult, as the interventions themselves are tangled with the descriptions, the context, and the concept. The event is not usually linear, and the outcome of the intervention may be tangled with the preconditions and the intervention itself. Even more difficult, qualitative researchers are working with small samples, purposefully selected, while managing their own perceptions; hence they are subject to all the accusations that come with poor design and bias. Qualitative design does not intend to prove, so results are not definitive.

In this context, when seeking interventions, the researcher must be well integrated into the topic, including both qualitative research and research in the library. One such program of research is Joanne Hall's research into women who have experienced abuse. She writes convincingly that it is possible that women who have been sexually abused as children could

develop an insight that allowed them to believe in themselves enough to recover and become responsible, productive and successful adults (Hall et al., 2009; Hall, 2011). To use narrative methods with such conviction that Hall says it is possible they could spearhead change gives credence to qualitative inquiry. Such change in focus is the most difficult type of change—for it works not by changing policy or rules—but by instigating change of the attitudes deep within others. This is the most important outcome we can ever hope for our research.

Working vertically through most of the levels

Usually developing change from research takes time. One of the first qualitative nursing researchers was Jeanne Quint Benoliel, the first doctoral student at UCSF, supervised by Glaser and Strauss, who became a pioneer in palliative care, and conducted studies within Levels 2 to 4 in death and dying, mainly caring for the dying and their family. She conducted studies for almost 40 years, with her dissertation, *The Nurse and the Dying Patient* (Quint, 1967), her first major qualitative research contribution. She continued to conduct qualitative studies of dying for the next 40 years— studies from the patients', the families' and the nurses' perspective, studies of societal values and norms about death, the ethics of practices surrounding dying, and of loss and bereavement, and her bibliography appears with a tribute to her in *Qualitative Health Research* (Stern, 2012).

How important is her research? Today, in 2012, we argue constantly about the efficacy and impact of research, focusing on impact and outcomes, and with statistics proving effectiveness. But for qualitative studies we do not usually have anything to measure statistically. Yet, although we cannot demonstrate effectiveness, this does not mean that our research is not effective or important. We will let Yale University, who recognized it with an honorary degree, a Doctor of Medical Science in 2002, speak to the effectiveness and impact of Jeanne Quint Benoliel's qualitative research program. The citation from Yale University reads:

> Through your pioneering studies of death and dying, you have helped society understand that death is a part of life. Your work has shown us the value of providing community-based care to those who are dying and the value of comfort when the body will not heal. With an influence felt world-wide, you have encouraged the inclusion of the family in caring for the dying, and you have advocated support and care for the bereaved.
>
> *(Honorary Degrees, Yale Bulletin and Calendar, 2002)*

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3

Building on "grab," attending to "fit," and being prepared to "modify"

How grounded theory "works" to guide a health intervention for abused women

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Grounded theories have unique potential for influencing clinical practice. The theory has *grab* (Glaser, 1978); it resonates for those who have experienced the situation that the theory explains, or know or practice with those who have. Because grounded theories can explain, interpret, and predict human behavior in specific social contexts, they *work* and have practical utility (Glaser, 1978). A fundamental premise of grounded theory research is that people actively shape the worlds they live in through the process of symbolic interaction and that their viewpoints are vital to generating useful knowledge of process, interaction and social change (Glaser, 1992; Strauss, 1987). "Nursing is a practice discipline whose essence lies in processes" (Stern & Pyles, 1986, p. 1). For clinicians, the theoretical rendering of what is most problematic in the study situation and how it is processed by participants offers insights into how and when a clinician might intervene. Thus grounded theory lends itself to conceptual utilization, that is, a rethinking of situational phenomena that may or may not lead to change in action (Estabrooks, 2001). Indeed, the effects of grounded theories on nursing practice appear to have been minor (Hall & May, 2001; Morse, Penrod, & Hupcey, 2000). Poor uptake is not a problem specific to research evidence with qualitative origin (Estabrooks, 2001). However, translation of grounded theories by researchers is essential to facilitate their utilization in concrete applications such as clinical protocols, decision trees or practice guidelines (Estabrooks, 2001; Sandelowski, 2004). Little has been written about how such purposeful translation takes place. Yet, as Thorne (2011) reminds us, nurses need to understand phenomena "in a way that will be applicable to the diversity of context and complexity within the actual real-time setting" (p. 449). Thorne calls upon researchers to mobilize research toward "meaningful social and pragmatic action" (p. 450). Importantly, with grounded theory, the work of knowledge translation not only makes the theory more accessible to practitioners; it also has potential to add breadth and depth to the original theory through the constant comparative process with multiple sources of new data. In this chapter, we discuss the processes, challenges and advantages of translating our theory Strengthening Capacity to Limit Intrusion (SCLI) (Ford-Gilboe, Wuest, & Merritt-Gray, 2005; Wuest, Ford-Gilboe, Merritt-Gray, & Berman, 2003) into

a primary health care intervention, the Intervention for Health Enhancement After Leaving (iHEAL) (Ford-Gilboe, Merritt-Gray, Varcoe, & Wuest, 2011), and conducting initial feasibility studies using the iHEAL with women who have left their abusive partners in the past three years.

Background

Grounded theory is distinctive among qualitative research methods in that its goal is the development of substantive theory, that is, theory that accounts for a human behavior within a particular social context (Glaser, 1978; Glaser & Strauss, 1967).[1] Through constant comparative analysis of data from interviews, observations, documents and/or images, researchers conceptually construct what is most problematic and the social-psychological process by which the problem is addressed. The analytic outcome goes beyond descriptive themes or the recounting of individual narratives to the articulation of a theoretical scheme in which key concepts are identified and defined, and the relationships among them delineated. While some grounded theories are reported in terms of a core category, more commonly they are written as basic social psychological processes (BSP), that is, a core category with at least two sequential stages. Vital to their usefulness is the naming of factors or conditions that influence variation in the core category or BSP, not just by their presence or absence, but also by their degree or intensity (Wuest, 2012). Conditions that influence variation are diverse and may include individual attributes such as age or family history, relational factors such as conflict, support, services and resources, and/or structural influences such as poverty or discrimination. Thus, a grounded theory is a substantive theory that accounts for the heterogeneity in how a basic social process unfolds for individual people in different contexts and suggests possibilities for action that previously may have been invisible (Glaser, 1978; Swanson, 2001). Substantive theory helps us transcend our finite grasp of the specific through its potential transferability to other situations (Glaser, 1978). "Analytic generalization and theoretical transferability are the bases for utility in grounded theory research" (Sandelowski, 2004, p. 1371).

The theory of Strengthening Capacity to Limit Intrusion (SCLI)

In our program of research focusing on women's health after leaving an abusive partner, we conducted a grounded theory study of family health promotion after separation from an abusive partner and developed the theory of Strengthening Capacity to Limit Intrusion (SCLI) (Ford-Gilboe et al., 2005; Wuest et al., 2003). We used a feminist grounded theory approach (Wuest, 1995; Wuest & Merritt-Gray, 2001) and analyzed repeat interview data from 40 mothers, ages 22–48 ($M = 36$) and 11 of their children. The families had been living separately from the abusive partners on average just under four years (range 1–20). As we coded and constructed provisional conceptual categories and the relationships among them, we shared our findings with the women during their second or third interviews, seeking their feedback for modification and confirmation of our emerging theoretical schema. In this way, we identified that the core problem related to health promotion for the families under study was *intrusion*, that is "external control or interference that demands attention, diverts energy away from family priorities and limits choices" (Ford-Gilboe et al., 2005, p. 482). Intrusion stems from ongoing abuse and harassment from the ex-partner (frequently exacerbated by child custody and access issues), physical and mental health problems of women and their children, the "costs" of seeking help (for example, measuring up to criteria imposed by policies, increased surveillance by income assistance workers or family members), and negative changes to daily life (Wuest et al., 2003). Leaving an abusive partner is a risk-taking act to position the family for a better future. However, increasing intrusion after

leaving forces families to focus on promoting health by creating stability in day-to-day survival. As stability is achieved, women are able to focus again on positioning for the future, an act which may lead in turn to increased intrusion.

Families spontaneously engaged in the process of SCLI in four ways: (1) providing; (2) rebuilding security; (3) renewing self; and (4) regenerating family (Ford-Gilboe et al., 2005). *Providing* involves meeting basic needs of income, housing, personal energy, food, childcare, recreation, transportation, medication and relief from symptoms. *Rebuilding security* includes safeguarding from threats to physical and emotional safety and cautious connecting with family, friends, services and the larger community. *Renewing self* refers to the process of developing personal capacity to make their personal needs a priority, make sense of the past, consider who they are and who they want to be, and find comfort and relief from day-to-day intrusions and distress. *Regenerating family* entails developing a family storyline to explain their past, increasing predictability in day-to-day life, and naming and using new standards for relationships. Within these sub-processes, the health promotion focus for women shifts from positioning for the future to surviving and back again according to the degree of intrusion the family is experiencing.

Significantly, when we shared the emerging theory with women, they readily connected with the grounded theory conceptualization and offered further data to help refine the theory. Similarly, the theory had grab for other researchers, clinicians, and other helpers. As we presented our work in the community, at professional conferences and in peer-reviewed papers, we discussed the implications of the theory for practice, largely at a level of "conceptual utilization" (Estabrooks, 2001). The theory shaped how we understood women's experiences of leaving and how we individually interacted with women with abuse histories. At the same time, the identification of intrusion from ongoing physical and mental health problems related to abuse helped us to recognize that, despite the dominant belief that leaving an abusive partner is the solution for abused women, little was known about the trajectory of women's health after leaving abusive partners. To address this gap, we conducted a four-year longitudinal study examining changes in women's resources and health after separation from an abusive partner, the Women's Health Effects Study (WHES). Annually, 309 Canadian women who had left abusive partners in the previous three years took part in structured interviews and health assessments (Ford-Gilboe et al., 2009). Baseline data revealed that the women (who had been separated on average 20 months) had significantly poorer physical and mental health and higher rates of service use than Canadian women of similar age with little relief from their symptoms, and that the annual health system costs attributable to violence were approximately $4,969.79 per woman (Ford-Gilboe et al., 2009; Scott-Storey, Wuest, & Ford-Gilboe, 2009; Varcoe et al., 2011; Wuest et al., 2007, 2008, 2009, 2010).

These quantitative results were useful as comparative data for further development of our grounded theory, particularly to expand the concept of intrusion from physical and mental health problems, "costs" of seeking help, ongoing abuse and harassment, and changes in lifestyle (for example, forced moves, income disruption). Despite the lack of attention to constant comparison with quantitative data in grounded theory scholarship today, Glaser and Strauss (1967) asserted that both quantitative and qualitative data are useful, and sometimes necessary, for the generation of grounded theory through constant comparative analysis. Although the WHES was not a grounded theory study, we found the WHES data to be an important source of secondary data for theoretical sampling, that is, purposefully choosing data for comparison in order to augment the original SCLI theory through the refinement of the properties of concepts and the relationships among them (Glaser, 1978).

Our grounded theory and the WHES findings, along with the dearth of existing health interventions for women after leaving, demonstrated the urgent need to develop a community

health intervention specifically designed to assist women who had experienced the trauma of abuse to promote their health (Ford-Gilboe et al., 2011). This compelling evidence also helped us to garner financial support and partnerships from funding agencies and decision-makers to develop and examine the feasibility of a health intervention for women after leaving. The theory of Strengthening Capacity to Limit Intrusion was the logical starting point for health intervention development.[2] The scope of the theory provides evidence that survivor health is socially determined. Thus, we decided to design the iHEAL to be delivered collaboratively by a nurse and a domestic violence worker. Based on the SCLI theory, we agreed that the aims of the intervention would be to improve women's health and quality of life after leaving an abusive partner: (1) by reducing intrusion; and (2) by enhancing women's capacity (knowledge, skills, and resources) to limit intrusion (Ford-Gilboe et al., 2011).

Processes and challenges in developing the intervention

Our theory captures the central pattern of health promotion behavior in mother-headed, single-parent families after leaving an abusive male partner, and its consequences (Ford-Gilboe et al., 2005). Importantly, this theoretical rendering captures the naturally occurring and intuitive actions taken by diverse women and their children to strengthen their capacity to manage intrusion at different points in time after leaving, and consolidates the lessons learned from them. A key intervention principle of the iHEAL is that

> women's own experiences of leaving an abusive partner and those of other women, as reflected in the theory of strengthening capacity to limit intrusion, will be a key source of knowledge to help women reflect on, reframe, and name their experiences, concerns, and priorities.
>
> *(Ford-Gilboe et al., 2011, p. 203)*

This principle draws on what Estabrooks (2001) called the persuasive power of research evidence which is akin to Glaser's (1978) *grab*. Stories of others' experiences are important "in evoking, persuading, and provoking; in promoting empathetic, feeling or visceral understandings of the people and events; in moving listeners and readers to act" (Sandelowski, 2004, p. 1373). Grounded theories, because they frequently focus on aspects of human experience that have received little attention, can help to mitigate feelings of isolation and alienation.

The theory, however, is more than individual stories; it captures a pattern of survivors' personal and social behaviors in terms of antecedents, consequences, and influencing factors. The theory then has potential to resonate with women's disparate experiences in different contexts, and to permit diverse women to name their experiences and see new possibilities for limiting intrusion, leading to better health. The SCLI theory presents what women do, with and without help from others, highlighting how contextual factors limit or enable women's growth. Although this theoretical scaffold directs clinicians to draw upon and augment women's expert knowledge and skills in supporting them to strengthen their capacity to limit intrusion, a limitation of the SCLI theory is that it *does not* explicitly explain *how* clinicians might do this. In short, it is not a theoretical construction of how to practice. However, the theory's concepts and the relationships among them can shape the underlying philosophical assumptions and practice principles for an intervention. Further, the process of Strengthening Capacity to Limit Intrusion provides direction for the intervention's structure. Just as the original grounded theory was generated, so the iHEAL was constructed in a series of reflective, strategic, iterative choices about which aspects of the theory should be highlighted in the context of our agenda to improve women's health. The

discussion that follows is a reconstruction of key challenges and processes in moving from theory to intervention, from our initial attempts to create a rough outline of goals, components and potential outcomes of the intervention (Ford-Gilboe, Wuest, Varcoe, & Merritt-Gray, 2006) to a more complete rendering some four years later (Ford-Gilboe et al., 2011). As with most retrospective accounts, our discussion reflects a more organized, conscious, and polished process of intervention development than was actually the case. It does not fully capture our false starts, dead ends, and stumbling steps in developing the iHEAL.

Theoretical sensitivity, constant comparison and emergent fit: naming underlying philosophical assumptions and principles of practice

Grounded theory analysis is informed by theoretical sensitivity, that is, the researcher's capacity to use knowledge of theoretical constructions from many disciplines as well as personal and vicarious experiences as a basis for constructing concepts and the relationships between them (Glaser, 1978). Theoretical sensitivity does not drive theory construction but it does open the researcher to theoretical possibilities that are then checked out and refined through theoretical sampling and constant comparison (Wuest, 2012). The philosophical assumptions delineated for the iHEAL reflect the shared perspectives and values that underpinned our program of research (Ford-Gilboe et al., 2011). Our theoretical sensitivity in the grounded theory research that generated the SCLI theory was informed by diverse philosophical assumptions, including a feminist viewpoint of intimate partner violence (Varcoe, 1996), health promotion as a process of enabling people to increase control over and improve their health (World Health Organization (WHO), 1986), health as socially determined (Health Canada, n.d.), and primary health care (WHO, 1978). This sensitivity influenced our theory construction; for example, it enhanced our ability to see women's agency, our recognition of women's health promotion taking place on social, relational and individual levels, and how we theorized "costs" of seeking help. As we scrutinized the theory with practice in view, we quickly identified the applicability of these assumptions for our health intervention, with women's health being socially determined and primary health care being key (Ford-Gilboe et al., 2011).

Some other key assumptions were named much later when the structure of the intervention and activities for the interventionists were under development. Drawing on our theoretical sensitivity, we progressively became aware that some existing expert practice philosophies *fit* with the theoretical scaffold of the iHEAL such as harm reduction (Pauly, 2008), cultural safety (Browne et al., 2009), and trauma-informed care (Elliot, Bjelajac, Fallot, Markoff, & Reed, 2005). In grounded theory, categories are inductively developed through substantive coding and constant comparison such that the category *fits* the data (Glaser, 1978). But not all categories must be new. Emergent fit refers to using constant comparison between pre-existing categories and the data to determine whether it fits the data (Glaser, 1978; Wuest, 2000). Using a process of emergent fit between the practice implications of data from both the SCLI theory as well as the WHES findings and expert practice philosophies, we identified philosophical assumptions true to our theoretical conceptualization and reflective of expert practice beliefs. One example of emergent fit is incorporation of harm reduction (Pauly, 2008) as an underlying philosophical assumption that aligned well with the processes in the theory of SCLI.

Our grounded theory process of *renewing self* conceptualizes how women, relieved from the oppression of abuse, initially relished *living free*, that is, finding release in a wide range of activities, some of which were potentially harmful such as substance use, extensive partying, overinvestment in children or work, and hasty connecting in new relationships (Ford-Gilboe et al., 2005). Most also continued to use some previously learned strategies to find comfort from the trauma of abuse

such as smoking, working long hours, eating, sleeping, or using drugs and alcohol. These theoretical findings were supported by the WHES study's findings; of 309 women, at baseline, 44% smoked and 53% were overweight or obese. In the previous 12 months, 27% had used street drugs, 16% overused prescription medication (Wuest et al., 2008) and 26% screened positive for potential high-risk drinking. Just over 3% reported having a sexually transmitted infection in the past month. However, our grounded theory findings also showed that as intrusion levels settled, women found that despite *living free*, they did not feel happy or satisfied and began to position for the future by engaging in the work associated with *living better* (Ford-Gilboe et al., 2005). One way of living better was to begin intentionally to take better care of themselves. The process of *living better* was facilitated by formal and informal support that focused on fortifying women and avoided undermining their dreams. Harm reduction is an intervention philosophy that focuses on engaging non-judgmentally and respectfully with people to help them find ways that they can be safer, healthier and more in control while risk-taking (Pauly, 2008). Our theoretical sensitivity to harm reduction initiated constant comparison with our data for emergent fit. Through constant comparison, we identified harm reduction to be a congruent and important philosophical orientation for supporting women whether they were *living free* or working on *living better*. By making the assumption that risky behaviors are a rational and purposeful response to the trauma and aftermath of abuse, and focusing on supporting women to reduce the health and social harms of such behaviors, we incorporated harm reduction as a key philosophical underpinning of the iHEAL (Ford-Gilboe et al., 2011).

Principles of practice

We also developed intervention principles for the iHEAL, that is, key guidelines to ensure that the intervention built on the practice implications of the theory. For each previous publication and presentation of the theory, we had carefully scrutinized and reflected on the theory, considering particularly how practicing from this theoretical base might differ from "usual" nursing practice. Collectively, we reflected and discussed and argued about meaning for practice over time as we did this scholarly work together and used it to inform our policy work related to the grounded theory and the Women's Health Effects Study. Developing the iHEAL, however, pushed our thinking to another level as we considered how we might articulate interventionist approaches based on the SCLI theory. Although we had worked together successfully for more than ten years, and shared many common values, this exercise made visible differing viewpoints. Notably, individual commitments to the Developmental Model of Health and Nursing (Allen & Warner, 2002) and relational inquiry (Doane &Varcoe, 2005) required intense and lengthy discussion regarding how these nursing approaches might *fit* with the SCLI theory. As well, because the intervention was being developed for delivery by nurses and domestic violence advocates, current best practices in domestic violence advocacy also were considered. Gradually we realized that rather than choosing an existing practice model or philosophy to guide the iHEAL, we needed a set of general practice principles that would fit with our shared assumptions and the theory of SCLI, and would guide practice by both nurses and advocates.

Some principles were identified readily. Principles such as the intervention being women-centered, that is "women will direct the pace, what is given priority and who is involved," and strengths-based, that is "women's strengths and capacities will be recognized, drawn upon, and further developed" (Ford-Gilboe et al., 2011, p. 203) reflected not only our own philosophies of nursing practice but also best practices in the domestic violence intervention sector. Other support for the latter principle stemmed from the SCLI theory demonstrating that survivors habitually had their deficits reinforced by ex-partners, other family members, and helping