The family theory–practice gap: a matter of clarity?

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Despite recognition of the importance of family in health-care and progress in family theory development, there has been limited transfer of family theory to acute care nursing practice. We argue that this family theory–practice gap results from a persistent lack of conceptual clarity in family nursing and other barriers. Lack of conceptual clarity takes the form of conceptual overlap and semantic inconsistency, as well as the complexity of language found in the family nursing literature. Barriers include practice contexts, relational problems, and knowledge types. Our exploration begins with a brief discussion of the intimate link between nursing theory and practice followed by an overview of some issues associated with the family nursing theory–practice gap. Based on a synthesis of family nursing literature, problems associated with conceptual clarity in family nursing theory are explored. We conclude with recommendations for family nursing research to develop concepts grounded in nursing practice.

Key words: family, nursing, practice, theory.

Notwithstanding the belief that family as a unit of care has always been a focus of nursing (Whall 1999; Friedman, Bowden and Jones 2003), the need for nurses to ensure that their focus of care includes family has never been greater. This renewed emphasis on family nursing has resulted, in part, from acknowledgment of the increased complexity of contemporary families and the reciprocal influence of families’ health/illness status on family members (Wright, Watson and Bell 1996; Wright and Leahey 2000; Friedman, Bowden and Jones 2003). Consequently, there has been a proliferation in family nursing literature, educational programs, and family nursing research aimed at incorporating family theory in practice (Vosburgh and Simpson 1993).

Despite efforts aimed at promoting family nursing, it has been observed that limited progress in the transfer of family nursing theory to clinical nursing practice has occurred. According to Friedman, Bowden and Jones (2003, xix), although family nursing should ideally be practiced in all areas of nursing, ‘it is well recognized that a considerable gap exists between the ideal (what ought to be) and the real (the actual practice of nursing today)’. In many clinical settings family nursing has not been visible or has developed slowly (Duhamel 1995).

While it is acknowledged that a variety of complex issues may be contributing to the growing divide between family theory and practice, we argue that it is a persistent lack of conceptual clarity in family nursing theory that is most troublesome. Confusion about concepts associated with family, family nursing, and health complicate communication about theory and implementation of theory (Denham 2003). Indeed, in our opinion, the lack of conceptual clarity, the degree of conceptual overlap, the level of semantic inconsistency, and the complexity of the language used in the literature, renders conceptual understanding virtually inaccessible to the general nursing population. It follows that nurses will experience misunderstanding, misinterpretation, confusion, and frustration when discussing family nursing theory or implementing family nursing theory in practice.
Our primary goal is to explore the conceptual clarity associated with family theory and the resulting family theory–practice gap, as well as to identify directions for future research aimed at bridging or closing the gap. We begin with a brief discussion of the intimate link between nursing theory and practice followed by an overview of some of the problems associated with the family nursing theory–practice gap. Based on a synthesis of family nursing literature, we discuss problems associated with conceptual clarity in extant family nursing theory and, based on those problems, we recommend new directions for nursing research.

THE RELATIONSHIP BETWEEN THEORY AND PRACTICE IN NURSING

Numerous definitions of theory have been articulated and each is dependent on the particular philosophical stance or perspective of the author. While the descriptive and explanatory properties of theory are sometimes emphasized, most definitions also stress a theory’s predictive nature or the extent to which the theory projects circumstances that create or alter a phenomenon (Chinn and Kramer 1999). Chinn and Jacobs (1997, 452), for example, define theory as ‘an internally consistent body of relational statements about phenomena, which is useful for prediction and control’. Those phenomena are, in part, the concept(s) or ‘building block(s)’ upon which the theory is based. Concepts designate, characterize or categorize selected properties of objects as well as dimensions or attributes of reality that are of interest (Hardy 1997b).

While conceptual meaning has always been important in theory development, emphasis has also been placed on the need for greater precision in defining and/or clarifying theoretical concepts. Indeed, conceptual clarity is critical to the process of providing a symbolic or abstract way of referring to empirical reality, and promoting organization of experience and communication about that experience (Jacox 1997; Rodgers 1989). When conceptual definitions are unclear, it is difficult to identify an example of the concept or distinguish it from other concepts that might be similar or related (Rodgers 1989; Chinn and Kramer 1999). Conceptual ambiguity and obscurity therefore can encourage individual interpretation and improvisation that undermines conceptual meaning.

Because theory is also defined, indeed evaluated, by its ability to predict and control the phenomena of interest, theory must be useful for predicting certain processes and controlling events to achieve desired outcomes (Hardy 1997b). Dickoff and James (1997) argued that a theory is in fact ‘invented’ for some purpose. A theory that fulfills the purpose for which it is intended is considered to be true or valid.

Although the exact nature and utility of theory remains a point of considerable debate, typically, nursing theory is linked to its ability to guide practice. In other words, the significance or value associated with theory is based primarily on its relevance, applicability and adaptability to practice realities; (Hardy 1997a; Chinn and Kramer 1999). Theory and practice therefore are considered inseparable entities as opposed to individual, isolated notions (Upton 1999).

If nursing theory is produced primarily for the purpose of guiding practice, it would follow that the practice environment offers opportunities to test the utility and relevance of theory ( Vaughan-Cole 1998). Although the process of linking theoretical concepts with empirical indicators in practice is critical to theory validation (Morse and Field 1995; Chinn and Kramer 1999; Upton 1999), it is problematic when a lack of empirical evidence results in the conclusion that the theory is not relevant to the practice world. If theoretical concepts are not clearly defined and their links to each other are not clearly articulated, family nursing theory will lack the components that are necessary for empirical testing and validation in clinical practice.

THE FAMILY NURSING THEOREY–PRACTICE GAP

The notion that theory is accessible and has some explanatory power is critical to its ability to contribute to valid goals in practice (Morse and Field 1995; Chinn and Kramer 1999). Without semantic and structural conceptual clarity and consistency and theoretical parsimony, family theory will not hold any meaning for, or relationship with practice. Family theory that is perceived to have limited utility in practice is what is referred to here as the family theory–practice gap.

The lack of ability to incorporate theory in nursing practice is often regarded as the main crux of the theory–practice gap phenomenon; several reasons account for this problem. One reason is that practice can fail to live up to theory (Allmark 1995). For example, in many acute-care settings ritualistic nursing practice that excludes families and focuses on individuals persists, despite developments in theory and research. Relational problems that exist most commonly between nursing scholars and practitioners can be another reason. Specifically, relational problems refer to a ‘hierarchical split’ between ‘knowledge generators’ (those who hand down their theories, models and research findings), and ‘knowledge appliers’ (usually practicing nurses) (Rolfe 1998). A third reason is that theory and practice
constitute distinctly different types of knowledge (Allmark 1995).

In relation to ritualistic nursing practice, Anham and Johnson (2000) refer to the persistent influence of the medical/bio-ethical model that focuses on the individual patient as the primary, if not sole focus of concern and care. While an individualistic, bio-medical model of care can interfere with family nursing in practice settings, that effect could be countered by applying theory about family to practice. However, if family theory lacks semantic and structural conceptual clarity and consistency, it will convey little meaning to nurses and fail to provide the practical guidance necessary to compete with the current model. Consequently, the status quo will prevail.

Several authors also propose that extant family theory may not adequately address or account for contextual factors that could have the potential to promote nurses’ ritualistic actions. These include lack of time, institutional routines, and restrictions on family visiting and care (Wright and Leahey 1999; Galvin et al. 2000; Levine and Zuckerman 2000; Wright and Leahey 2000). Such contextual factors can also promote the status quo by constraining nurses’ efforts to include families in care. Ritualistic practice is also more likely to occur in the absence of understanding about the nature of the nurse–family relationship as it develops and evolves in clinical practice (Bell 1995; Vaughan-Cole 1998; Denham 2003). Vaughan-Cole (1998, 29) for example, writes: ‘Although many nursing textbooks present family theory or family nursing care approaches, only a few nurses have attempted to write about the interface of nurses and families in clinical practice.’ Requesting nurses to change their practice is problematic when processes of interaction between nurses and families have not been described or examined in any detail.

Relational problems imply a unidirectional flow of theory down to practice, with academics suggesting that practitioners lack awareness of research findings and/or implement them incorrectly (Rolfe 1998). Although lack of theory uptake may be related to a lack of awareness and/or incorrect implementation of theory on the part of practicing nurses, many authors are quick to point out that this situation is more likely the fault of those who generate and disseminate theory. Rolfe (1998, 1317) aptly captures this stance when he writes:

Few academics stop to consider that perhaps the theory–practice gap is a result not of the failure of nurses to put theory into practice, but of the inadequacy of the theory itself; that perhaps theoreticians are out of touch with the needs and realities of clinical practice and are generating theories and models which either have no relevance to practicing nurses, or else which are impossible to translate to practice.

Explanations as to why theory lacks relevance in practice are plentiful within the nursing and family nursing literature. Hewison and Wildman (1996), for example, argue that the theory–practice gap is linked to the fact that theory (that which nurses are taught in school) bears little relationship with that which is experienced in practice thus rendering theory meaningless in the practice realm.

Although theory may be deemed ‘meaningless’ (lacking function) on the basis that it fails to work within the realities of practice, theory may also be judged as lacking relevance and utility in practice because it holds little or no meaning. In other words, theory implementation may be limited due to nurses’ inability to comprehend or discern the meaning of theoretical concepts and subconcepts associated with family nursing, and therefore to determine how they might fit with practice.

Part of the problem associated with meaning may be that theory and practice constitute distinctly different types of knowledge (Allmark 1995). Theory, with its descriptive and explanatory properties, typically translates to normative statements reflecting nursing as it ought to be to achieve a particular outcome. Academics are generally interested in normative statements and may not consider the implications of gaps between those statements and practice realities. Knowledge associated with practice is linked to understanding ‘nursing as it is’ (Upton 1999), and many important practices are developed in the absence of theory or resist explanation. One’s knowledge of theory therefore may not necessarily yield good practice and good practice may not necessarily occur in the absence of theory. According to Allmark (1995), understanding is paramount, not theoretical knowledge; in fact, understanding precedes explanation. We argue that in order to reduce or resolve the family theory–practice gap, knowledge must not only reflect but also convey an understanding of the intimate and reciprocal link between nursing as it is and nursing as it ought to be. Consequently, efforts to promote family nursing in practice would be enhanced by theory that emerges from practice and, as such, resonates with those for whom the theory is intended.

The family theory–practice gap is also associated with a lack of conceptual clarity in family nursing theory. To date much of the family nursing literature has been based on research rather than practice. In other words, extant theory is driven by knowledge gained formally through constructs (the pre-existing ideas of others) as opposed to experiential knowledge gained through doing (Bell 1995; Hayes 1997). The lack of linkages among published research, theory, and family nursing practice can leave practicing nurses with piecemeal understandings of family nursing and a lack of
consistent direction for focusing their family interactions (Hayes 1997).

Adding to the confusion and lack of direction is the fact that multiple definitions and conceptualizations of family can be found across the nursing and family nursing literature and there is little agreement about what family nursing actually encompasses. Indeed, defining family as the unit of analysis remains one of the most problematic areas of family nursing research (Ganong 1995). Theoretical explanations that are accessible are frequently characterized by obscure, complex language and conceptual overlap, which makes achieving common understanding within practice difficult. Structural-functional theorists, for example, define family as an open, sociocultural system and focus on interactional patterns within and between families and other social systems as they strive to adapt to environmental demands (Hanson and Kaakinen 2001; Friedman, Bowden and Jones 2003). Systems theorists describe family as a hierarchy of systems and emphasize the importance of interactive and reciprocal processes among systems within the whole family (Wright and Leahey 1991, 2000). Family developmental theorists view families as unique, open, and dynamic systems that engage in interactive processes with progress indicated by identifiable markers over time (Vaughan-Cole 1998; Hanson and Kaakinen 2001; Friedman et al. 2003). When communicating about such theories, authors, policymakers, educators, and healthcare providers often slide between definitions of family without noting differences resulting in oblique and unclear ideas (Denham 2003). We now provide a more detailed discussion of the lack of conceptual clarity in family nursing theory.

THE CONCEPT OF FAMILY

Family nursing is based on groups of concepts, principles, assumptions and hypotheses that converge into three dominant theoretical conceptualizations and practice models or frameworks of family. These are namely family as context/ family-centered care; family as unit/family nursing; and family system theory/family systems nursing (Vaughan-Cole 1998; Wright and Leahey 2000).

Family as context

Using family as context is regarded as providing nursing care in the context of family. Therefore, care is primarily directed toward individual patients with families viewed as a patient’s most important resource (Newton 2000; Friedman et al. 2003). According to Friedman et al. (2003), the family, although sometimes viewed as a stressor, is generally considered central to the individual’s overall well-being; therefore, nurses tend to involve the family in their care to varying degrees. Questions that continue to generate considerable debate around using the family as the context of care in practice include, By what means do nurses determine how and to what degree family ought to be involved in care? Under what conditions might a nurse involve or not involve family in care? Do nurses have control over decisions to involve families in their care? How is family involvement in care inhibited or facilitated in acute care settings?

Family as context is typically operationalized in family-centered care models of practice. In those models, family education and support are identified as important factors in promoting and maintaining ‘healthy’ families and children. Families are also recognized as an important resource in the care of children and more recently in the care of patients of all ages (Anham and Johnson 2000). As Hutchfield (1999) argues, currently there is no consensus about the meaning of family-centered care. Descriptions of family-centered care illustrate the lack of consensus in the literature about the concept.

Anham (1994) describes family-centered care as a philosophy that calls for partnerships between parents and professionals that support parents in their central caring roles. Newton (2000) defines family-centered care as a view that respects and values the expertise and strengths of the family in caring for a child. Gedaly Duff and Heims (2001) describe five principles of family-centered care that include such subconcepts as: recognizing families as constants in the lives of children; sharing of information with families; partnering by professionals with families; respecting family diversity; and supporting and strengthening families’ abilities to grow and develop.

Each of these descriptions of family-centered care carries a somewhat different view of family (parent(s) to broad descriptions of family); however, some subconcepts from each perspective are similar. These elements include partnership, collaboration, participation and communication. Application of the subconcepts in practice, however, remains problematic and the meaning of each continues to be heavily debated (Gedaly-Duff and Heims 2001). Issues associated with applying such subconcepts to nurses, families, and patients include: role stress, overlapping roles, negotiation failure (secondary to opposing care and treatment views), and power struggles (Levine and Zuckerman 2000; Newton 2000; Ward-Griffin and McKeever 2000).

While most descriptions of family-centered care tend to emphasize the well-being of the individual patient, others imply that family-centered care is a holistic approach to family health by virtue of the fact that nurses interact with and
develop collaborative partnerships with families to benefit the family as a whole (Hutchfield 1999). Glasper (2002, 250), for example, refers to family-centered care as a philosophy of care in which the child and family are perceived as an indivisible unit. These holistic perspectives aim to shift the focus of care to all family members—a view easily confused with the concept of family as unit of care and the family system model.

**Family as the object of interest**

Confusion arising from the myriad ways in which family is defined is compounded by various descriptions: family as unit (Wright and Leahey 1991); family as client (Friedman et al. 2003); family group (Robinson 1995a, 1995b); and family as domains of human action and experience (Hartrick and Lindsay 1995). Each of these perspectives will be discussed in terms of their descriptors.

According to Friedman et al. (2003, 37), when family is considered the client, the entire family becomes the focus of assessment and care. These authors state that ‘the family is now in the foreground, while the individual family member is the background or context. The family is viewed as an interactional system’.

While it could be argued that their description is an attempt to combine two somewhat contradictory theoretical conceptualizations of family (family as focus with individual as context vs. focus on the whole family), opposing philosophical perspectives in terms of parts vs. wholes drive the views. How can a family be viewed as a ‘whole’ interactional system when one of its members is in the background? How would a nurse work with that description of family in an acute care setting where care priorities are directed at the ill patient?

Robinson (1995a) prefers the term group rather than unit to describe family. Family group is defined as ‘family is foreground and the individual/family members and their relationships are background’ (Robinson 1995a, 28). In other words, the focus is on the overall attributes of the family group while influence of individuals or patterns of interaction are obscured. What remains unclear, however, is what attributes of the family group are of concern or interest? Moreover, how can a family be defined in the absence of relationships? Are the relationships between and among family members not a family attribute and are they not central to the notion of a family as a group?

The lack of emphasis on family interaction described above stands in sharp contrast to the view of family as client, which is described as an interactional system by Friedman et al. (2003) and Wright and Leahey (1991). They regard the family as the unit of care (theoretical conceptualization) based on a nursing practice model. According to Wright and Leahey, the family unit is conceptualized as the whole family where ‘concentration is on both the individual and the family simultaneously’ (25). The preceding conceptual definitions of family clearly have areas of overlap. For example, Friedman et al. (2003) and Robinson (1995a) view the individual as in the background, with the major difference being the emphasis or lack thereof on interactional patterns.

Hartrick and Lindsay (1995) describe families as domains of human action and experience with a number of actors who have related and diverse experiences. Hartrick (1995) maintains that acts and imaginings are the soul of the family and that through dialogical relationships with one another family members embrace both attachment to the family and resistance or autonomy as a family member. Family members act and interact, share memories, create new meanings through imagination and share through language. Hartrick places emphasis on family interactions and relationships within the family group. Nurses are to cocreate with family members an understanding of the family’s health and healing experiences (Hartrick 1995). The overlap of Hartrick’s work with other theories is limited, except in terms of interactional patterns; however, nurses could be left with questions about how to proceed if family members are unable to articulate or agree on the nature of their health and healing experiences.

With the conceptual overlap and confusion in the literature, we might correctly or incorrectly conclude that family as client is synonymous with family group, unit and/or system. Such confusion is not uncommon according to Robinson (1995a), who indicates that throughout the literature the word unit, for example, is often used synonymously with group and system although they do not always share the same meaning. According to Chinn and Kramer (1999, 102), theoretical clarity is obscured by excessive verbiage: ‘similar concepts are used interchangeably when one would suffice.’ In other words, when theorists try to communicate subtle distinctions among conceptualizations of family, and use different but related terms, the general meaning of such terms is often assumed and clarity is lost.

**Family as system**

Loss of clarity and confusion about meaning may also result when concepts are inconsistently presented (Chinn and Kramer 1999). Although family systems theory has been identified as one of the most influential of family theory frameworks (Hanson and Kaakinen 2001), implementation in practice has been limited. This is primarily because of the
variation in emphasis placed on parts of families vs. wholes as the focus of care (Robinson 1995a; Vaughan-Cole 1998). Such variation creates difficulties in practice in terms of indicating the client of interest and the interventions that are appropriate.

Central to systems theory in nursing are the concepts of wholes and systems. According to Wright and Leahey (2000), the whole family unit is greater than the sum of its parts. In other words, the family’s ‘wholeness’ is more than simply the addition of each family member. Vaughan-Cole (1998, 23) expresses this idea as: ‘family cannot be subdivided and still remain the same.’ The notion of systems, however, refers to both wholes and parts within the whole in dynamic interaction (Vaughan-Cole 1998). Each part or element of a whole is a system in and of itself—distinct from its environment (Wright and Leahey 2000; Hanson and Kaakinen 2001).

When systems are considered to be both wholes and parts how do nurses decide the focus of nursing care? Artinian (2001) suggests that the family systems perspective guides nursing care toward individual system functioning, family subsystem functioning or whole family functioning. Wright and Leahey (2000) describe the focus of assessment as being more on the interaction among individuals within the family than on the individual. What remains unclear using these perspectives is the difference between more or less focus and subsystem vs. family focus.

To add to the confusion, Wright and Leahey (2000) argue that families are best conceptualized as a hierarchy of systems that include complex individual systems, subsystems (dyads), as well as various larger systems (suprasystems) such as neighborhood, work/school environment. All systems are conceptualized as being in dynamic interaction. Thus, a change in one system causes a change in other systems (Vaughan-Cole 1998; Wright and Leahey 2000). Wright and Leahey maintain that a more comprehensive understanding of family functioning is obtained only when the nurse is able to observe interaction between all family members.

Having all family members present at one time in an acute care setting is a difficult task; however, determining the hierarchy among the complex individual systems and subsystems within a family system would be even more taxing in fast-paced and understaffed acute care settings. On what basis is the hierarchy determined and how is this useful in terms of directing nurses’ focus to the whole family when the notion of hierarchy suggests reducing the family to various classes or ranks of systems? Robinson (1995a, 23) writes:

When persons are distinguished as systems, family becomes part of an amorphous background called context or environment that may be addressed or ignored. When family is the system of interest, persons are conceptualized only at the level of family members, are encompassed by family, and are lower on the hierarchical order.

The view of family as a hierarchy of systems sets up an artificial separation between individuals and families, which Robinson (1995b) refers to as either/or positions that are characterized by competition and exclusion, and that are essentially reductionistic.

Definitions of family associated with systems theory tend to be comprehensive, meaning that families are self-defined and may in fact include individuals outside the traditional legal bonds of marriage, blood and adoption (Leahey et al. 1995; Wright, Watson and Bell 1996; Wright and Leahey 2000; Friedman et al. 2003). In the words of Wright and Leahey (2000), ‘family is who they say they are’. That statement raises a number of questions. What is the practicing nurse to do if each individual family member has a different view of family? Although Wright, Watson and Bell (1996) argue that important beliefs related to family membership are illuminated when individual members are invited to define who constitutes the family, it appears impractical to expect nurses working in acute care settings to gain understanding about such relationships, in the face of high patient acuity and short lengths of stay. Moreover, when providing care to ill family members, whose view of family takes priority? In the face of particular family’s definition of self, what practice and/or administrative factors promote or restrict the nurses’ ability or willingness to honor families’ unique definitions or configurations?

Robinson (1995b) argues that given our current understanding of the recursive, reciprocal link between health, illness, patient (individual) and family, a new definition of nursing practice that is inclusive of both individuals and families is needed. She proposes an alternative framework based on four different views not of family nursing but of nursing — each inclusive of both individuals and family, namely:

1. Nursing of individual/family member where the person is viewed as both separate from and part of family.
2. Nursing of individual/family subgroups where the focus is on relationships within family dyads as well as each individual’s characteristics relevant to the relationship.
3. Nursing of family group that focuses on the characteristics of the whole family.
4. Nursing of individual/family system that is concerned equally with the interactions within and between all family members as well as each family member individually.

Although Robinson (1995b) makes a valiant effort to resolve the dichotomy between individual systems and the family system by offering various pluralistic views of
individuals and family, her proposal is, by her admission, extremely complex and confusing. She suggests that such classifications add complexity and require nurses to deal with boundaries that were formerly viewed as fixed entities and which have become blurred or changed. We ask is the complexity and confusion associated with the blurring of boundaries between individual and family systems limited only to a period of transition? Or is it based on a lack of understanding of the differences associated with subtle shifts of emphasis from individual systems to subsystems to family system? Moreover, if the focus of care in systems nursing varies from individual systems to subsystems, how do those shifts occur in practice and what are the implications of such shifts?

**IMPLICATIONS FOR FAMILY NURSING RESEARCH**

Developments in the conceptualization of family to date have resulted in what Wright and Leahey (2000, 13) refer to as a rich tradition of nursing literature that has enabled a new language to emerge through naming, describing, and communicating about the involvement of families in healthcare. Despite such efforts, concepts necessary to link theory and practice continue to elude us. Family nursing practice has often been reduced to how individual nurses define, interact and work with the families, as well as being defined by practice environments (e.g. unit philosophy and working conditions) (Friedman et al. 2003). Conceptualizations that arise from and are based in discrete practice environments complicate communication about family theory, dilute the notion of family nursing, and further the need for research in family nursing to shift its emphasis from description (theoretical knowledge) to understanding (practice knowledge).

Rodgers (1989) argues that concepts are continually subject to change as they progress through the significance, use, and application stages of concept development. The application phase directs the researcher to seek understanding of conceptual attributes as they have evolved or developed through application. Identifying and examining attributes as they have evolved in discrete practice will promote deeper understanding of concepts grounded in practice and, thus, ongoing conceptual development.

We suggest that research in family nursing must turn its attention to how nurses practice in an effort to gain further understanding about the meaning nurses attribute to ‘family nursing’ and the implications of their views. Given that we have argued that theoretical concepts are not clearly defined and their links to each other are not clearly articulated, developing family nursing theory that is grounded in practice has the potential to produce concepts that are amenable to empirical testing and validation in practice. A change in the way theory is developed requires an examination of nurses’ beliefs and values about family nursing, meanings attributed to experiences with family nursing, and their understanding of contextual and systemic issues that affect their practice with families.

We have suggested that, in many acute care settings, ritualistic nursing practice that excludes families and focuses on individuals persists, despite developments in theory and research. Research that examines contextual features, such as the use of the medical bioethical model and staffing constraints may increase our understanding of the purpose of ritualistic practice and how it affects family nursing. Academics who develop theories, models and research findings and expect practicing nurses to apply such knowledge rarely take into consideration the complexities of relationships with families and patients from nurses’ and clients’ perspectives, as well as nurses’ use of relational and tacit knowledge. Research approaches are necessary that obtain the perspectives of all persons ultimately affected by family nursing — nurses, patients and family members.

Given our arguments that family nursing concepts are lacking in clarity in terms of family identity, focus of care, and treatment outcomes, and are mutually exclusive or overlapping in terms of their emphases, family nursing investigators must turn their attention to how nurses and their clients use or adapt existing language or invent new language about the family as the intended recipient of nursing care.

**CONCLUSION**

Despite growing recognition of the importance of family in healthcare and considerable progress in family theory development, only limited progress in the transfer of family theory to acute care practice has occurred. We conclude that one of the most troublesome reasons for the family theory-practice gap is the persistent lack of conceptual clarity in the family literature. We view family nursing theory as characterized by conceptual overlap, semantic inconsistency and linguistic complexity that neither conveys, nor reflects meaning in relation to the practice domain. In an effort to bridge the gap between family theory and practice, we propose that research about family nursing must shift its focus to illuminating the nature of nurses’ practice with patients and families. Only by understanding the nature of nurses’ approaches to family nursing and the meanings that they attribute to family, which is grounded in the practice realm, will we see clear and meaningful concepts that capture family nursing begin to emerge.
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