

Theoretical Coalescence: A Method to Develop Qualitative Theory

The Example of Enduring

Janice M. Morse

Background: Qualitative research is frequently context bound, lacks generalizability, and is limited in scope.

Objectives: The purpose of this article was to describe a method, theoretical coalescence, that provides a strategy for analyzing complex, high-level concepts and for developing generalizable theory. Theoretical coalescence is a method of theoretical expansion, inductive inquiry, of theory development, that uses data (rather than themes, categories, and published extracts of data) as the primary source for analysis. Here, using the development of the lay concept of enduring as an example, I explore the scientific development of the concept in multiple settings over many projects and link it within the Praxis Theory of Suffering.

Methods: As comprehension emerges when conducting theoretical coalescence, it is essential that raw data from various different situations be available for reinterpretation/reanalysis and comparison to identify the essential features of the concept. The concept is then reconstructed, with additional inquiry that builds description, and evidence is conducted and conceptualized to create a more expansive concept and theory.

Results: By utilizing apparently diverse data sets from different contexts that are linked by certain characteristics, the essential features of the concept emerge. Such inquiry is divergent and less bound by context yet purposeful, logical, and with significant pragmatic implications for practice in nursing and beyond our discipline.

Conclusion: Theoretical coalescence is a means by which qualitative inquiry is broadened to make an impact, to accommodate new theoretical shifts and concepts, and to make qualitative research applied and accessible in new ways.

Key Words: concepts • enduring • midrange theory • qualitative • suffering • theoretical coalescence

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We are proposing a theory of theories that sees theory as a conceptual system invented to some purpose—when seen in its full consequences—has revolutionary possibilities. (Dickoff & James, 1968, p. 203)

The often-cited goal of qualitative inquiry is to develop concepts and theories; yet, to date, qualitative researchers have only partially fulfilled this promise. The concepts developed from qualitative inquiry have been local and specific, and qualitative theories are frequently highly descriptive and context bound, rather than abstract, explanatory, and capable of impacting and guiding nursing practice. As a result, qualitative inquiry has made a relatively minor contribution to nursing knowledge. Furthermore, significant

Janice M. Morse, PhD (Nursing), PhD (Anthropology), FAAN, is Professor and the Barnes Presidential Chair, College of Nursing, University of Utah, Salt Lake City, and is Professor Emeritus, University of Alberta, Canada.

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behavioral concepts that have been broadly adopted into nursing research, such as social support, adherence, or quality of life, have arisen from quantitative inquiry—and have been generally used in nursing. These behavioral concepts have been deliberately introduced to the scientific community concurrently with measurement of the concept. This is important as the concurrent development of an instrument makes the new concept immediately useful for other researchers or clinicians and facilitates the investigation of the concept in other populations or groups. Furthermore, the concept is adopted for clinical assessment and, ultimately, introduced into education.

In general, few qualitative concepts have been introduced and adopted by other researchers. In sociology, Goffman's (1963) work on stigma is one such exception and one that has had a significant impact. Yet, in nursing, the work of qualitative researchers who have made significant contributions is often not listed in nursing theory—or even in basic practice texts. For instance, the foundational work of Jeanne Quint (1967) in care for the dying is not acknowledged in basic palliative care texts (e.g., see Ferrell, Coyle, & Paice, 2015; Matzo & Sherman, 2015).

Granted, the adoption of a theory and the subsequent changes in care takes time. Quantitative researchers have documented an average of 17 years from results to implementation (Green, Ottoson, García, & Hiatt, 2009) and are now deliberately putting effort and resources into decreasing this gap. This is not occurring with qualitative inquiry, and the systematic conduct of inquiry into a selected area by a single investigator (or team) is not usually supported by granting agencies. Qualitative research is often scattered by a lack of systematic funding and slowed by an inadequate funding for qualitative research programs. Articles are published in various journals, cited individually, and often not synthesized. Thus, even if the researcher has brought the inquiry to the level of practice, with few exceptions, impact is diminished.

Impediments to Qualitative Generalization

Several notable characteristics of qualitative inquiry impede its development of mature concepts and theory. Qualitative inquiry is largely conducted as small projects, most frequently as doctoral dissertations. These projects use delimited samples and highly circumscribed topics. The level of conceptualization, abstraction, and scope of these studies is limited. Qualitative research is not usually conducted programmatically. Yet, if it could be incrementally interpreted and conducted stepwise, working toward a larger conceptual goal, then the results would have a far greater impact.

Recent movements to overcome these limitations for qualitative inquiry have been in the development of meta-analysis (McCormick, Rodney, & Varcoe, 2003) and meta-synthesis (Sandelowski & Barroso, 2007)—in which qualitative researchers search the literature to identify similar studies conducted by other investigators and then reanalyze the categories, themes, and concepts, using processes of synthesis (Thorne, 2017). However, as qualitative inquiry does not intentionally replicate the work of others (as such practice violates induction and may compromise the validity of subsequent studies) and the raw data sets from which the original studies were derived are not available to the meta-analytic/synthesis researchers, this work is primarily confirmatory label-smoothing, with limited innovative model or theory building.

In this article, I will:

1. Introduce and justify theoretical coalescence as an approach that overcomes the limitations of scope, generalizability, and restricted abstraction in qualitative studies and the resulting midrange theories; (Morse, 2017a); and
2. Illustrate the methodological strategies of theoretical coalescence using a collection of studies targeting various situations and contexts of enduring (i.e., one of the components of the Praxis Theory of Suffering) to illustrate processes of theoretical coalescence for developing a higher-level concept or theory.

THEORETICAL COALESCENCE

Theoretical coalescence is a method of eliciting data from multiple sources in a research program by supporting a developing

concept and/or fitting concepts to develop midrange theory. Despite the fact that higher-level concepts are not restricted to a single context, in qualitative studies, they are usually treated as context-bound and therefore are limited in application. Although all of the attributes of the concept studied are present in each case, they may appear in different strengths and even occur in different forms within different contexts and uses of the concept (see, e.g., the case of hope; Morse & Doberneck, 1995). By expanding research projects and comparing and contrasting the concept as it is manifested in several contexts, a rich description of the concept is obtained, enabling a higher-level, more abstract description of the concept to be obtained. The concept is more widely recognized and even applied to new situations.

The first theoretical coalescence in nursing was the synthesis of analysis of five grounded theories that each addressed different topics to develop the illness constellation model of cooperative family care (Morse & Johnson, 1991a). Other published examples of theoretical coalescence include traumatic childbirth (Beck, 2015), trust in healthcare relationships in chronic illness (Robinson, 2016), Praxis Theory of Suffering (Morse, 2001, 2011b, 2017b; Morse & Carter, 1996), and Praxis Theory of Comfort (Morse, 2017c).

Here, I use theoretical coalescence to show the maturation of enduring from a lay concept to a scientific concept and apply it within the Praxis Theory of Suffering. I use a program of research exploring suffering to show the unique role and linkages of enduring within the theory. Inquiry proceeds inductively. As enduring was not the focus of the initial studies, briefly, its significance emerged in the comparison of these studies (Figure 1). The method was (a) recognition into the significance of the emerging concept; this new focus then necessitated (b) secondary analysis of the original studies and recoding/reinterpreting these data; next, (c) early theoretical models were developed to locate enduring as a stage within the process of suffering; then, a series of studies were conducted to (d) build evidence about the characteristics, clinical manifestations, and utilization of the concept; and, finally, (e) confirmation of the theory by exploring the theory using alternative research approaches, including a naturalistic experiment, to determine the outcome, if that which was being endured was removed.

METHODS: DEVELOPING ENDURING

At first, when using theoretical coalescence—or even developing a research program in qualitative inquiry—one may complete the task with an unanticipated goal. In this case, in the 1980s, I had a series of master's degree students who conducted excellent grounded theories exploring participants' experiences of illness. Synthesizing their research in 1991 as the Illness Constellation Model (Morse & Johnson, 1991b) began this research trajectory. When developing the Illness Constellation Model, we were struck by the commonalities in the

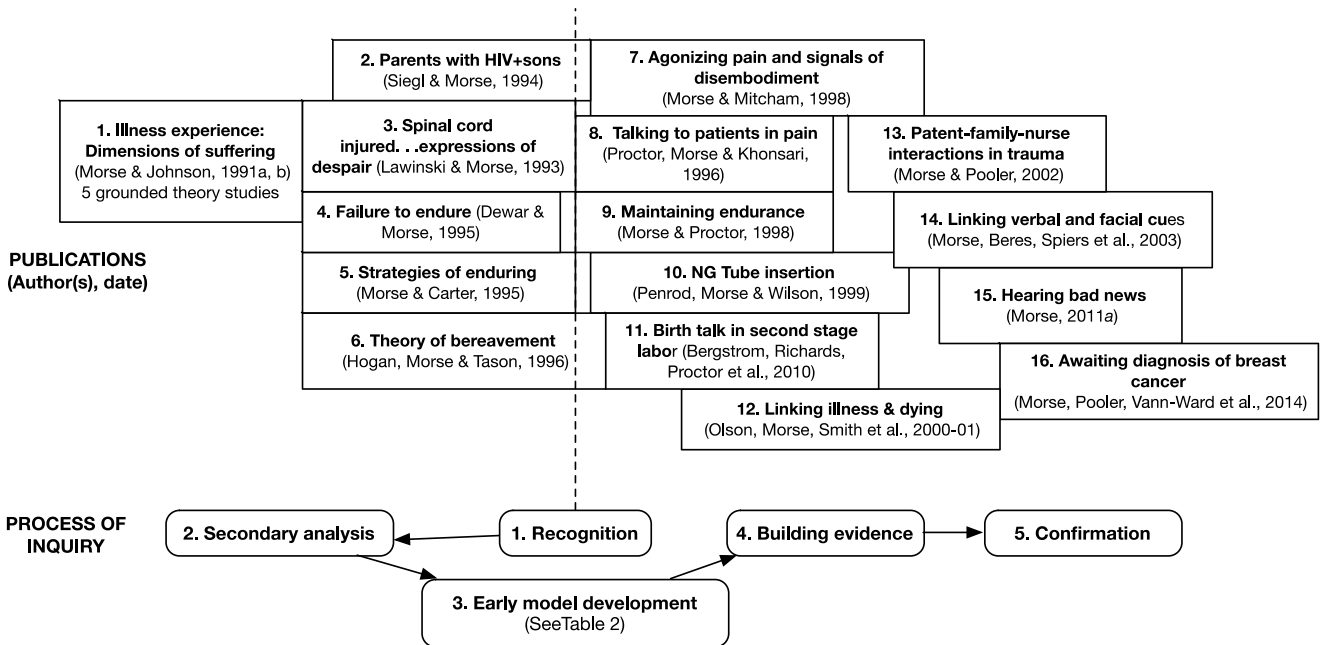


FIGURE 1. Publications (by date) contributing to the development of the concept of enduring and the process (pacing) of inquiry. Recognition of the significance of enduring (1) resulted in the reanalysis of Studies 1–6, shown to the left of the vertical dashed line. Descriptions of early model development are shown in Table 2. Studies 7–14 were designed to gather evidence about the description, role, and function of enduring. Studies 15 and 16 were designed to confirm aspects of enduring.

emotional responses of the participants in five studies, despite the fact that they were conducted on different topics, in different contexts, and by different investigators. Recognizing these similarities in the experiential processes, the authors’ data and the category labels used were reanalyzed for commonalities and synthesized (see Morse & Johnson, 1991a, pp. 315–342, for details)—which became the trigger, and foundation, for a research program on suffering. At this time, suffering was conceptualized as a broad concept, encompassing both processes of enduring—in which emotions were suppressed—and suffering (later renamed “emotional suffering”), in which emotions were released. Despite the linkage of suffering with pain (Zborowski, 1969), I realized from my dissertation work that culture also dictated stoic behaviors (Morse, 1989), and this was also linked to the cultural perception of the painfulness of pain events (Morse & Morse, 1988). Initially, in the Illness Constellation Model, only one investigator (Wilson, 1991, pp. 237–314) used the term “enduring” in her analysis. We recognized that the second stage of each study contained descriptions of enduring. One author wrote about “preserving self” and “distancing oneself” (Johnson, 1991); another described the process as though they were “automated,” that they “had trouble grasping what was happening to them” and that things appeared “foggy” and “unreal” (Morse & Johnson, 1991a, pp. 326–327). As a whole, these descriptors provided insight into an expanded and complementary understanding of the conceptual domain of enduring—more than obtained from one study alone.

Recognition

Later, during a series of studies (from a National Institutes of Health-funded grant exploring comfort), it became evident that enduring was a significant independent concept—and a separate state within the process of suffering—and that it was necessary to reanalyze previous studies for characteristics of that state. This process of insight is important: Once the investigator recognizes the fit of previously collected data, he or she must return and recode those data.

Clarification

We reanalyzed the original raw data, comparing incidents of enduring from different studies and contexts, looking for similarities in behaviors, affects, responses, and circumstances. Data had to be recoded because, in the original studies, authors contextualized the labels according to the questions asked and the researcher’s analytic agenda. This secondary analysis differs from methods used in meta-analysis and meta-synthesis methods, as researchers are now working at a different level of abstraction. Because of context stripping and the different labels used for similar concepts, normal search keywords used for locating other studies fail. In addition, we were looking with a new perspective at “old” data: In our case, the focus was on the participants’ responses, and we were not concerned with the particular contextual details of the causes of the emotional responses in each study.

How can the institutional review board and participant consent issues address the reuse of data? In this case, all initial

consents had included a clause allowing the reanalysis of data in subsequent projects, and these data were stored without identifiers. For all subsequent new projects, institutional review board review and consents were obtained. With data banking facilities becoming more common, additional data sets may be available for theoretical coalescence, but in my experience, qualitative data are so detailed and subtle that it may be difficult to know exactly where to look—especially if these data have not been collected by the investigator or at least by the research team.

Thus, when conducting theoretical coalescence, ideally, the researcher must be intimately involved with all data brought into the new study and be familiar with previous analyses. For instance, to study enduring, we sought data obtained from any experience that was severe enough and states of distress acute enough to require strategies for “preserving the integrity of self” (Morse, 1997). We used studies that exemplified extreme distress: labor and delivery, serious accidents, severe illnesses, and studies from lay and professional caregivers. The extreme distress of these participants was deliberate and met an important principle of qualitative inquiry: The experience being studied must be extreme, biased, and clear for the confounding “noise” that occurs with average events to be minimized (Morse, 2006).

Building Evidence

Next, we conducted a series of studies to identify the behaviors of those who were enduring. Observational methods (participant observation and video ethnography during trauma care) were invaluable, as often patients were too ill to be interviewed. Furthermore, enduring itself suppressed the emotions that we were investigating—when enduring patients were unable to describe the emotions they are suppressing. We moved away from the acute phase and asked patients and families to reflect on their experiences after rehabilitation, about 6 months after the accident or illness. By this time, they had been able to cognitively process (“make sense of”) their experiences (and our data were then descriptive) and the patients who had transitioned into emotional suffering were able to describe enduring. We interviewed burn patients, patients with cancer, accident victims, and their families about their experiences. The videotapes of many types of trauma resuscitations ($N = 178$) recorded in three Level 1 trauma centers in the United States and Canada provided observational data of those who were enduring. We used different methods, different populations (injuries and illnesses), and different caregiving activities to explore enduring. This led to a competent understanding of the patients and families’ emotional responses to accidents and illnesses. Analysis of the patients’ emotional states, and analysis of the concomitant behaviors of the patients, their families, and the responses of the staff, enabled us to develop a comprehensive and detailed analysis of states of suffering overall. Importantly, we were

able to describe enduring as a major state—one that had been virtually ignored in the professional literature.

ENDURING

Enduring is derived from the Latin word meaning “to last” and refers to an innate capacity of the individual to “get through” an extraordinary physical or physiological assault or stressful conditions and remain intact (Morse & Carter, 1996, p. 47). The essential characteristic is the absence of emotion (“shutting down”); “maintaining control” requires all of one’s energy (Morse, 2000, p. 2; Morse & Carter, 1996, p. 48). Enduring is work. When enduring, individuals intuitively recognize and fear that to give into emotions will result in emotional release—emotional suffering—that is so powerful, that they will lose control, “break down,” disintegrate, and not be able to function and last through the situation. If the pain is overwhelming, enduring enables the patient to tolerate it, to lie still so that caregivers may provide essential care without the person resisting and fighting caregivers. In this way, enduring is a protective concept. If the person experiences psychological pain, enduring enables the person to go about daily tasks, caring for children, working, and maintaining normalcy (Wilson & Morse, 1991). For relatives, it enables them to “get through” and to “be there” for their family members. However, importantly, we recognized that, while the person was enduring, cognitive changes were occurring. People remained in a state of enduring until they were able to accept the physical or psychological loss; people endure as long as they needed to accept the unimaginable tragedy that is occurring. Only when they recognize that their living nightmare was indeed true and they felt emotionally strong enough to suffer could they transition to emotional suffering and release the suppressed emotions of enduring as emotional suffering. This was evident despite the nature of what was being endured: serious injury, chronic or acute illness, bereavement, recovering from serious burns, and cancer (Table 1). We identified three types of enduring according to what was being endured: enduring to survive (physiological distress, e.g., from trauma care, or extreme pain, such as breakthrough pain in cancer), enduring to live (psychological, e.g., refusing to panic; Morse & Carter, 1996), and enduring to die (serious illness, e.g., the trajectory from illness to dying; Olson et al., 2001).

Enduring proved to be a complex concept, yet it is manifested in behaviors that are easy to see and recognize. The behavioral description developed from distinct gross motor movements to microanalytic facial coding, linguistic intonations, and speech utterances (Table 1). Observations of enduring behaviors and interactions with patients, family members, and staff, and descriptions of caregivers’ observations and their own experiences, were significant and consistent. One data set could provide data for several areas: verbal and facial expressions, bodily stance, affect, and interaction with others. We observed enduring in those attending funerals (Hyland &

TABLE 1. Characteristics and Signs of Enduring by Context and Project Data Sources

Characteristic/signs	Context	Data source
Behavior: lack of emotional affect ^a		
○ Distress suppressed ○ “Shut down” ○ Flat ○ Emotionless	NIC	Video interview
Behavior: facial expression ^a		
○ Brow furrowed ○ Expressionless ○ Eyes gaze into distance ○ Faces blank ^a	NIC	Video interview Oral interview
Behavior: posture ^{b,c}		
○ Upright ○ Walk rigidly ○ Hold arms stiffly on the side, across the chest	Trauma	Video ethnography
Behavior: behavior ^{a,c}		
○ Stands apart from others ○ Avoids eye contact	Trauma	Video ethnography Video interview
Cognitive control		
○ Present focused ^a	NIC	Interview Video interview
○ Holding on ○ Watching the clock ○ Counting ^d	Burns	Interview Case study
○ Avoids talking about the event ○ “Shutting it out” ^e	Bereavement	Interview
○ Do not disclose to others ^f	Breast cancer diagnosis	Interview
○ Feeling detached ○ “Going through the motions” ^e	Bereavement	Interview
○ Refusing to consider future ramifications ○ “Placed at the back of the mind” ○ Enduring for preserving self ^f	Breast cancer diagnosis	Interview
○ Concealing, pretending distress ○ Hiding tears ^{a,c,g}	Chronicity trauma	Interview
	Family narratives	Video ethnography
	NIC	Video interview
○ Disembodying for pain control ^h	Burns	Interviews (burns)
○ Linguistic detachment ○ “Dissociated” self from body ^d	Transplant ^d	Interviews, secondary analysis (other)
	Spinal cord injury ^d	
	Myocardial infarction ^d	
Linguistic changes		
○ Short Sentences ○ Single words ○ Voice expressionless ^a	NIC ^c	Video interviews
○ Present tense ○ May respond nonverbally		
○ Silent ○ Use short sentences if necessary ^j		Video
Releases from enduring		
○ May have explosive, emotional response ○ “Building up” ^g	Chronic rehabilitation	Interviews
Learning to endure		
○ Tolerating, managing ○ “learning to bear it” ○ Covering (pain) ^g	Rehabilitation	Interviews
○ “Facing realities” ○ “Going through the motions” ^e	Bereavement	Interviews
○ “Wrapping your mind around it” ^f	Breast cancer diagnosis	Interviews
○ Maintaining control with comfort talk register ^{j,k}	Trauma	Video ethnography
	Birth	Video ethnography
Failure to endure		
○ Manifest terrified or out-of-control behavior ^g		Interviews
○ Scared or anxious ^{c,l}	Trauma	Video ethnography
○ Losing it ^{g,m}	Illness/injury	Interviews
○ Anger, frustration ^{g,m}	Spinal cord injury	Ethnography
Exit enduring: enduring to die		
○ Progressive withdrawal with rapid physical deterioration ⁿ	Palliative care	Interviews
○ Family “cocoon” patient ^l		
Exit enduring: removal of stressor		
○ Exits with relief ○ May be a short period of tearing ^f	Breast cancer diagnosis (negative)	Interviews
Transition: from enduring to emotional suffering ^o		
○ Pacing ^a	Chronic illness/caregiving	Video interviews
○ Facial expression (changes) ^{a,p}	Chronic illness/caregiving	Video interviews
○ Speech (changes) ^a	Chronic illness/caregiving	Video interviews
Interactions to enhance enduring: follow lead of patient/nurse		
○ Silence/presence ○ Being with ^c	Trauma care	Verbal/nonverbal interactions with nurses

(continues)

TABLE 1. Characteristics and Signs of Enduring by Context and Project Data Sources, Continued

Characteristic/signs	Context	Data source
Interactions to enhance enduring: intense focusing/self-control		
○ “Requires all of one’s inner, resources, all of one’s energy; therefore, when one is enduring to survive, suffering is absent” ^d	Burns	Interviews
○ Talking through enables patient to focus ^{j,q,r,s}	Trauma care Childbirth (second stage) ^{k,s}	Video ethnography Video ethnography

Note. NIC = narratives of illness and caregiving. ^aMorse, Beres, Spiers, Mayan, and Olson (2003). ^bMorse (2000). ^cMorse and Pooler (2002). ^dMorse and Carter (1995). ^eHogan, Morse, and Tasón (1996). ^fMorse et al. (2014). ^gDewar and Morse (1995). ^hMorse and Mitcham (1998). ⁱProctor, Morse, and Khonsari (1996). ^jMorse and Proctor (1998). ^kBergstrom et al. (2009). ^lMorse (2018). ^mLaskiwski and Morse (1993). ⁿOlson, Morse, Smith, Mayan, and Hammond (2001). ^oOccurs when enduring can no longer be contained and emotionally strong enough to suffer. ^pUsing Facial Action Coding System (Ekman & Friesen, 1978). ^qDuring nasogastric tube insertion or resuscitation. ^rPenrod, Morse, and Wilson (1999). ^sBergstrom, Richards, Morse, and Roberts (2010).

Morse, 1995) and in family members during trauma resuscitation (Morse & Pooler, 2002). Our video data enabled nonparticipant observation of trauma studies and revealed behavioral changes. Family members endured at the bedside (concealing their distress from the ill member) and released their emotions (as emotional suffering) in the family room. In certain contexts, the suppression of emotions in enduring could control the individuals’ behavior and inhibit the transition into emotional suffering. However, in other instances, we observed (and nurses also reported) that enduring failed, and some events “sideswiped” the person, even causing him or her to become emotionally distraught or collapse on the floor.

We kept each data set separate during analysis, so that characteristics in one instance could be compared with other similar events and behaviors in different contexts, thus building a compendium of enduring behaviors from multiple instances. In addition, when we were interviewing using video recordings, we could observe the person’s affect, and using

Ekman and Friesen’s (1978) facial coding system, we noted how they changed expression during the course of the interview (see Corbin & Morse, 2003). Narrative interviews reflect the emotions felt at the time of the original event (as emotional reenactment; Morse, 2002), as well as the ongoing significance of the event (Seigl & Morse, 1994).

Initial Model Building

We began model building by diagramming suffering early in the research program (see Table 2). Initially, in 1995, we noted that enduring was a mode of preserving self (Morse & O’Brien, 1995). The early models used grounded theory, but linear configuration did not fit the apparently chaotic movement from enduring to emotional suffering and the changing intensity of both emotions. In 1996, Morse and Carter began to diagram the Praxis Theory of Suffering, representing enduring and emotional suffering as two adjacent circles linked at transition. This model has since been refined since (Morse, 2001, 2005,

TABLE 2. Theoretical Evolution of the Praxis Theory of Suffering^a

Theory	Stages
The Illness Constellation Model ^b	I: The stage of uncertainty II: The stage of disruption III: Striving to regain self IV: Regaining wellness
Preserving self: from victim, to patient, to disabled person ^c	I: Vigilance II: Disruption III: Enduring the self IV: Striving to regain self
The essence of enduring and the expression of suffering ^d	I: Enduring II: Suffering ^a III: Reformulated self
Responding to threats to the integrity of self ^e (a combination of the Illness Constellation Model and the Preserving Self Model—to form an emerging Praxis model)	I: Vigilance II: Disruption: enduring to survive III: Enduring to live: striving to regain self IV: Suffering: striving to restore self V: Learning to live with the altered self
Linking concepts: enduring, uncertainty, suffering, and hope ^f Toward a Praxis Theory of Suffering ^g	Determining the fit of concept to transition (uncertainly) and to exit suffering (hope) Development of the model of suffering
Further development of the Praxis Theory of Suffering ^{h-k}	Basic concepts remained as in the 2001 model, but the interactions of the components were refined.

^aSuffering became the name of the entire model encompassing both processes, enduring and emotional suffering. “Suffering,” as the second component of the model, was renamed emotional suffering (Morse et al. 2003). ^bMorse and Johnson (1991a). ^cMorse and O’Brien (1995). ^dMorse and Carter (1996). ^eMorse (1997). ^fMorse and Penrod (1999). ^gMorse (2001). ^hMorse (2005). ⁱMorse (2011b). ^jMorse (2017a). ^kMorse (2017b).

2011b, 2017b), as our research became increasingly focused. For instance, the study exploring facial expression (Morse et al., 2003) refined our description of enduring to the extent that others could recognize the facial expression and behaviors and also describe the intonation and speech patterns of those who were enduring.

Building Evidence

We asked many questions of our emerging concept. For instance: If enduring was an essential response, what happened if a patient was not able to endure? As we learned about enduring behaviors, recognizing their characteristics, we could also recognize the ramifications to the provision of care when enduring was not present. For instance, enduring was often not present with small children who screamed and resisted emergency care. Enduring was not present in trauma care when the injured person was inebriated, had been taking drugs, or was profoundly shocked. These patients fought emergency care—an extremely dangerous state—and caregivers had to resort to physical restraint to provide essential treatments, until the patient could be sedated. Thus, we identified behavioral states in the absence of enduring. Using nurses' descriptors, we documented the behavioral states from scared (a state of enduring) to conditions where enduring often failed (but could be supported by nursing): anxious, frightened, and terrified and, when enduring was absent, out of control (Morse, 2011b). We documented that nurses' patterns of care were distinct for each state, but when the patient was "out of control" and unable to respond to even the loudest command, all interactions with the patient ceased and essential trauma care went ahead.

We identified interventions that enabled enduring. For patients who were terrified, nurses used "talking through" to help them maintain control (i.e., enduring). We recognized the importance of this when a patient reported in an interview that she was so shocked that her vision failed. She said: "I just heard the nurse's voice, and held on." We documented the linguistic features and labeled it as the Comfort Talk Register (Morse & Proctor, 1998; Proctor et al., 1996), which was used with patients who were acutely distressed to facilitate enduring. This work has been replicated with nasogastric tube insertion (Penrod et al., 1999) and patients in the second-stage labor (Bergstrom et al., 2009).

Interview data contained information about cognitive control during enduring. Patients who were enduring reported focusing intensely (on a clock or ceiling tiles or by counting) or "zoning out" to remove themselves from a situation (Morse & Carter, 1995). In our interviews with patients who had experienced excruciating pain, we observed that the text of their interview changed as they disembodied the most painful parts of their bodies. This was evident in their descriptions, as they detached and referred to their own limbs as "it" rather than "my" (Morse & Mitcham, 1998). Thus, we realized that enduring was a cognitive state.

As our understanding grew, our inquiry then changed from a more passive, inductive learning mode to one of naturalistic inquiry. We sought and analyzed biographical lay literature about, for instance, enduring when hearing bad news (Morse, 2011a). These data provided detailed examples about enduring behaviors during the immediate shock phase. We planned a "naturalistic experiment" to determine how the model performed. Important questions were asked. For instance, our data showed that the major exit from the state of enduring was by transitioning through emotional suffering when the emotions of enduring were released. However, we asked, "Was it possible to exit the model directly from enduring, without entering emotional suffering?" To do this, we had to identify a situation in which enduring would be intense, and then whatever was being endured would be removed. The situation selected was to interview women undergoing diagnosis for breast cancer, which has been reported as one of the most severe and threatening experiences for women—and then explore women's reactions when they were given negative results for their biopsy (Morse et al., 2014).

The answer to the question was a tentative "yes." Some women who received negative results exited from enduring without emotionally suffering, moving directly to "relief"—which was sometimes manifested as a dizzy high. Others exited briefly into emotional suffering with a few tears and then to relief. However, others, also with negative biopsy results, remained in a state of enduring. These women believed that they actually had cancer but the doctor simply had not yet found it. The tentative nature of the physician's talk, "We will check you again in six months," kept these women in the state of enduring (Morse et al., 2014).

Integrating the Literature (Initial Abstraction)

During all phases of the research project, we monitored the literature. Suffering, per se, had appeared in the literature: Cassell's (1998) work in medicine and, in nursing, Kahn and Steeves (1986), Gregory and Russell (1999), Ferrell and Coyle (2008), and Eriksson's (2006) works are significant, but none of these theorists were interested in the behaviors of suffering and did not separate the state of enduring from emotional suffering. Furthermore, counseling continues to support the notion that suppressing grief (i.e., not displaying grief emotionally) is not therapeutic (McLeod, 2001), but our research challenged this assumption. In cancer care, the "distress thermometer" (Holland, Bultz, & National Comprehensive Cancer Network, 2007; Jacobsen et al., 2005) asks patients to rate their distress on a linear scale and is now in common usage. Early studies showed that patients who did not display emotional suffering (and perhaps were in the state of enduring) were diagnosed with alexithymia, a classified mental illness (see Iwamitsu et al., 2003; Pieterse et al., 2007). Our research indicates the opposite—that enduring is an essential state that enables individuals to cognitively adjust to changing untenable circumstances.

There is an urgent need for careful qualitative inquiry into the emotional states of patients undergoing the course of cancer therapy, the development of distress as a concept, and reassessment of the way that it is evaluated.

Confirmation: Seeing Enduring Everywhere

Astonishingly, enduring is virtually absent from the scientific literature, including nursing. Some of the signs of enduring do appear in the psychological literature—for instance, the unfocused gaze of those in PTSD, (who are enduring) is referred to as the “thousand mile stare” (Ursano, McCaughey, & Fullerton, 1994). However, the predominant perspective of counseling psychology is that enduring, and the suppression of feelings, is an unhealthy stressor. Counseling is targeted toward resolving enduring by moving the person into emotional suffering to resolve the distress (McLeod, 2001).

Although we do not know the physiological ramifications of enduring, behaviorally, it appears to be an essential state in certain circumstances. It is often necessary to be aware, even hyperaware, in emergency situations; to be focused; and to react appropriately. This is not possible when one is emotionally suffering—a state in which perspective is internalized.

Confirmation

Enduring is a high-level concept, encompassing—and recognizable—in many different situations. As our understanding of the concept matured, patients and relatives’ behaviors became clear. We appreciated the silent “stoic” behavior of survivors as patients grappled with how to “come to grips” with their injuries or diagnosis and how their lives would change. We now know it is no coincidence that puzzles and coloring books fill rehabilitation hospital lounges: They allow patients to intensely focus on something else. Once we understood these sets of behaviors, we could see enduring in groups in many untenable situations: in the behavior of those in prisoner of war camps, bystanders observing accidents, attendees of funerals, participants in court rooms, and visitors of prisons and even in adolescents experiencing bullying.

Despite the fact that enduring is poorly developed in the scientific literature, there is a wealth of data in lay descriptors and metaphors describing enduring behaviors: “holding oneself together,” “taking it well,” “being strong,” “holding up,” “bearing it,” and “managing well.” When enduring fails, it is described as “breaking down,” “collapsing,” and “not being able to take anymore.” Observing how the public responds to those who are enduring and how people stand beside the enduring person (rather than facing them to use comforting touch, hugs, and soothing talk) shows that by sensitively following the person’s lead, appropriate care may be given to those who are enduring. Such comforting behaviors were appropriate for those who were in emotional suffering, but are actually harmful when offered to those who are enduring, for it gives them something additional to endure. Empathy

makes what they are suppressing real and brings forth emotions that those who are enduring are attempting to suppress so they may continue to function. Once we understand the complexity of suffering, much of the literature on empathy and touch appears inaccurate when applied *carte blanche* to all caregiving situations and all states: The golden rule for providing appropriate care (and culturally appropriate care) appears to be to understand and interpret the patient cues and follow the patient’s lead.

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DISCUSSION

The concept of enduring, as a major component of the Praxis Theory of Suffering, has tremendous implications on the nurse-patient interactions for comforting and the well-being of patients. Application means making complexity simple and teaching nurses to “read” patients’ behaviors and to respond accordingly. Such teaching, rather like responding to a patient’s pain cues, may be extraordinarily difficult. Measurement, in particular, the very simple linear scaling, is presently a silent, albeit essential, requirement for clinical usability. To teach the “reading” of patient behaviors would be breaking a barrier in clinical education, despite the fact that it underlies some of the most fundamental clinical research; Nightingale advises, “In dwelling upon the vital importance of *sound* observation, it must never be lost sight of what observation is for. It is not for the sake of piling up miscellaneous information or curious facts, but for the sake of saving life and increasing health and comfort” (Nightingale, (1859/1946, p. 70).

How is such research developed and disseminated? The great disadvantage of theoretical coalescence is that it takes too many years to complete, and the first studies have already fallen beyond the nurses’ criterion of “recent” publication (5 or 10 years) before the process is completed. The conceptualization and linking of the research projects is lengthy, and preparing a monograph is not supported by the current modes of research funding or from one’s university.

Would team grant funding accelerate the rate of completion for theoretical coalescence? Perhaps yes, but it would be hard to engage a research team for long enough and to entice a funding agency to take the risk in funding an interesting major question without interim results. Of greater concern, research that introduces new insights or concepts tends to be ignored by methods of meta-synthesis, perhaps because of the mechanics of research terms. For instance, a recent systematic review (2000–2016) of emotional distress and help-seeking in cancer, focused on emotional

states of distress and ignored states of enduring (Carolan, Smith, Davies, & Forbat, 2017).

Where should my research program be directed from this point? There remains much to learn descriptively about enduring; here, we have only scratched the surface. We do not know the physiological ramifications of enduring. Do those with prolonged enduring develop a stress response? We do not know if supporting enduring behaviors will alter their duration. We do know that those who are enduring are not “emotionally available” to others, so that parents who are enduring may be meeting their children’s material needs but not be emotionally able to parent. There is a great need for family research from this perspective.

Furthermore, there is a need for additional studies on enduring in trauma care. Although it is obvious that enduring is a state that enables trauma care to be administered more quickly and safely, trauma centers do not provide a nurse to be available to take care of the adult patients’ needs in situations of overwhelming terror and pain (although some centers provide care for pediatric patients during trauma resuscitation). Patients with trauma are medically complex, physicians are preoccupied with the puzzle of diagnosis, and nurses are preoccupied with providing rapid critical care, but the fact that no one is assigned to provide “talking the patient through,” to orient and respond to their distress, is an ethical responsibility that, if attended to, may have very positive health outcomes. This aspect of care is the domain and responsibility of nursing that may be lost in the work of a transdisciplinary team. Finally, there is a need to explore enduring physiologically. During prolonged periods of enduring, what is happening to stress indicators, such as cortisol levels?

Concluding Thoughts

Researchers, especially qualitative researchers, tend to consider inquiry as finished once their question is answered and the study is published. We do not step back to examine the potential of our research; rather, we wait for it to be noticed, cited, used, incorporated into fat texts, and taught in the classroom. Strangely, this dissemination does not happen. We forget that, if our humble contribution is correct, original, necessary, interesting, and even important, it must fit into the domain of nursing knowledge (even by disagreement/correction) and contribute to something greater than itself. Research that does not fit these criteria simply dissipates. Small, “one off,” projects rarely make a contribution. Inquiry must move to the next level, and researchers must be supported to take this step.

In 1968, Dickoff and James proposed a “theory of theories.” We do not know if they envisioned meta-analysis/synthesis, a research program, or some type of formal inquiry that deliberately builds theory, such as theoretical coalescence—or all of these approaches. However, we do know that

continuing inquiry beyond the first qualitative project, and subsequently developing higher-level midrange theory, has extraordinary potential for nursing research. In this case, enduring is a concept with significant ramifications for the improvement of care. These studies exploring enduring extended beyond the original context of trauma care, and the results explain behaviors that occur beyond the scope of nursing. Nursing research will come of age once other disciplines notice, borrow, and incorporate our nursing concepts and theories into their theories and practice.

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Corresponding author: Janice M. Morse, PhD (Nursing), PhD (Anthropology), College of Nursing, University of Utah, 10 South 2000 East, Salt Lake City, UT 84112 (e-mail: Janice.Morse@gmail.com).

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