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Don’t Wait with Theory – Know What You Are Looking For!

Why, When and How Theory Matters in Qualitative Empirical Studies

Kristian Larsen & Kim Esmark

Abstract

This paper offers a reflexive reappraisal of the role of theory in qualitative research, challenging the dominant norm of theory-late, inductive inquiry. Drawing on Bourdieu’s concept of the epistemological break, the argument centres on the premise that constructing an empirical object is already a theoretical act. Rather than obstructing empirical openness, theory provides the conceptual tools necessary to focus inquiry, reduce complexity, and render social phenomena analytically tractable. Against the backdrop of symbolic gestures to paradigms and meta-theories, the paper promotes the use of middle-range and field-specific theories as instruments of epistemic precision. A typology of theoretical applications in health sociology illustrates how theory can guide empirical work—from patient narratives to institutional logics and pedagogical practices. Through this, the paper advocates for a reflexive, theory-led methodology that foregrounds theoretical labour as central to the sociological craft, enabling not just description but also critical analysis and context-sensitive interpretation.

Keywords

Construction of object, methodology, Bourdieu, historical epistemology, deduction, health sociology, empirical theory

An Invitation to Reflexive Theorising in Qualitative Research

It often appears both methodologically sound and ethically commendable to commence qualitative inquiry in an open-ended, inductive fashion – posing broad questions, employing minimally structured interviews or observations, and deferring theoretical engagement

until after an initial condensation of meaning (e.g Braun & Clarke, 2006). This is frequently presented as the 'gold standard' in qualitative research: to remain open to the empirical world so as not to impose premature order upon complexity. Warnings abound – 'Do not narrow your lens too early'; 'Let the field speak for itself' – and such imperatives have, with considerable nuance, served to distinguish qualitative inquiry from quantitative, deductive, and so-called positivist approaches.

Yet, this paper invites a reappraisal. Taking its examples from the field of health sociology, and drawing on Bourdieu's insistence on the *epistemological rupture*, it argues that the very act of researching already involves theoretical labour. The very moment a research question is being defined and formulated (that is, before the actual investigation has even begun), the researcher inadvertently uses concepts, taxonomies, assumptions, hypotheses etc. The question is just whether these are used unconsciously or consciously, implicitly or explicitly. Except within Christian religious imaginaries there is no such thing as immaculate conception. That is why, according to Bourdieu, the

> … dream of an epistemological state of perfect innocence papers over the fact that the crucial difference is not between a science that effects a construction and one that does not, but between a science that does this without knowing it and one that, being aware of work of construction, strives to discover and master as completely as possible the nature of its inevitable acts of construction and the equally inevitable effects those acts produce. (Bourdieu, 1999: 608)

Reality never speaks for itself. It "cannot reply unless it is questioned" (Bourdieu et al., 1991: 36), and the moment you put the question, you are initiating a work of construction. In other words: no matter how sensitive, open-minded and 'value-neutral', the qualitative researcher always brings preconceived ideas into the process. Because the social world is "inscribed both in things and in minds", including the minds of sociologists, "it presents itself under the cloak of the self-evident which goes unnoticed because it is by definition taken for granted" (Bourdieu & Wacquant, 1992: 251). To escape the uncontrolled effects of such preconceptions (about health-care and welfare, for instance) that are built into common-sense, public discourse and everyday language, the sociologist must arm herself with a 'new gaze', "*a sociological eye*" – and to that end, she needs theory. In fact, according to Bourdieu, that is really the primordial function of theory in sociological work: to secure the epistemological break and facilitate the construction and exploration of an *autonomous* object (Bourdieu et al., 1991).

Far from being an impediment to empirical richness, therefore, theory is the very condition for empirical focus. Rather than obscuring complexity, theoretical frameworks allow researchers to reduce the social world meaningfully, enabling attention to be directed, distinctions to be drawn, and objects of inquiry to be constructed with reflexive precision. In short, theory is not an optional adornment but the most vital instrument in the sociologist's craft.

From Paradigms and Meta-Theories to Applicable Theories

A common pitfall in empirical research, especially within qualitative traditions, is the reliance on abstract meta-theoretical paradigms that remain disconnected from the research practice itself. References such as "this is a phenomenological-hermeneutic study" or claims of being "constructivist and feminist" often function symbolically rather than instrumentally. These philosophical positions, though intellectually significant, do little to help the researcher construct the empirical object in a grounded, operational sense (Johannessen, Rafoss, & Rasmussen, 2018). Instead of hovering at a meta-level, we argue for the importance of working with middle-range theories or field-specific theoretical frameworks that offer concrete tools for empirical engagement. Such theories, when properly selected, provide sharper analytical lenses and guide empirical focus. The 'tool' metaphor is important here: Rather than conceiving of theory as belonging to a lofty world of thoughts and ideas, elevated above the mundane activities of selecting informants, preparing questionnaires, organising field notes, coding data, etc., we should think of concepts and models in *craft terms*, as practical utentils to be used for practical purposes of research. The value of a given theory thus cannot be determined in the abstract, only in relation to a specific research problem. Applying a related metaphor of Todorov's (1986: 177), we might say that theoretical concepts "are a little bit like workers: in order to measure their real value, one has to know what they can do, not where they come from."

Theories are Conceptual Constructions

Theories do not emerge in a vacuum. They are products of intellectual labour embedded within professional, institutional, and historical contexts. Theories, particularly those that survive through widespread scholarly testing and critique, constitute condensed intellectual responses to patterned phenomena. Consider the theoretical development surrounding 'professions' or 'the welfare state'. These are informed by decades of empirical studies and critical refinement. They serve to organise, synthesise, and ultimately enable insight into broader social mechanisms.

Types and Levels of Theoretical Abstraction

We can roughly distinguish between three types of theoretical abstraction:

1. Grand Theories (e.g., Giddens, 1991; Beck, 1992): Highly abstract frameworks concerned with the structure of modernity, identity, and institutions.
2. Middle-Range Theories (Merton, 1968): Operate at an intermediate level, enabling generalisation while remaining empirically anchored (e.g., theories of transition in health).
3. Micro-Theories: Highly contextualised and specific, e.g., theories of a given patient group's experience with a particular diagnosis.

Each level carries different capacities for generalisation, applicability, and abstraction, and the choice should reflect the research question's scope and context.

A Typology of Theory Use in Health-Related Sociological Research

Diagram: Seven Types of Theories and Their Empirical Focus

Type of Theory	Primary Focus	Level	Example Theorists/Works
Disease and Patientology	Illness experience, coping, identity	Micro	Kleinman et al. (1978); Bury (1982); Antonovsky (1979)
Social Medicine and Prevention	Risk, vulnerability, health determinants	Meso/Macro	Bengtson & Settersten (2016); WHO ICF Framework
Organisational and Institutional	Structures, rules, logic of healthcare fields	Meso	Weber (1968); Goffman (1961); Emirbayer & Johnson (2008)
Cultural and Materiality	Power, technology, intersectionality	Macro	Hall (1973); Crenshaw (1989); Latour (2005); Mol (2002)
Professions and Specialisation	Work, autonomy, interpro-fessional struggles	Meso	Abbott (1988); Brante (2010); Bourdieu (1996)
Education, Learning, and Didactics	Formation of habitus, learning environments	Meso	Bourdieu (1977); Dewey (1902); Schön (1983)
Sociological Theory and Modernity	Inequality, risk society, field dynamics	Macro	Bourdieu (1991); Foucault (1991); Giddens (1991)

From Theoretical Awareness to Reflexive Practice

Theory is not a postscript. Nor is it merely a decorative reference to intellectual ancestry. Rather, it is a foundational component of empirical design, analysis, and reflection. In line with Bourdieu's concept of the epistemological break (Bourdieu et al., 1991), the act of constructing the research object itself is already a theoretical operation. Words such as 'patient', 'care', or 'rehabilitation' carry implicit classifications, exclusions, and assumptions. They must be interrogated and refined through conceptual work.

Applying the Seven Theory Types: Examples and Use Cases

1. Disease and Patientology

This theoretical area centres the subjective and embodied experiences of illness, positioning the patient not merely as a biological entity but as a social actor negotiating meaning, identity, and continuity in life. Bury's (1982) notion of biographical disruption provides a framework for understanding how chronic or acute illness fragments one's narrative coherence and forces a re-evaluation of past, present, and future selves. In rehabilitation contexts, this lens enables nuanced insight into how patients engage in identity work—re-establishing social roles, relationships, and self-conception after trauma or disability. Similarly, Antonovsky's (1979) Sense of Coherence (SOC) model conceptualizes health as a process rather than a state, grounded in comprehensibility, manageability, and meaningfulness. This helps to explain variations in resilience and adaptive capacity across different populations and illness trajectories. In short: This theory type foregrounds the patient's experience of illness as a disruption of meaning, identity, and continuity, and highlights how some sustain coherence through adaptive sense-making.

2. Social Medicine and Prevention

This area draws attention to the social determinants of health and the structural conditions that create differential exposures to risk and resilience. It critiques individualistic models by embedding illness within broader systems of inequality – poverty, aging, environmental factors, and marginalization. The WHO's ICF framework exemplifies an integrated biopsychosocial model that does not merely categorize impairment but also considers how social structures and environments compound or mitigate functional limitations. In rehabilitation, such theories allow scholars and practitioners to diagnose not only physical deficits but also contextual barriers—be they infrastructural, economic, or attitudinal. In short: Social medicine theory emphasizes the interplay between structural determinants and embodied outcomes, challenging reductive biomedical framings of prevention and recovery.

3. Organisational and Institutional Theories

This cluster explains how health and rehabilitation settings operate not only as technical systems but also as cultural and bureaucratic structures with embedded norms, power relations, and logics of practice. Goffman's total institutions frame such environments as enclosures where everyday autonomy is constrained by routines, surveillance, and institutional narratives – reshaping how patients perceive themselves and are perceived. Emirbayer & Johnson's reworking of Bourdieu's field theory illuminates the meso-level tensions within and between institutions, revealing how actors navigate hierarchies, legitimacy struggles, and professional boundaries. In short: This theory type helps decode the rules, rituals, and symbolic orders that govern institutions, offering insight into both constraint and agency within organizational life.

4. Cultural Theory and Materiality

Theories in this domain interrogate how cultural meanings, identities, and material practices co-produce realities in health and rehabilitation. Technologies are not neutral tools but mediators of care that embody assumptions about the body, normality, and treatment. Actor-Network Theory and Mol's concept of the body multiple uncover how diseases are enacted differently depending on the sociotechnical configurations at play—what counts as a disease or improvement shifts across contexts. Crenshaw's intersectionality offers a lens to examine how overlapping social locations (race, gender, class) shape differential treatment outcomes, making visible systemic biases embedded in ostensibly 'objective' care. In short: This area highlights the entanglements between culture, identity, and material practices, showing how health is co-constructed across social and technological domains.

5. Profession and Specialisation

This theory cluster attends to the dynamics of expertise, boundary-work, and legitimacy in healthcare. Abbott's system of professions conceptualizes the health field as a competitive arena where groups negotiate jurisdiction over tasks, knowledge claims, and authority. Interprofessional conflicts – between doctors, nurses, therapists – can thus be read as strug-

gles over symbolic and material capital. Brante's work extends this by exploring how 'professional complexes' evolve, especially in welfare-oriented systems where professions must balance autonomy with institutional and state logics. Bourdieu's framework shows how professionals accrue symbolic capital through credentials, networks, and conformity to institutional habitus. In short: These theories make visible the power relations within and between professions, revealing how status, expertise, and recognition are socially produced and contested.

6. Education, Learning, and Didactics

This theoretical area concerns how health knowledge is taught, internalized, and performed. Medical education is not merely cognitive; it entails the cultivation of dispositions, language, and perceptual schemas – the habitus – that align with professional norms. Becker et al.'s ethnographic work shows how students gradually acquire the 'clinical gaze', learning not just what to see, but how to see like a physician. Dewey's emphasis on experiential learning and Schön's reflective practice underscore the importance of real-world engagement and iterative sense-making in professional formation. These theories are particularly relevant in interprofessional education and simulation-based learning. In short: This domain focuses on how medical subjectivities are shaped through education, blending formal curriculum with tacit socialization into professional worlds.

7. Sociological Theory and Modernity

This final category offers macro-analytical tools to interrogate the broader societal shifts shaping health, governance, and subjectivity. Foucault's governmentality critiques how modern health systems subtly produce self-monitoring, self-governing citizens who internalize responsibility for health – a dynamic evident in e-health and wellness platforms. Giddens and Beck examine late modernity as a period of uncertainty and reflexivity, where individuals are tasked with constructing identities amid rapid social change and systemic risks (e.g., pandemics, genetic screening). Bourdieu's field theory remains crucial for understanding how symbolic capital and habitus reinforce stratification even within ostensibly meritocratic systems. In short: These theories allow for a critical perspective on how modernity, power, and identity converge in shaping contemporary health discourses and practices.

Operationalisation of Theory in Empirical Research

Operationalising theory refers to the process of translating or converting abstract theoretical concepts into concrete research tools – questions, indicators, or coding schemes – that can be systematically used in empirical data construction and analysis. It's a crucial step that ensures theoretical coherence throughout the research process and maintains a strong link or "two-way traffic" (Merton, 1968: 279) between concepts and evidence. In fact, following Bourdieu, theory and research operations ideally should *interpenetrate each other entirely* (Bourdieu & Wacquant, 1992: 34-35). Here are some basic examples:

1. In Surveys

Quantitative instruments like surveys often require theoretical constructs to be broken down into measurable indicators or scales. Antonovsky's (1979) Sense of Coherence (SOC) theory, for example, has been systematically operationalised into a standardized SOC scale, consisting of items that measure comprehensibility, manageability, and meaningfulness. A sample item like "Do you usually feel that the things that happen to you in your daily life are hard to understand?" targets the individual's perception of the world as structured and predictable – core to the SOC framework. Additional items might assess one's belief in being able to handle challenges (manageability) or the perceived value of investing emotional energy in life's demands (meaningfulness). These become quantifiable data points for exploring the relationship between sense of coherence and outcomes such as rehabilitation success, quality of life, or adherence to treatment. Theoretical clarity guides scale construction, while operational indicators allow for large-scale pattern detection and hypothesis testing.

2. In Interview Guides

In qualitative research, theory is operationalised by informing the design of interview questions that elicit narratives, meaning structures, or symbolic associations aligned with theoretical concepts. Using Bourdieu's concept of habitus, questions such as "Can you describe your upbringing and education and how that shaped your approach to health or illness?" aim to uncover durable dispositions and social conditioning that structure how individuals perceive, interpret, and act upon health-related situations. Responses can reveal how class, education, and early experiences inform one's health behaviours or attitudes toward healthcare professionals. Applying Goffman's (1961) total institution theory, an interview question like "How does your daily routine here compare with your previous experiences outside the hospital?" seeks to explore the institutional scripting of time, behaviour, and autonomy. This might illuminate the loss of personal agency or reveal adaptive strategies patients use to retain a sense of self. Operationalisation here is interpretive – questions are crafted to provoke reflections that align with theoretical constructs, and analysis involves coding these responses in terms of the theoretical lens.

3. In Observational Studies

Ethnographic or participant observation allows theory to be operationalised through sensitising concepts that guide what to observe and how to interpret it. Inspired by Mol (2002), one might observe how a medical technology (e.g. glucose monitors or mobility aids) becomes part of different "enactments" of disease. For instance, clinicians may use the device to calibrate treatment, while patients might see it as a symbol of dependency or autonomy. The theory prompts researchers to look for multiplicity and contextual variability in practice – how the same object means and does different things in different hands. Using Latour's Actor-Network Theory (ANT), operationalisation involves mapping out the actors (both human and non-human) and the networks they form. Observations might focus on how a medication dispensing machine structures the morning workflow, influences com-

pliance, or shifts the distribution of authority among staff. Rather than looking only at human intention, the theory leads one to trace chains of action and delegation that include devices, protocols, and spatial arrangements. The observational lens becomes theoretically attuned, not neutral – foregrounding specific interactions, objects, or power dynamics that otherwise might go unnoticed.

Summing up. Operationalising theory is very important and means *putting it to work* by translating abstract concepts into concrete tools for data collection and analysis. This is not a mechanical act but a situated practice, requiring sensitivity to the theory's ontological assumptions and the research context. In surveys, interviews, and observations, operationalisation ensures theoretical coherence by shaping indicators, guiding questions, and attuning the researcher's gaze. And once again: No measuring instruments come without built-in theoretical presuppositions. In the words of Bourdieu et al. (1991: 39), "all the operations of sociological practice, from drawing up questionnaries and coding to statistical analysis, are so many *theories in action*, inasmuch as they are conscious or unconscious procedures for constructing facts and relations between facts."

The Descriptive and Analytical Power of Theories

A central function of theory in empirical research is its capacity to enable statements, produce structured understanding, and guide empirical focus. Theories highlight certain aspects of the empirical world while rendering others less visible. This selective illumination is not a weakness but a necessary and productive constraint that helps the researcher to avoid becoming lost in data.

What Theories Help Us Do:

Describe	Theories offer language and categories for describing practices, roles, relationships, and institutions in empirically sensitive ways. For example, using Goffman's concept of the *total institution* allows one to describe the institutional routines of a rehabilitation ward more precisely than everyday language would permit.
Analyse	Theories such as Bourdieu's concept of field or habitus allow researchers to go beyond surface-level descriptions and examine underlying logics, power relations, and dispositions.
Distinguish	Theories allow the researcher to distinguish between phenomena that may appear similar on the surface but operate under different logics. For example, distinguishing between patient compliance as a behavioural issue and as a response to institutional power.
Contextualise	Sociological theory helps locate the empirical case within broader social, historical, or political frameworks (e.g., neoliberal governance, medicalisation).

Examples:

- Theory of Professions: Provides concepts like jurisdiction, social closure, and symbolic capital to distinguish and analyse the power dynamics between doctors and nurses.
- Learning Theories: Help uncover how knowledge, skills, and professional identities are shaped through formal education and clinical training.
- Cultural Theories: Offer tools to analyse how norms, beliefs, and material practices influence patient-provider interaction across gender, class, or ethnicity.

In short, theory is not just about 'explaining' data after it has been collected. It helps shape what we see, what we consider significant, and how we articulate findings in ways that resonate within scholarly and professional communities. It gives our research voice, direction, and authority.

From Description to Normativity: The Epistemological Fallacy

In critical realism, particularly as articulated by Roy Bhaskar (2008), there's a caution against the epistemological fallacy: the error of conflating knowledge about a phenomenon (epistemology) with the nature of the phenomenon itself (ontology) – or in other words, the error of sliding from the model of reality to the reality of the model (Bourdieu, 1990). In the context of health sociology, this fallacy warns against *overgeneralization* - assuming that insights from a specific context universally apply to all contexts – and *normative overreach* – deriving prescriptive conclusions solely from descriptive data without considering underlying mechanisms or broader structures. Graham Scambler (2013) emphasizes this in his work on health inequalities, noting that while we can describe patterns of illness across social classes, prescribing solutions requires a deeper understanding of the underlying social structures and power dynamics.

Summing up. Descriptive theories are powerful tools for understanding specific aspects of phenomena. However, transitioning from description to prescription necessitates caution. By acknowledging the stratified nature of reality and avoiding the epistemological fallacy, we ensure that our normative conclusions are grounded in a comprehensive understanding of both observable events and their underlying mechanisms. In an example about educational reforms this could be overlooking *contextual factors* such as cultural attitudes towards collaboration, student motivation, teacher preparedness, and curriculum design, or *institutional structures* like the availability of resources to support such learning methods.

Conclusion

Qualitative research benefits significantly from early and consistent integration of theory. It not only sharpens focus but also adds reflexive depth. Rather than treating theory as an afterthought or an abstract ornament, it should be operationalised as an instrument of thought – a guide to constructing, interrogating, and contextualising the research object.

Theory is what allows researchers to 'see' differently, question more rigorously, and construct knowledge that is both empirically rich and conceptually robust, and that *goes against the grain* by breaking with implicit common-sense.

Kristian Larsen Head of research Center of health Research (UCSF) and Professor University of Copenhagen, Public Health, Copenhagen Denmark. Professor 2 OsloMet University, Oslo Norway. Email Kristian.larsen@regionh.dk

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