EXPANDING CARING
Theory and Practice intertwined
in municipal elderly care

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Theory without practice has no power
Practice without theory is blind.

Kant
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ABSTRACT
The Swedish Agency for Higher Education evaluated in 2007 the nursing programs at Swedish Universities, and confirmed at several programs lacked definition of the main subject of the discipline; namely caring- and/or nursing. The caring science disciplines showed indications of increasing signs of fragmentation, in that sub-disciplines were evolving. There is a unique foundation of theoretical knowledge that is specific for the caring professions grounded in caring theory and philosophy. For some reason the theoretical foundation and contexture of providing care seems to fade off with time in clinical practice, as well as an explicated theory-practice gap; that theory does not go along with clinical practice. An assumption in this thesis is that caring theory somehow seems to evaporate as nurses become clinically active- caring theory does not seem to be much reflected upon. The overall aim was to investigate into the meaning of caring to nurses in municipal elderly care, and into their explicit and implicit understanding of caring theory in their daily practice. The theoretical perspective was caring science, while the epistemological frame was of a phenomenological hermeneutical life world approach. Data was gathered by interviews with nurses working in elderly care and analyzed to grasp the structure of the phenomenon of caring in theory and practice. The thesis comprises four studies of which three empirical was consolidated with a Jean Watson’s specific caring theory, ending up in a better understanding of the approach of caring in nursing and the role of theory in practice.

The findings of the studies show that the lived experience of caring as narrated by the participating nurses comprises both implicit and explicit theoretical foundation to existential caring theory. The explicit use of theory or certain theoretical affiliation was not obvious; rather what may be theoretical inputs was expressed as the importance of being present and the necessity of having a health perspective in caring. By illuminating caring and concepts from caring theory, the meaning of caring in their professional lived experience, the primary intention or choice of working as nurses became apparent again. There seems to be different perspectives related to caring theory, but as the empirical findings shows, there still seems to be a consensus behind what caring is, both in theory and in practice. As a result from the analysis the aim of caring itself may be more salient and focused if based on existential phenomenological caring concepts and theory, as this corresponds with the nurses understanding of holistic intentional caring with a health perspective.

A gap exists, but is more related to organizational restrictions such as role constraints and time pressure than to the meaning of caring in theory and practice. Mediating care is a concept that embraces the implications of all the outcome concepts of the analysis and it has the possibility of being the expression of immanent and transcendent dimensions in caring. Mediating care represents the expression of our understanding of life, our values and norms. It is given expression through the insights into, and the ways we connect to one another, our ability as carers (nurses) to reach out to another in his or her being, as well the understanding of ones own being in caring. Theoretical and practical reflection and cultivation of clinical sensibility has the opportunity of inspiring for an expanded caring consciousness, manifested in the mediation of care.

Keywords: caring in theory and practice, municipal elderly care
List of Papers


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INTRODUCTION

Caring and Nursing

Caring and nursing theories developed at times when nurses started formulating their knowledge and improving the quality of their profession (Meleis, 2007; Tomey, 2006). The discipline became targeted on nursing theory as it developed within the profession of nursing. At the same time, there was and still is an important school of thought in which caring is the fundamental cornerstone and which is thus emphasized in theory, as described in caring science theories by several researchers (Watson 1979, 2008; Benner & Wrubel 1989; Eriksson 2001, 2009; Ray 1989; Dahlberg et al 2009, 2010).

In 2007, the Swedish Agency for Higher Education (HSV 2007; 23) made an evaluation of the nursing programs at Swedish Universities, and confirmed in several of the programs a lack of definition of the main subject of the discipline- namely caring and/or nursing. The evaluation suggested that the caring science disciplines showed increasing signs of fragmentation, in that sub-disciplines were evolving. The report also asserted that the development of nursing care and its funding seems to remain linked to medicine, and the practical and technical aspects of nursing care still seem to be dominant (Enns & Gregory 2007; Corbin 2008).

In recent decades, Swedish nursing education has gone through various changes, from being a practical profession assisting physicians, to an academic form of education with a bachelor’s degree in the main subject (Öhlen et al 2009). The latest reform came in 2007, as the system adjusted to the Bologna Process (HSV 2007). The development of the main subject has shown variations in individual universities and academies, as the authority to decide on the content of the main subject is handled by each higher education institution (Öhlen et al 2009). The Swedish Society of Nursing (SSF) highlighted in a report the existence of a range of denominations since the debate has been prolonged over the last decade within this organization. Five variations over the domain are categorized, and Öhlen et al (2009) shows that not only are there diversities in the denomination of the discipline or main subject, but also its content is a matter of discussion in Sweden. Principally these discussions are related to the main subject linked to being discipline-based or professional-based knowledge. It is not unproblematic to separate nursing and caring, and the definitions may seem unclear and even impossible to make (Sarvimäki & Lutzen 2004).
theory the conceptualization of nursing and caring are even more unclear than in the Nordic countries (Tomey 2006; Meleis 2007).

Within the discipline, caring has been used extensively to describe all aspects of for example patient and nursing encounters (Watson 1979, 2008; Benner & Wrubel 1989; Leininger 1993; Swanson 2005; Eriksson 2009; Dahlberg & Segesten 2010). Nursing is confined to the profession and as such to the nursing work itself. Caring embraces more than the nurses’ work, and departs from a distinguished basic value that comprises the core question of caring, namely what is the deeper meaning of caring (Eriksson 2001; Dahlberg & Segesten 2010). As such, caring is situated in the existential region of understanding and knowledge, and to make the distinction clearer between caring and nursing one may claim that it is possible to manage nursing without being caring (Pearcy 2010).

There is a unique foundation of theoretical knowledge which is specific to the caring professions. During my education and career as a nurse, a recurrent question was; how do we use this specific theoretical caring knowledge of the phenomenon of caring that is unique and specific to the nursing profession. For some reason the theoretical foundation and context of providing care seems to fade with time in clinical practice. Working in clinical practice one has noticed nurses give voice to an experienced theory-practice gap; that theory does not correspond to their clinical practice. An assumption in this thesis is that caring theory somehow seems to evaporate as nurses become clinically active, and caring theory does not seem to be much reflected upon.

The experienced gap between theory and practice has been theorized and problematized in several discussions and studies over the years (e.g. Cody 2003; Gallagher 2004; Maben et al 2007; Ekebergh et al 2004, 2009). This thesis is meant to serve as a contribution to the debate by applying the questions of a ‘theory-practice gap’ to caring for the elderly, to further understand the possible disparity between theory and practice and to show if and how nurses in elderly care relate caring theory to their professional practice. Being a primary health care nurse with a working domain that also involved the elderly may have colored the research path. In this work, respect for the elderly and their life conditions in the municipal care context has been a guiding force.
BACKGROUND

Defining theory

Theory is defined in various ways and is often related to practice, with the intention of highlighting the interrelationship between theory and practice. One might suggest that in the education becoming a nurse, both the basic theory of the discipline as well as its practice should be incorporated. An everyday meaning of theory is often related to something abstract, which is something that is not of a concrete nature and referred to as not applicable in reality. Within scientific definitions, the understanding of theory depends on the epistemological stance taken. In physical science for example, theory is a complex model or system formed of axioms that reinforce the theory with a high level of seemingness that gives the theory its evidence (Moser, 2005).

Within the human sciences a scientific theory is built on a number of concepts, definitions, and assumptions and describes the interrelationships between these (Nordenfeldt 1982). A theory might be on a general level, describing the theoretical foundations on a meta-level. It might also be more particular and as such describe a limited phenomenon. A theory might be strictly descriptive and testable, but it can also be normative as its purpose is to describe how something should/could be.

From ancient Greek understanding, ‘theoria’ means beholding, looking at, and refers to contemplation (Oxford Advanced Dictionary 2000). Everything is already enrolled in theory, everything is theory, and is part of us, of the human life (Gadamer 1983; Liedman 2001). The old understanding of the word ‘theoria’ means contemplative prayer resulting from the cultivation of watchfulness (Gadamer 1983). This is the existential aspect of ‘theoria’ and also the ontological, as it suggest that during all practice, one always aims at something that is transcending the practice - namely the meaning that makes us perform the practice (Hansen 2009). Later, Pythagoras gave theory the meaning leading to the modern understanding of it as uninvolved, neutral thinking (www.etymonline.com). Theories are grounded in empirical phenomena, consistent with scientific methods or approaches. In human sciences the scientific approaches are grounded epistemologically in, for example, phenomenology or hermeneutics, where understanding of being is intertwined in a historical
and temporal context and shows itself as understanding and meaning. Theory is in this reasoning not an abstract description of an outer reality; it is related to the knowledge of lived experience.

**Retrospective view of caring and nursing**

Theoretical aspects of nursing and caring were defined in text by Florence Nightingale between 1858 and 1870. Her ‘Notes on nursing’ (1969) are considered a landmark in nursing and caring science. Nightingale found that nature fostered healing powers and that health care as far as possible should enhance this power and obviate factors that are hindrances to the healing processes. Positive factors include good sanitary conditions, ideal temperature, fresh air, sound and light in reasonable levels, as well as the need of social and existential access. Since then, theory development has developed rapidly over the decades, leading to the establishment of nursing and caring as an academic discipline with its own body of knowledge (Carper 1975; Chinn & Kramer 2008; Fawcett 2000; Meleis 2007; Tomey 2006). Theory development, articulation, and testing took a new departure in the fifties in the USA through theorists such as Rogers (1970) and Leininger (1993), and the discipline of nursing and caring was founded. Although these new thinkers within theory development inspired the evolution of nursing and caring as a profession and an academic discipline, nursing practice continued for another twenty years as a mere vocation where no theory was said to be needed (Tomey 2006). Then, in the 1970s came a new dawn in which the needs for concepts and theory arose internationally. This became evident in the USA where the National League for Nursing carried out a standardization of curricula for the nursing masters’ degree. The developments in the USA were numerous; in the years between 1975 and 1982, 781 dissertations on nursing/caring science were submitted (ibid).

In a European perspective the Workgroup of European Nurse Researchers (WENR) founded in 1980 an organization to support and promote relationships between researchers in Europe (http://www.wenr.org/). In Sweden, education in nursing and caring was given status as a university discipline in 1977 by the National Board for Higher Education (SOU 1978:50). This meant a radical change in the education as research became a central aspect.
In Scandinavia a new awareness of nursing care as a profession and academic discipline became apparent (Eriksson 2001; Dahlberg & Segesten 2010). In 1986 the first chair of caring and nursing science at the University of Gothenburgh was established. Finland was the first country in Scandinavia where it was possible to defend a thesis on caring science (Eriksson 2001). In the Scandinavian tradition, the caring sciences are manifested specifically in the Academy of Vasa, Finland, which has two foundations in basic and applied research, and these are again represented through basic systematic research, basic clinical research, and contextual clinical research (Eriksson 2009). In Sweden, the caring science tradition has been more specifically developed within the University of Växjö, represented by phenomenological life world-led caring (Dahlberg et al 2007, 2008, 2010). Norway and Denmark also have an anchor in the phenomenological–existential caring science tradition, and may be represented by Martinsen (1996) as a scientist and author that has contributed to the theoretical substance in this discipline.

Clinical caring science as an academic autonomous discipline, orientated in the human science paradigm has as its overall aim to promote caring ideals leading to reality and vice-versa (Eriksson et al 2003; Dahlberg & Segesten 2010). The idea is to make the intrinsic value of caring science obvious or manifest in a clinical context. The dedication of clinical caring science is anchored in knowledge where the understanding comprises the whole human being (Eriksson 1999; Kapborg & Berterö 2004). Research within this area leads towards the integration of theory- research- practice, and suggests patterns or method as tools or factors to decrease the possible gap between caring as a practiced art and caring theories (Eriksson et al 2003).

The arrival and development of caring and nursing theories during the 80s provided several perspectives of practice, research and education. Fawcett (2000) introduced a meta-paradigm that could be seen as an organizing structure for theories and frameworks that had developed. She classified models and theories within this meta-paradigm. In this way the theorist’s works were included as an integral part of a larger context. Usually the theorists are presented and categorized into four general kinds of theoretical works, as in Tomey (2006) or Parker (2006).
First, there is caring and nursing philosophy, which constitutes the meaning of caring and nursing phenomena. Philosophies should provide a broad understanding, being the very solid basis of the discipline, and provide advancements in its professional application. The Nordic caring theorists are classified in this context (Eriksson 1995; Martinsen 1996: Dahlberg & Segesten 2010).

Second, is nursing conceptual models based on the work of the grand theorists of nursing and caring works. The models of these grand theories include their perspective on each concept building up the meta-paradigm; these are person, health-well-being, environment, caring (Fawcett 2000). These models provide aims or actions for the professional nurse. Examples of such theorists are Rogers (1970) or Boykin and Schoenhofer (1993); the latter provided a nursing model for transforming practice that speaks more directly to nursing behaviors.

The third type is nursing theory, derived from the two previous types of work or from works in other disciplines related to nursing. The theories indicate specificity to a certain aspect of the practice as, for example in Leininger’s culture care theory of diversity and universality (1993). The fourth and last category is called middle-range theories. These are characterized as being much less abstract than grand caring or nursing theories. They focus on answering concrete practical questions on nursing. Such theorists represent, for example, pain control programs in cancer care, as developed by Dodd et al (2004). Seen from an international point of view, the general discussion of theories within nursing and caring has been dominated by the American meta-theorists, who also set out the taxonomy of the differentiation between them (Fawcett 2000). The grand nursing theories that were developed in the 60s and 70s have been criticized for being compounded and for lacking empirical and clinical support, as well as for being too abstract (Hall 1997).

Consequently, there is this thick marrow of theory as a structure of knowledge that underpins the education, the profession, and the science of caring and nursing. Yet, the distinction or visibility of theory as a fundamental structure is not obvious in nursing practice.

A recurring question concerns the relevance of caring and nursing theory to practice, considering the lack of a theoretical manifestation on our wards where most nurses work adjusted to the medical technical milieu that are most apparent and dominate the caring scenes (Enns & Gregory 2006; Maben et al 2007).
Theoretical definitions on caring

Care/caring has been defined as having ontological dimensions of being - or being the very foundation of being and developing in being, for example by Heidegger (1992) and Mayeroff (1972). Heidegger’s being (Da-sein) refers to being which, in turn, understands its own being, and this being (Da-sein) reveals itself as care. Caring (Sorge) is relating to the ‘thrownness’ in the world - being ‘thrown’ into an existence we did not choose in which death is the limiting end. Care includes taking care of objective things, taking care of things at hand and taking care of being itself. According to Heidegger, care takes things closer to being (Da-sein). Heidegger came to believe that the human being is fundamentally characterized by care, and in short, all human needs are met through the primordial condition of human caring.

Mayeroff (1972) gives caring the dimension of ‘helping the other grow’ and actualize him/herself. In helping the other grow it is the direction of the others growth that is guiding and helps determining how to respond; we are closest to a person or an idea when we help it grow. This is viewed as a process of relating to someone that involves development, and in his thinking, the two concepts of ‘caring’ and ‘being in place’ are cornerstones of the human condition. Mayeroff argues that man finds himself by finding his place, and he finds his place by finding appropriate others that need his care and that he needs to care for.

Care is both a noun and a verb, and when used as a noun, it has a different and distinct meaning. First, is the meaning of conscientiousness, diligence and cautiousness in avoiding harm or danger. The second definition is protection, guardianship, custody or safekeeping (Oxford Advanced Dictionary 2000). The third meaning relates to a concern, an affliction or worry. ‘Care’ is the root word of the term ‘caring’, and the concept of caring is ubiquitous in nursing literature and theory, and as such is considered a core concept of the discipline (Watson 1979, 2008; Eriksson 1995).

Within caring theory the term consists of carative factors that result in the satisfaction of human needs (Watson 2008), or is defined as a nurturing way of relating to a valued other
towards whom one feels a personal sense of commitment and responsibility (Swanson 2005). It is even defined as a transpersonal process (Watson 2008). The caring tradition is based on explicit distinguishable principles of value for caring, meaning caring can be considered as a phenomenon or existence.

Watson (1979, 2008) defines caring as a value and an attitude that has to become a will, an intention, or a commitment that manifests itself in concrete acts. According to Roach (1984) caring is not simply an emotional or attitudinal response. Caring is a total way of being, of relating, of acting; a quality of investment and engagement in the other person, idea, project, thing, or self. In Scandinavia, a leading caring scientist is Eriksson (2001), who states that caring is relationships that form the meaningful context of caring, and derives its origin from the ethos of love, responsibility, and sacrifice, that is, a caritative ethic.

Dahlberg et al (2009, 2010) describes caring as grounded in an understanding of the worlds of others, and as based on experiences of how people are living through complex situations - a contextual understanding of the quality of life.

Caring is primordial to existence, and its basic motive is the intention or will to do good towards another person (Eriksson 2002). The natural caring departs from the caring relation that can originate between patient and nurse/carer in that the caring relationship is a professional one. The caring relationship is an encounter when the nurse/carer makes use of his/her personal knowledge and experience while, at the same time, integrating medical knowledge to achieve understanding of how the patient experiences the situation.

Watson (2008) maintains that caring is the basic ontological substance for the nursing profession as well as for other health professions, and that it underpins epistemology. She is quite radical in her ‘postmodern nursing and beyond’(1999), proposing that caring itself serves as an archetype for healing represented by evolving aspects of a caring consciousness, intentionality, and human presence, and the personal evolution of the practitioner. She states that caring can be most effectively demonstrated and practiced interpersonally; however, caring consciousness can be communicated beyond time, space and physically (Watson 2002a). Further she holds that responses of a person is not only as the person is now but as what the person may become, and as such caring is in her words more ‘healthogenic’ than curing (2008). Eriksson (1995) in her theory of caritative caring, says that the act of caring comprises basic ontological caring elements such as faith, hope, love, tending, playing and learning. Eriksson argues that the new key of caring has to be
characterized by more humanistically orientated thinking, and the sounding board for this new key is to be found in its ontological core (Eriksson 2002). Two leading conceptions of caring come to the fore that constitute the caritas motive in her theory- the concepts of compassion and human love. According to Eriksson, the main idea of caring is to alleviate human suffering and to preserve and safeguard life and health (1995).

**Caring theory**

Caring theories are defined as the conceptualization of the reality of for example nurses. The intention is to verbalize and communicate caring phenomena, and to explicate the relationship between these phenomena (Eriksson 2001; Tomey 2006; Parker 2006; Meleis 2007; Dahlberg & Segesten 2010). The meaning of such theories is to describe what caring is, that is; what makes care caring, and why we are caring at all (Dahlberg & Segesten 2010).

Theorists in caring motivate their efforts in work as emerging from a quest to bring new meaning and dignity to the work and world of caring, and to patient care cf. (Eriksson 1995; Watson 1979, 2008; Dahlberg et al 2010). Theoretical concepts have emerged from professional and personal experience; they have been clinically inducted, and empirically grounded. The quest has been to deepen the understanding of humanity and life itself, and as such, the theories have philosophical, ethical, intellectual and experimental foundations.

In her revised edition of her theory ‘Nursing ; the philosophy and science of caring’, Watson (2008) claims that she then, thirty years later, might as well have framed the theory; ‘Caring; the philosophy and science of nursing’. Her first basic assumption is that caring theory is the essence of nursing and the basic disciplinary core of the profession.

Through the long series of research results on the phenomenon of caring that have appeared over the years, one might claim that caring comprises context-specific situations where openness, authenticity, and sensibility appear to be involved qualities (Watson 1979, 2008; Nortvedt 2003; Todres et al 2007). Caring may be defined as being context-specific inter-relational processes between a caring person and the human being as patient. Caring proceeds according to the needs and openness to receive care of the one who is being cared for, and by the carers professional and personal maturity and moralistic foundation. Caring is further described as being an attitude, ability, a capacity or characteristic of various inter-related accomplishments (Finfgeld-Connet 2008).
Caring in Theory and Practice

An interesting perspective is given by Todres et al (2007), who argues that caring comprises several dimensions that cannot be separated; rather they must be seen as a holistic quality full of interrelated horizons. One qualitative part or moment is part of a greater whole, and considering caring in this way may give an understanding of caring that cannot be explained by dichotomies in theory and practice, or doing, being and becoming. From this perspective caring must be seen and comprehended as a dynamic movement of all categories, interrelated and inseparable (ibid 2007).

Theorists claims that caring is fundamental to all nursing (Roach 1984; Watson 1979, 2008; Boykin & Schoenhofer 1993; Leininger 1993; Eriksson 2001; Dahlberg 2010). The concept of caring is one of the meta-paradigm concepts that builds caring and nursing theory. An understanding of what the phenomenon of caring comprises should be vital for any caring culture, as an understanding (and interpretation) of caring gives color to any caring culture (Rytterström et al 2009), and even political directives and standards (ICN 2000, SFS 2001:453, SFS 1982:763). The way nurses understand and interpret caring is thus fundamental to how we are as nurses - to our caring efficacy and the way we perform our caring work. This is probably also true for the understanding and interpretation of the other meta-paradigm concepts as well: how we understand and interpret the human being, health, suffering, well-being and environment. Theories are intended to be reflective builders of the practice (Fawcett 2000; Cody 2003; Chinn & Kramer 2008). Through the use of theory, nurses may find ways of looking at and assessing phenomena that are different from unreflective (tacit) and taken-for-granted assumptions. With an explicit theory base nurses have a better rationale both for their practice and for the evaluated outcomes (Cody 2003). Science and extensive experience in Sweden illustrate that caring theory can energize creative thinking and make communication easier (Ekebergh 2004, 2009). Reasons for the caring professions being grounded in theory include ethical ones. As an example, Cody (2003) states that practical nurses have an ethical responsibility to develop a knowledge base that is specific to practice.
Studies on caring in theory and practice

Cody (2003) states that there is little enthusiasm in universities or at schools of nursing to teach about elements of caring and nursing theories. Such teaching is often done halfheartedly, and the majority of practice settings do not value the use of nursing or caring theories (ibid). The same tendencies are shown in studies in Sweden. Studies made by Ekebergh (2004, 2009) show that nursing education shows doubt about the use and need for caring theories, which is confirmed in an analysis (Eklund-Myrskog 2000) of sixty Swedish nurse students on their relation to caring theory. The findings showed that many students at the end of their education have difficulty in comprehending the relation between the caring theory and the practical caring reality.

Often it is the benefit of practical experience, common sense and problem-solving that colors the practice of nursing care. Rather seldom are clinics or wards grounded in a philosophy of caring or nursing that guides the work of the caring profession (Cody 2003). The reason for this may be historically understood from the fact that the number of educated professions of diverse categories within the healthcare systems was defined by medical science up until the 1970s (Dahlberg & Segesten 2010).

In a concept analysis study by Sivonen and Kasen (2003), the authors ask whether human beings as patients are losing their wholeness, as health, soundness and integrity are linked together, and when the human becomes a patient, integrity and dignity is violated through the state of illness. A basic value of caring mean preserving human dignity, and is related to the reflections on the above-mentioned study; this is related to caring for the patient as an entity with a body, soul and spirit. The concept of entity is essential in a clinical perspective as theory tells us that understanding is expressed in action (Gadamer 1989).

Watson (2002) presents a number of instruments that have been developed to try to identify the inter-related dimensions of caring in different ways in clinical practice. At the same time, she states that these instruments must be seen as indicators of dimensions that are not measurable or understandable in their entire depth. They are only meant as indicators of the many faces and nuances of the caring phenomenon. One such instrument is the CDI-35 (Caring Dimensions Inventory), which may give an indication on how both the carer and the one cared for (patient) understand caring. In a study where both patients and
nurses commented on 35 assumptions of what constitutes caring, the experience of caring differed between the groups on several meanings. ‘Listening to the patients’ was interestingly scored as the most caring of all tasks by the nurses, whereas the patients rated more highly statements such as ‘involving the patient in care’ and providing privacy for the patient’. The result of the utilization of this instrument points to the necessity of sensitivity to the patients’ experience of caring. Other formalized tools for measuring the importance of certain caring behaviors are the Care–Q instrument (von Essen 1991). However, studies like these do not give any suggestions for how such a perceptiveness or clinical sensibility can be cultivated in caring clinical practice. Tools for self-awareness in mediating care or cultivating one’s caring perceptiveness are not mentioned.

In a study where nursing students give meaning to the phenomenon of caring and the caring process, this is described as embodying the interaction of hand, heart and head (Kapborg & Berterö 2003). This means that the actual caring act comprises the existential presence in the encounter with the patient, the theoretical knowledge basis of caring, and the reflection on this knowledge in clinical practice. The study suggests the necessity of reflexivity between theory and practice to be able to see caring as a complex phenomenon constituted of differing forms of knowledge, which is confirmed by theorists such as Carper (1975) and Chinn and Kramer (2008).

The art of caring and being present and conscious in caring is characterized by concepts such as interpersonal sensibility, and the ability to be empathic, open, and flexible in the caring relation (Le Vasseur 2002; Nortvedt 2003). Studies have shown favorable results for both patient and nurse when the meaning of caring and the phenomenon of caring have been examined (Edvardsson 2003, Arman et al 2008).

According to Parker (2006), the predominant international caring theorists describe a need to explore integration of caring theories in practice, both with the aim of deepening the knowledge of the core of caring theoretically, and to make visible and make conscious the conceptual basics of theory in action. The question of integration between caring theory and clinical practice is the core question in the development of the caring science paradigm (Eriksson 2001). The challenge is how such integration is approached, applied, and implemented. Studies, for example by Cameron (2000), of theoretical models for ethical decision-making in caring, have a tendency to focus on how the nurse should behave or be,
to be able to make wise decisions. This may be of little use if the nurse does not possess this kind of knowledge, and if the nurse does not have an underlying wish to develop authentic and not rule-bound caring practice (Carlsson et al 2006).

Cody (2003) argues for an integration of basic caring concepts and for the cultivation of caring consciousness tools for nurses in clinical practice. Another study supports this and argues that nurses easily become “need-orientated” on the behalf of sensibility and focus on the situation, and that a repeated and conscious position is needed to be able to relate to basic caring categories (Delmar 2002). Freshwater & Johns (2001) argues that guided reflection in practice provides a milieu for the practitioner to understand and develop him/herself as caring in ways that acknowledge the unique but elusive nature of caring.

A recent study (James 2010) shows that what nurses describe as fundamental for their judgments in caring is what they called emotional knowledge. This knowledge was the foundation of their practical wisdom in knowing, understood as an ongoing movement of judgments made from being, as the study expresses metaphorically, among various rooms described as normative, critical, affinitive or confidential, which were all interrelated and part of emotional knowledge. Accordingly, James et al (2010) take a stand against the strict differentiation between rational and emotional knowledge that occurs in our Western culture-dominated knowledge tradition.

Transforming this to an assumption of evidence of caring (Eriksson 1999; Kapborg & Berterö 2003), the meaning is that that there exists no such possibility of doing anything from a solely theoretical stance that does not have consequences for (being and doing) ‘heart’ and ‘hand’. It is not possible to carry out any practical activity that does not affect or implicit ‘heart’ and ‘head’ etc. Dahlberg et al (2007) means that the challenge in practice becomes a consciousness-making (sense-making) of the dynamics and cogency of all dimensions without getting stuck in any category: that is, if holistic caring based on humanistic values is to be accomplished through theory, ethical insight, and aesthetical handling. The theory (2007, 2009, 2010) is called lifeworld led care, where ensuring health and well-being is the meaning of caring.
The complexity of caring work consequently demands cultivation of different forms of knowledge for the theories and concepts in caring science to make sense (Carper 1975; Eriksson 1995; Martinsen 1996; Chinn & Kramer 2008). Chinn and Kramer name these empirical, aesthetical, ethical and personal forms of knowledge. They claim that empirical knowledge is the one most practiced, and is therefore the easiest to relate to in clinical practice. Ethical and aesthetical knowledge often remain veiled, and as such are vaguely expressed and not clearly or consciously reflected in clinical practice. Eriksson (2009), Kikuchi (2003) and Dahlberg (2010) state that the core of caring is ethical by nature, and that this is what constitutes the primary substance of caring science. A consequence of these assumptions should initiate that ethical and aesthetical forms of knowledge are essential to conceptualize, train and reflect in education and in clinical practice, and there should be no suggestion that these forms of knowledge are self-evident.

**Municipal elderly care context**

Gustafsson (2009) shows that there are differing expectations of the nurses working in municipal elderly care from physicians, social workers, or from the enrolled nurses. They are expected to be leaders, equals, as well as subordinates. They are expected to keep up the complexity of the caring culture, but at the same time they should keep to their own field of activity of medical advice and support (Gustafsson 2009). Municipal elderly care is characterized as comprising the norms of social services such as safety, community and caring values, and the medical ones such as treatment, technique and pharmacology, all gathered in their homes. Through structures and routines that are created by the caring personnel, the institutional hallmark is a fact, and the intention of creating homes for the elderly is an illusion (Whittaker 2009). In such a milieu as a home for the elderly, which is usually the last home for an elderly person before death, the being becomes pregnant with the possibilities of existential questions and ponderings. The question of recovering from illness is not as central as the question of how to obtain health when often multiple health problems exist (Summer Meranus 2010).

In a report from 2008, the National Board of Health and Welfare stated that there exists a lack of competencies in municipal elderly care due to the fact that the elderly are affected to a larger extent by the drawdown in public medical services, and as such, are suffering from
chronic diseases in homes for elderly, where medical staff are scarce. In a petition by the Swedish Nursing Foundation (SSF) they claim that it is not acceptable that the knowledge that exists within nursing and caring sciences, and specifically within geriatrics and gerontology, is enjoyed only when they are cared for within the County Council. They also claim that it is noteworthy that the medical and caring needs of the elderly vary, depending on the legislation the caring staff works under (SSF 2010).

Altogether, frameworks, theories, and concepts exist as well as studies that confirm the multidimensionality of caring. The complexity and structure is made clear by their multitude. A question that arises is whether the grounding in human science that caring theory seemingly has, has insufficient connection to or integration with ethical and aesthetical ways of knowledge.
AIMS

The overall aim of the thesis was an investigation of the meaning of caring to nurses in municipal elderly care, and of their explicit and implicit understanding of caring theory in their daily practice.

The specific aims were:

**Study I** To see if and how experienced nurses described caring, and whether they included any theoretical basis in their caring acts.

**Study II** To inquire into the participant nurses’ experiences of rhythmical embrocations (RE) and present their reflections about caring theory into the caring act.

**Study III** With the objective of investigating the possible disparity between theory and practice, this study inquires into nurses’ lived experience of the understanding of caring theory in practice in the context of municipal elderly care.

**Study IV** To better understand the approach of caring in nursing and the role of theory in practice, we wanted to consolidate the empirical findings from three studies to reveal nurses’ caring intentions and their lived experience of reflecting caring theory in practice, with the caring theory of Watson (1979-2008).
RESEARCH APPROACH

Besides the ontological framework that was previously described, the research also has an epistemological and methodological framework. The epistemological perspective of this thesis is best described as phenomenological/hermeneutical. My ambition has been to understand the theory practice dilemma from a lifeworld approach, i.e. based on the lived experiences of the nurses and their everyday caring practice. Further, with this approach I wanted to establish a distance from that which is too close and well-known, i.e. care and nursing, in order to gain a deeper insight. Phenomenology holds that all ‘taken-for-grantedness’ needs to be alienated to become visible (Bornemark 2010). Inspired by Husserl, who laid the phenomenological ground, Heidegger (1992), and later Gadamer (1989) aimed at establishing a new understanding of ‘the being of the human being’ with the idea that the human being is always situated in ‘being in the world’ and cannot escape this. Consequently, all understanding of being is intertwined in a historical and temporal context, or in the words of Gadamer (1989), “we are immersed in our beings.”

From such a phenomenological perspective the dichotomy between subject and object evaporates and the aspects of meaning, understanding and interpretation are revealed as ontological structures in being. The reality is not observed; rather it shows itself as understanding and meaning, and this process of understanding and meaning is both phenomenological and hermeneutical (Gadamer 1989). Due to this reasoning, theory is not an abstract description of an outer reality, of an empiric on the outside; rather it is related to the knowledge of lived experience.

Departing from caring theory as a human science implies a choice of perspective and a perception of knowledge. According to the epistemological perspective, it is essential that in a professional caring relationship there is a consciousness that there is no objective reality that seems the same for all. This can be accommodated by following the human science tradition with its ontological, epistemological, and methodological foundations, as for example in a hermeneutic or phenomenological tradition (Eriksson 2001; Todres et al 2007; Dahlberg 2008). It is a challenge that needs to be made conscious constantly, health care professionals primarily are used to understanding the human being from a natural science
perspective. Nursing, based on theories of caring, is anchored on the basic questions: ‘What is health and experienced health?’ and as a practice-oriented science, ‘Is my caring alive and efficient?’

A departing point and a primary assumption for this project is that concepts and theory give meaning and value to how we relate to the world and how we gain our experiences. When the philosopher Gadamer (1989) claims that understanding happens in language, he does not mean a certain form of language in the way linguistics defines language, but rather he means what is mediated through language. An assumption is that basic caring concepts and theory may represent a field or an area where we are confronted with our inherent preconceptions and prejudices. We may get to learn something about ourselves and our pre-understandings through this confrontation (Austgård 2008; Ekebergh 2004, 2009).

Basic methodological concepts within the phenomenological and hermeneutical approach can be related to as principles that guide the research in finding the structure of meaning that belongs to the phenomenon of research. These principles can be seen as guiding the research process at an overall level as well as on the level of collecting data in an interview situation (Dahlberg et al 2008; Lindseth & Norberg 2004). The basic methodological principles are intersubjectivity, openness, flexibility, immediacy and meaning. An open and accommodative approach to the phenomena and their wealth of meanings, gives the opportunity of seeing their particularity and what makes them unique. Phenomenology and hermeneutics speak of scientific sensitivity to the intricacy of the lived world. Intersubjectivity is a primordial quality of the lived world of the human being - it is a primordial notion of being. The world is a world that I share with others, and one may say that the ‘intersubjective dimension is a part of the total horizon that makes our world meaningful’ (Dahlberg et al 2008, p.58).

The data in this thesis have been developed and analyzed in complementary ways. The first study has its approach in a phenomenological position, and is analyzed according to the approach of Reflective Lifeworld Research (Dahlberg et al 2008). In studies two and three, an approach of phenomenological hermeneutics was used to process and analyze the data (Lindseth & Norberg 2004). In study four, a content analysis (Mayring 2000) and a
simultaneous concept analysis (Haase et al 2000) (SCA) were used to analyze data from the three earlier studies together with basic concepts from a theoretical caring science theory (Watson 1979, 2008).

**METHOD**
A reasonable condition for any proper research within any area is that it is initially directed according to the character of the researched area. This character sets the basic direction for the approach and methods, i.e. how the research will achieve knowledge, its way of anchoring and providing its conceptuality, and its potential for truth and clarity. In these studies, the character of the phenomenon of caring sets the tone of the ways the inquires have been conducted. Reflective life world research and phenomenological hermeneutics were considered as approaches since the meaning of caring and caring theory in practice were the phenomena to be studied. The research question of the relation or dynamism of caring in theory and practice was elaborated using a simultaneous concept analysis (SCA) to scrutinize and clarify the caring concepts.

**The Context**
The context of the studies is municipal care in a middle-range community in the mid-east of Sweden. Municipal care in Sweden is regulated and organized by two separate laws; the Social Services Act (SFS 2001:453) and The Health and Medical Service act (SFS 1982:763). The Social Services Act is responsible and sets the juridical framework for the social aid administrator, the heads of nursing homes, and enrolled assistant nurses, whereas the Health and Medical Services Act governs the nurses and physicians in their work. The nurses in municipal care are not team leaders for the enrolled assistants. The nurses and the enrolled nurses have separate responsible authorities (Gustafsson 2009). The caring responsibility (SFS 1998:531) in municipal elderly care is laid on nurses in their function of managing and practicing medical and nursing care, and being responsible for medical and caring treatments (Carlström 2005). Working as a municipal nurse in elderly care does not demand any specialist competency, as for example within geriatric care, and the nurses mainly work alone in their function that comprises medical guidance and treatment, counseling, supervision, and caring that demands their authorization (Tunedal & Fagerberg 2001).
Presentation of the studies

Study I.

This study’s aim was to see if and how experienced nurses described caring, and whether they included any theoretical basis in their caring acts.

Eleven nurses from seven units of elderly municipal care in central Sweden participated. The criteria for informant selection were determined through purposeful sampling for age, years of working, social background, sex, and geographical spread. Interviews were carried out as everyday dialogues that allowed the informants to talk freely about their experiences in a milieu that was familiar to them. The interview situation was initiated with a question along the lines of, ‘What does caring mean to you?’ The interviews differed from everyday conversations since, in line with the approach of the study, they included several follow-up questions, such as ‘What do you mean?’ or ‘Could you please tell me more?’

Follow-up questions had two main aims, namely to encourage the interviewees to deepen their narratives, as well as to ‘bridle’ the interviewer (Kvale 1997, Dahlberg 2001, 2008).

Arguing for the choice of methodological approach was the intention of entering into the deeper lying meanings of caring, and therefore a reflective lifeworld research (RLR) approach was utilized (Dahlberg et al 2001, 2008). The phenomenological concept of the lifeworld implies both ontology and epistemology for health science research in which the question of meaning is paramount. Health science phenomenology seeks to understand the meanings of health-related phenomena, for example, in our everyday experiences of health, well-being and illness. These meanings are often implicit, “tacit”, and taken for granted, and it is through research that the implicit becomes explicit, can be seen and heard, problematized, and reflected upon (Dahlberg 2008).

In this study, the RLR was used in two ways. First, it directed the empirical work consisting of the interviews and the analysis of data. Second, empirical and philosophical insights from the field of phenomenology were used in order to shed light on implicit meanings in the text.

The analysis was descriptive and sought meaning, and the informants’ multifaceted and unique descriptions of their lived experience of the phenomenon gave the general structure of the phenomenon; caring in theory and practice. The analysis followed the qualitative approach of movement between the whole and parts. Mainly in the analysis, the text was read and re-read to get to know the data (the text) until an understanding of the text as a
wholly was reached. Openness and immediacy were important matters for reaching a consciousness of the different aspects of the phenomenon, as well as for developing the possibility of extracting unexpected meanings from the text. This work was a challenging part of the process, as remaining in a state of openness over time is an arduous task. Dahlberg et al (2004, 2008) calls this attitude “bridling”¹, a word which means putting a hold on the process of understanding and at the same time restraining one’s pre-understanding in the form of beliefs, assumptions or theories that otherwise could mislead the description of meaning in the phenomenon, and thereby limit the research openness.

Transcribing the interviews and reading them over and over again brought familiarity with the substance of the texts. The knowledge of transcribing the data gave sensitivity to the informant’s tone, voice, and mood. These notations were written down in the interview texts as well. This handling brought to life anew the interview situation and the informant’s stories. Subsequently the text was separated into meaning units to identify the meaning or implications of the phenomenon. Such a meaning unit can vary from being only a few words, to larger amounts of text as one moves around in the text trying to identify or unpack and understand its meanings. On the way, in searching for the structure of meanings, the making of clusters was important and of structural help. This meant putting together meaning-units that seemingly belonged together, all the time observing the wholes and the parts - that means not seeing clusters as separate categories but rather as elements that should be moveable in and out of the whole as parts of the whole.

To describe the phenomenon’s essence or structure of meaning implies an understanding of the phenomenon that is deeper than before the research. A description of the essence and its constituents (the general structure), is presented in the findings later on in the text.

Study II.

The aim of study II was to inquire into the participant nurses’ experiences of a caring act called rhythmical embrocations (RE), and present their reflections about caring theory into the caring act.

¹ This is a term that has been developed within a phenomenological lifeworld approach, (used in Reflective Lifeworld Research). The term means the inclusion of phenomenological reflection, which is the mental activity of slowing down the natural process of conscious understanding. This means not to make definite what is indefinite - not to ascribe meanings to things in just any way. (Dahlberg et al 2008, Dahlberg & Dahlberg 2004).
The aim was built on the assumption that certain caring acts may give nurses the opportunity of reflecting an awareness of caring theory and its influence on their care. The idea of the study was presented to 25 nurses who were all working in municipal care in various homes for the elderly. Inclusion criteria were the ability to participate in the project for six months, training in RE, the possibility of performing RE two to three times a week for four months, and attendance at regular monthly meetings with the project team, where clinical experiences were discussed and compared with theoretical caring concepts. Voluntary participants in the study were four registered and three assistant nurses, six of whom were female. They had 5–35 years of work experience in caring for elderly persons. Five units geographically spread across the municipality were involved. Each participant nurse performed the caring act of RE on two or three elderly persons who attended on a voluntary basis.

Data was collected through tape-recorded conversational interviews, lasting 40-60 minutes with each participant. In studies I, II, and III, open-ended questions were asked in the interviews. Kvale (1996) argues that if you want to know how people understand their world and life, you must ask them. He also argues that the professional qualitative research interview is a professional dialogue that is established in everyday conversations, but it presupposes methodological consciousness. Challenges that occurred in the process were to get the right immediacy in the interview that would create an opening to get the participants to tell their stories. This became easier as the project went on, as the focus was to be the participant and the phenomenon. What would be supportive in the interview situation was trying to demonstrate phenomenological naivety - asking questions that did not presuppose any particular answer. Thus, the interview situation demanded considerable self-awareness and, as Dahlberg (2008) calls it, bridling.

The choice of methodological approach was the phenomenological hermeneutical method (Lindseth & Norberg 2004), as the research question comprised the lived experience of a phenomenon, namely the experience of giving RE and the nurses’ ideas about how caring theory was reflected in the caring act. The approach was developed by Lindseth and Norberg, inspired by Ricoeur (1976), and was published in 2004, and the purpose of this method is to uncover the meaning of a given phenomenon. In brief, the methodological principles are that the interpretation of a text constitutes a dialectic movement between understanding and explanation, and the analysis dialectic process involves three phases: 1.
Naïve reading, 2. Structural Analysis, and 3. Comprehensive Understanding. According to Ricoeur (1976), we are formed in tradition and context, and also by what he calls pre-configuration. By narrating how we understand our life world, our pre-understandings are translated, reflected, and verbalized (configuration). The advent of new meaning that emerges can give new possibilities in life (refiguration). There is always a ‘before’ and an ‘after’ the narrative, and he uses the concept of mimesis, as in classical Greek the word means an image of nature/reality (Ricoeur 1976). Gadamer (1989) in turn calls these movements the ‘eternal excursion’ and ‘return of the human spirit’.

The narrative interview texts were transcribed, and a naïve understanding was formulated from an initial reading of the texts. In fact, this naïve understanding actually began with the transcription of the texts. This meant taking a phenomenological approach, which implied setting one’s own pre-conceptualizations aside - being touched by the text, becoming unknowing and amazed by it.

The next step was the structural analysis. This implied a de-contextualisation, of the text into meaning units that were condensed and abstracted to form sub-themes. The sub-themes were elevated into main themes, and these were reconnected and identified in the naïve reading. The last part of the approach was the comprehensive understanding. According to Ricoeur (1976), the process of arriving at a comprehensive understanding should be considered as a ‘non-methodical’ pole of understanding. This means that it is not possible to strictly follow methodological rules. The text was now read and understood in the light of the literature chosen, and in turn, the literature chosen was seen in light of the text. The comprehensive understanding disclosed new possibilities for being in the world, and as the results of phenomenological hermeneutical investigations are about the meaning of lived experience, they can only be used to affect the meaning of lived experience - that is, as understood by the interpreter.

Study III.

With the aim of investigating the possible disparity between theory and practice in caring, this study inquires into nurses’ lived experience of the understanding of caring theory in practice in the context of elderly care. This study addresses the question of a theory-practice gap in municipal elderly care. In this context, the patients are often suffering from multiple incurable diagnoses, and central existential caring questions become dominant.
Contact with the township’s chief of staff was initiated, and an arrangement made for information gathering with interested nurses. A total of 30 nurses were asked (= total sum of nurses employed in the municipal elderly care). Twelve agreed to participate, and another information gathering session was held, where actual questions about the research project were answered in detail. The participating nurses gave informed consent to their participation in the study and were free to choose the date and location of the interview.

Interviews were conducted as described in former study; they were open-ended with an initial question and follow-up questions in order to deepen the narratives, and as such the meanings of the lived experiences of the phenomenon. The interviews were transcribed verbatim and analyzed using the phenomenological hermeneutic approach as described in study II.

**Study IV.**

To better understand the approach of caring in nursing and the role of theory in practice, we wanted to consolidate the caring theory ‘Nursing, the philosophy and science of caring’ of Watson (1979, 2008 rev) and the empirical findings from three studies performed to reveal nurses’ caring intentions, their lived experience of reflecting caring theory in practice, and the verbalization of the (possible) discrepancies related to theory and practice in intention and organization.

To do this, the findings from a qualitative content analysis (Mayring 2000) of Watson’s caring theory (Watson 1979, 2008) were intended to be used in the simultaneous concept analysis (Haase et al 2000). The theory was read through a number of times - both the original from 1979, and the revised theory from 2008. The concepts and theory development that constitute the caritas processes (the carative factors in 1979) were thoroughly elaborated and analyzed using Mayring’s (2000) content analysis. This is a systematic text analysis process following rules of procedure dividing the material into content analytical units and building categories. In the study, Watson’s theory (1979, 2008) was subjected to this analytical process. Emanating from the substance of the ten caritas processes, the elaboration and interpretation gave six components that were determined as being the concept of caritas. (Table1). Caritas comprises complex and integrative qualities that constitute caring, such as practicing of loving kindness and equanimity towards others and oneself. It has to do with the cultivation and deepening of self-awareness, of going beyond
oneself, and being authentically present in the caring encounter, as well as being present to
and supportive of both positive and negative feelings. The creative use of self is part of the
caritas process as well as engaging in genuine teaching or learning experiences. Caritas
involves assisting with gratification of human needs, having an intentional caring
consciousness, and allowing for unknown existential dimensions.

Table 1. Concept and Components of The Philosophy and Science of Caring (Watson 1979,
2008).

<table>
<thead>
<tr>
<th>CARITAS</th>
<th>Altruistic Values</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Being Authentically Present</td>
</tr>
<tr>
<td></td>
<td>Creative use of Self in knowing/doing</td>
</tr>
<tr>
<td></td>
<td>as part of the Caritas Process</td>
</tr>
<tr>
<td></td>
<td>Engaging in genuine teaching / learning</td>
</tr>
<tr>
<td></td>
<td>experiences</td>
</tr>
<tr>
<td></td>
<td>Reverentially and respectfully assisting with basic needs</td>
</tr>
<tr>
<td></td>
<td>Opening and attending to spiritual and unknown existential dimensions</td>
</tr>
</tbody>
</table>

These concepts were further considered in the simultaneous concept analysis (SCA) together
with concepts from the three empirical studies.

Methodological principles in SCA (Haase et al 2000):
Walker and Avant (1988) brought concept analysis into nursing and caring theory in an
attempt to clarify concepts of interest for theory construction and clinical use. Haase et al
(2000) take the concept analysis further by constructing SCA, as the SCA highlights caring
concepts as complex and interrelated, and because these interrelations exist, the concepts
cannot be analyzed in isolation. Because of the existence of the interrelationship, these
concepts should not be analyzed in isolation. Critical ingredients of an SCA process are
consensus-group processes, the application of validity matrices, and the development of a process model. In an introduction to SCA, Rodgers (2000) states that concepts are like a mental image of reality tinted with the theorists’ perceptions, experience, and philosophical bent. There is a consensus, she states, that concepts are cognitive in nature and that they comprise attributes abstracted from reality expressed in some form and utilized for some common purpose. They function as a reservoir and an organizational entity, and bring order to observations and perceptions (ibid). Consequently, concepts are more than words or images alone. From this perspective - that concepts and language evolve from a complex constellation - we wanted to consolidate the expressions that arose from a clinical practical lived experience of caring in elderly municipal care, with concepts from caring theory. What is notable about an SCA is that each concept in the analysis is developed simultaneously to all the other concepts taken into consideration. The method explains the individual concept and the inter-mutual relations. The method is described as guidelines in the form of nine steps where the steps merge into each other. Each step is briefly described below:

Step 1: A consensus group was built and consisted of the researcher, the two supervisors, and a PhD-student. Each of the individuals brought their expertise to the group in the form of various fields of knowledge within the caring and nursing paradigm.

Step 2: Nine concepts were chosen. One from the content analysis of the caring theory; caritas, and eight from studies I, II and III: Sense-making as moments of embodied reflection, gaining meaningfulness, caring in distress, becoming aware, embodied moments of presence, abstractions and confirmations, caring as leading star, and intention of caring.

Step 3: Refinement of the individual concepts and their components to be analyzed are shown here in table 2:
Table 2: Refinement of the nine concepts and their components to be analyzed in step 3.

<table>
<thead>
<tr>
<th>Sense-making as movement of embodied reflection</th>
<th>Gaining meaning-fullness</th>
<th>Caring in distress</th>
<th>Becoming aware</th>
<th>Embodied moments of presence</th>
<th>Abstractions and confirmations</th>
<th>Marginalisation of caring</th>
<th>Intention of caring</th>
<th>Caritas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being a detective of the senses</td>
<td>Becoming aware</td>
<td>Getting things done</td>
<td>An opening act of care</td>
<td>Rhythm</td>
<td>Narrow and abstract structures</td>
<td>Being medical consultants</td>
<td>Experienced health</td>
<td>Altruistic value</td>
</tr>
<tr>
<td>Creating a sphere of confidence</td>
<td>Responsiveness</td>
<td>Performing duties</td>
<td>Calming and warmth</td>
<td>Confirming practice</td>
<td>Neglected caring</td>
<td>Neglected caring</td>
<td>Caring efficacy</td>
<td>Being authentically present</td>
</tr>
<tr>
<td>Grasping the healing force</td>
<td>Creative caring</td>
<td>Earning a living</td>
<td>Atmosphere</td>
<td>Theory and practice intertwined</td>
<td></td>
<td></td>
<td></td>
<td>Creative use of self</td>
</tr>
<tr>
<td>Finding the tune in a harmony</td>
<td>Contact with self and others</td>
<td></td>
<td></td>
<td></td>
<td>Engaging in genuine teaching and learning</td>
<td>Revertentially assisting with basic needs</td>
<td>Opening to unknown existential dimensions</td>
<td></td>
</tr>
</tbody>
</table>
Step 4: Clarifying the concepts: they were discussed and elaborated in the consensus group. Sense-making as moments of embodied reflection (study I) is about caring in terms of sensibility, sensitivity and being alert, as well as in terms of vulnerability. Gaining meaningfulness (study I) is about caring becoming creative when allowing for individual solutions in dialogue, giving caring an aesthetic dimension. It is about creating conditions for the patient to understand their situation and strengthen their life force. Caring in distress (study I) comprises the caring approach of performing duties, or when the caring becomes pure doing. Becoming aware (study II) comprises an expansion of senses in the caring situation, a resourceful tentativeness that would allow for an increased feeling of presence. Embodied moments of presence represents the sensitive awareness that was brought forward, giving rise to registering phenomena that earlier had been beyond conscious awareness. Abstractions and confirmations (Study III) assembles both the experienced gap between caring theory and practice, as well as a confirmation in caring theory that explains caring practice. Marginalisation of caring (Study III) explains the experienced organisational gap between the intentional caring and the actual caring practice. The last concept from the empirical studies was intention of caring (Study III) in which health and well-being was expressed as the central perspective in caring and in the nursing profession.

Caritas is the concept that emanated from the content analysis of the caring theory of Watson. Caritas comprises a deeper vision and ethical commitment to the human dimensions of caring in nursing, based on humanistic altruistic values. Clarification of the concepts was carried out in the consensus group. The refined concepts were discussed, scrutinized, and considered from all angles until agreement was reached about the antecedents, the critical attributes, and the outcomes of all the concepts.

Step 5: This step in the process covered the development of a validity matrix. In this, all individual concepts and components were contrasted and compared with all other. Again, this process cultivated the definitions and clarified antecedents, critical attributes and outcomes. The matrix consisted of the nine concepts from step 2 and the 30 components in step 3; a total of 270 concepts and components.

Step 6: Re-examination of all individual concepts was carried out by the consensus group. Revisions were conducted as necessary to clarify the concepts.
Step 7: In this step the semantics were considered in the consensus group, and necessary changes made. Similar components were clustered and labeled together.

Step 8: The analysis generated a process model where the advanced concept of Mediating care became a meta-concept. The process model is presented under Findings: (Figure1).

Step 9: The results of the analysis, and the process, were now presented to colleagues at a seminar. This gave the opportunity of reworking the concepts again and getting perspectives from more participants. In this process, the consensus group made the most important contribution.

ETHICAL CONSIDERATIONS

The planning of the project developed following ethical research principles according to the declaration of Helsinki (2002). Permission to conduct the interviews was obtained from the chief of staff in the current township the local administrator, and from each contributing participant. Information on the study and the whole project was given at three gatherings with the chief in charge and the nurses. This procedure was followed before each of the three studies and in accordance with the law of ethical approval of research concerning human beings (SFS; 2003:460). All studies in the dissertation were carried out in accordance with this law. Simple and clear information was given to the participants, and the aims of the studies, methods and approaches that were used and information on the responsible authorities behind the research were also given. Permission to perform the studies was given from the County Council as well as from the chiefs in charge at the units and the individual participants. The participants were assured that all information would be treated in confidence and according to the principles of research ethics as defined by the Helsinki declaration (2002). They were also assured that they were free to decline participation in the study at any time without giving any reason for doing so. The studies were performed after receiving the participants’ informed consent, responsibility was taken for the participants’ safety, and guarantees of confidentiality were given. The empirical studies were agreed by the central ethical committee.
Methodological considerations

The collection of data was carried out using a qualitative approach and approaches of analyzing data, in accordance with the aims of the studies. An open report on the research process was made in the partial studies’ sample, approach (method), analysis and report of findings.

Reliability in the interview situation can be discussed in relation to leading questions which may, when not considered as an interview technique, influence the answers. Open-ended interview questions were asked, with follow-up questions. The initial question was similar. Challenging aspects of the research process included being aware of the need for bridling one’s own understanding and intention, as well as being sensitive to the creative moments in the interviews that would lead to promising new discoveries along the way.

Efforts were made in each study to make visible the material in its entirety as well as the distancing momentum that permeated the interpretations through the process.

Where possible, there are citations from the raw collection of data, to strengthen and vitalize the reports on findings.

The methodological approaches that have been used in the thesis are all well documented and have been used in a number of studies by various researchers. All analysis has been performed in a collaboration process with supervisors, and manuscripts and approaches have undergone critical examination in seminars with junior and senior researchers. This reduces the risk of single-minded interpretations (Lindseth & Norberg 2004; Dahlberg 2008).

Methodological principles are openness and pliability in the research process. This implies an open and accommodative approach to the phenomenon and thus makes it possible to see the uniqueness and particularities of the phenomenon, in both gathering of data and in the analysis (Dahlberg 2001, 2008).

Immediacy and openness existed in the process when an engaging participation allowed for a high level of nearness or open-mindedness. This is a way of listening that implies being in an inter-subjective relationship of openness and pliability. Engagement with the phenomenon can in this way be broadened and deepened when the researcher allows for the otherness of the phenomenon. Accordingly, it is not possible to achieve total impartiality, as we are always subject to some form of pre-understanding. The effort of ‘bridling’ one’s pre-understanding became a conscious and continuous endeavor all through the research process, and this endeavor had to be trained and trained again.
Since the contextual phenomena are existential and ontological, a wider possibility of generalization is given. Kvale (1996) highlights that the researcher’s responsibility is primarily to provide a description that is rich and loaded, with a precision that the interpreter or the clinician can use as a starting point. The generalization of the findings in the presented study is partly dependent on the context of the gathered data. However, it is possible that other contexts can benefit from the general points and transfer these to the actual context.

However, generalization does not only mean to describe that which is, but also to describe what may be found (Kvale 1996). Regarding this, the findings from the studies constitute an innovation which opens up the possibility of seeing something known in a new way. The findings might, as such, contribute to opening up the caring world for nurses.

In the SCA (Haase et al 2000) the process of constant validation takes place during the analysis. Validity is systematically incorporated and is confirmed through the use of the validity matrix, the discussions in the consensus group, and also in the seminar with colleagues. The consensus group is formed of persons with various perspectives, and through dialogues and discussions from the differing angles, consensus on the concepts is reached. Effort is put into the accuracy of defining the concepts.

**FINDINGS**

Summary of papers

**Caring and its ethical aspects – an empirical philosophical dialogue on caring (I)**

The aim of this study was to see if and how experienced nurses described caring and whether they included any theoretical basis in their caring acts.

Overall, the findings show caring as a fine integration of different levels of knowledge. There is neither a distinct beginning nor ending of caring. Care happens, and is supportive of the medical treatment, and autonomously supports the patient’s health processes. The essence of caring can be seen as a seamless integration of the dimensions of the practical, the aesthetical, and the ethical fields of forces. The meaning given caring in this study is ‘sense-making as embodied moments of presence’, that is, the nurses use of their alert senses and thus an awareness that offers an opening for the patient’s life world in caring. This attention to sense-making and reflection is seen as a path to professional development. ‘Gaining
meaningfulness’ is another essential meaning of caring, and, according to the interviewees is expressed as the need for care to be careful and comforting, and to make room for gaining meaningfulness. This is because in all human beings there exists a general need to experience meaningfulness in terms of deep contact with oneself as well as with others in life, and such contact may serve as a basic motive for patients to reach a state of well-being and for nurses to be caring. This deep contact with oneself is not contradictory to helping others, but is an important basis for helping others realizes this experience.

Creating conditions for the patients to gain hold of their situation and strengthen their life-forces was experienced as being an important element in the caring process.

‘Caring in distress’ is a third element of meaning in the result. Caring involves a complexity of processes, and when caring becomes pure doing, i.e. mechanical, it was expressed as caring in distress. Attentive caring could be neglected as it could be seen as not productive when the organization demanded effective and productive work. This problem was described as a conflict in which external, formal obligations undermined the nurses’ inner obligations - the ones that constitute caring.

A finding of this study is that caring that enables the caring goal of health and well-being opens to the patients’ life world expressions and does not split between theory and practice in caring as they are intertwined dimensions. This seamlessness applies equally to the relation between theory and practice. Caring that enables the caring goal of well being does nor split theory and practice. The findings show that these aspects are intertwined when caring functions in the intended way.

**Embodied reflection in practice - ‘touching the core of caring’ (II)**

The aim of this study was to inquire into participant nurses’ experience of giving RE (rhythmical embroocations), and present their reflections about caring theory into the caring act.

The findings shows that there exists a dynamic integration of levels of becoming aware - of what is expressed as embodied moments of presence, as well as a contemplation of the nurses’ own abilities and efficacy in the caring encounter. The analysis of the texts reveals two essential themes of meaning and six sub-themes. The participants were able to reach an understanding of deeper concerns in relation to another human being; the dimensions of becoming aware of one’s own efficacy and self-awareness, as well as a sense-making and
embodied enquiry. The caring act created the ability to become an opening power to both freedom of trust and vulnerability, and provided a widened understanding of this ambiguity of human openness. The participant nurses’ sensitivity increased and their abilities in observation grew wider and more receptive by performing this caring act (RE), through the increase in self-awareness and an expanded awareness of the Other. The caring act represented a widening of the focus of self and Other and enabled broad embodied enquiries and the possibilities of verbalizing them. Reflecting on fundamental caring concepts made it possible for the nurses to conceptualize embodied experiences, and they stated that the movement between embodied experiences and reflection on theory provided opportunities to unveil hidden caring relationships.

The caring act of performing RE gave the participants the potential to expand their attentiveness in caring, their observation ability, and their awareness and creativity in caring. In particular, the attitude towards their inner obligations in caring intentionality became more clarified, and this may show development of caring theory in practice.

**Challenge for theory and practice in elderly care – intertwining forces (III)**

With the aim of investigating the possible disparity between theory and practice in caring, this study inquires into nurses’ lived experience of the understanding of caring theory in practice in the context of elderly care.

Three themes of meaning that are interrelated and must be understood as intertwined, arose from the analysis. ‘Abstractions and confirmations’ constitutes the meaning of that theory was spontaneously identified as a weak, un-reflected body of knowledge. At the same time, theoretical bases were seen as giving opportunities for reflection. Caring or nursing models were referred to as constraining – as more limiting than lifting. The ranking of empirical experience was higher than theory, even if theory confirmed and verified the nurses’ experience. Theoretical knowledge could be supportive of their personal knowledge and understanding of caring, and as an all-embracing notion of caring. Constitutive to the understanding of the possible theory-practice gap in caring was the marginalization of caring. It became clear that as nurses in municipal care for the elderly, their mission had drifted away from the mission of their caring profession, since their work now mainly involved being medical consultants and administrators. They no longer worked close to the patients, and this was experienced as impairing the refinement and development of their
clinical judgment, since they no longer shared the caring scene and had to make secondary judgments from staff reports. The analysis also revealed that ensuring health and well-being was the caring goal. Health was more significant and comprised more dimensions than the absence of illness. The meaning of caring centered around the sensitivity and perceptiveness to the needs of the elderly on all levels, which meant being initially open-hearted and passive in an open-minded interaction. An ability to have an open and accommodative awareness both of the patient and of oneself was necessary, particularly in the care for elderly persons with dementia. The ability to see the healthy human being despite severe changes demanded self-perception and a consciousness of one’s own efficacy as a nurse.

From the findings it is obvious that one can conclude that there are not two sides to the phenomenon of caring (i.e. caring in theory and in practice); rather, caring must be seen as an intertwining structure of knowledge. Otherwise there will be a lived experience of disparity between the two, and they will be seen as separate fields of forces that cannot intertwine. The nurses described their experience of distance to caring theory, but when describing their caring intention the relation to theory became apparent, and even confirmed their practice. The experienced gap in this study related more to the gap between organizational demands and the caring intention than to a gap between caring theory and practice. As such, a seedbed exists for caring theory to be reflected upon and cultivated in practice, but as the nurses describe, the caring theory must be sensitive enough for the nursing practitioners to accept.

**Caring theory and caring practice – entering a simultaneous analysis (IV)**

To better understand the approach of caring in nursing and the role of theory in practice, a consolidation of a caring theory (Watson 1979, 2008) was performed with the empirical findings from three studies on the lived experience of nurses reflecting on caring theory in practice, their caring intention, and the verbalization of the (possible) discrepancies related to theory and practice in intention and organization. The concepts and theory development that constitute the caritas processes (the carative factors in 1979), were thoroughly elaborated and analyzed using Mayring’s (2000) content analysis. Emanating from the substance of the ten caritas processes, the elaboration and interpretation gave six components that were decided as being the concept of *caritas*. These components were
further elaborated in the SCA together with concepts and components from the three empirical studies. There is different perspectives related to caring theory, but as the empirical findings show, there still seems to be a consensus behind what caring is, both in theory and in practice. This was verified through the analysis. The analysis indicates that the aim of caring itself may be more salient and focused if based on existential phenomenological caring concepts and theory.

The findings from our analysis are that our efforts in research and theoretical development are not only required to improve health care, but also to improve ourselves in the process. This study (IV) added a theoretical perspective of caring in theory and in practice. The outcomes of the analysis generated a process-model where the advanced concept of mediating care became a meta-concept. Figure 1.

Mediating care embraces the implications of all the outcome concepts in the analysis, and it has the possibility of being the expression of immanent and transcendent dimensions in caring. Mediating care represents the expression of our understanding of life, our values, and norms. It is given expression through the insights into, and the ways we connect to one another, our ability as carers (nurses) to reach out to another in his or her being, as well as the understanding of ones own being in caring.
DISCUSSION ON THE OUTCOMES OF THE PROCESS MODEL

As we can see from the results of the analysis, equanimity for self and others was a critical attribute that manifested itself in several of the outcomes in the process model of mediating care.

Equanimity for self and others in the outcome of interconnectedness involves the foundation for being able to reach the others’ lifeworld. This means working on the insight and self-awareness of one’s own existential and ontological foundations as well as the sensitizing and enabling of reaching the others’ lifeworld in a caring encounter. The lifeworld foundation for caring has, besides Watson (1979, 2008) which was considered in the analysis, been
researched and anchored in lifeworld-led healthcare theory as developed by Dahlberg et al (2007, 2009, 2010). The research above states the importance of ontologically grounded ethics in caring that are anchored in a humanistic view of man, a view of health and well-being and not just illness, and a philosophy of care that is consistent with this. They argue that this requires knowledge that develops from an existential view of the human being and an existential view of health, illness, and well-being.

Interconnectedness involves the feeling of being part of something, relating to something. De Vries (2004) relates to interconnectedness in a study where nurses were practicing beyond their role definition of duty of care. They were performing an act of humility (washing feet) that was positive and participatory. This caring experience was described as moving beyond the act of observing to a level of awareness that was absorbing the present situation, and this was described as an occurrence of interconnectedness.

To be human is to care for the meaning of things and experiences for personal life, which involves a motivation to bring things together; to make wholes out of parts. In caring, seeing the human being in her or his lifeworld must be the goal to be strived for, and to do this, we need theories that are sufficiently sensitive.

In the analysis, the outcome of contemplation is given meaning and reflected through the critical attributes of ‘reaching open awareness’ and the ‘creative use of self’. Contemplation as a caring quality means the abiding expansion of existence. Todres et al (2010) calls this moment the source of the possibility of dwelling with things as they are. ‘Abiding’ means holding something back to let something else emerge. He elaborates on this in a study on Heidegger and his notion of Gegnet (abiding expanse), meaning that abiding expanse is a sense in which there is both the openness and freedom of mobility as well as the coming back home to itself of dwelling (ibid).

Such ontological togetherness is called Das Spiel by Gadamer (1989); it is the provider of the existential experience of ‘being with’ or ‘being present in the moment’. This is a condition of being able to open up to new interpretations or the merging of new horizons. To encounter someone or something and contemplate it is to set yourself at play- to become part of what is happening. In the play one becomes familiar with others’ understanding that at first is very different. At the same time, one’s own familiar understanding is put to play, with the help of the others, and it thus becomes unfamiliar and different.
Certain caring acts may be tools for the nurse to practice access to this open awareness that is a prerequisite for any sensation or reflection. An empiric example of this is the statement that when they stopped interfering or stopped being ahead of themselves in concerns about coming duties or getting caught up in their own thoughts, the nurses suddenly became aware of and registered things they had not previously recognized. They registered sounds in the room they hadn’t earlier heard, nuances in mood, softness and temperature of tissue etc. This was expressed as letting oneself go and being in the moment with the patient, and can be understood in this way or as being in a state of openness and pliability. This perceptiveness, or open and listening awareness, is shaped in the metaphor of the play. An open awareness like this does not happen by itself, it has to be trained or opened for. Epstein (2003) describes how a mindful practice can be trained in clinical practice by paying attention, on purpose, to one’s own mental and physical processes during everyday tasks and being aware of one’s own expectations, judgments, and categorizations. To be able to be present and aware of the patient in front of you implies being charged with something that has become present to you. Martinsen (1996) explicates this wonderfully as: perceptions are pregnant with undelivered impressions of what is substantial in life - the things we easily look through in all our doings. Consequently, we have to work on the birth; the development and growth of these perceptions that can nourish our being and that may in turn give caring an expanded dimension.

Equanimity for self and others in the outcome of *Intergrade* has to do with the process of approaching in the caring encounters. Intergrading is an approach of interacting with others, doing what is expected of us in our profession as nurses, but also using the individuals’ authentic creative ability in giving care. Again this approach is intertwined with one’s understanding of caring, and is given expression through this understanding. Mårtenson (2009) shows in a study on information exchange in pediatric care that the concept of intergrade comprises a series of interconnected aspects such as acting according to accepted procedures, social intercourse, completeness, and interdependence - all of which interact with each another.

The outcome of *Insight* is aimed at the gaining of meaningfulness in caring, at creating well-being in dialogue - being an embracing notion in caring. This postulates the critical attribute
of equanimity for self and others as it presupposes a humanistic view of the human being cultivated from seeing the patient from a wider perspective in the gaining of meaningfulness and well-being. An expanded insight will develop along with the process of intergrading as described above. Merging gradually through a continuous series of intermediaries has the qualities of a hermeneutic process - constantly challenging and widening one's horizon in the movement of openness and reflection; that is if the qualities of openness and pliability are present. Obstacles to this process occur when caring becomes mechanical doing. If caring is enacted as pure doing, as if by a program, it cannot be authentic. This is argued for in two Swedish studies where authentic personal and detached impersonal caring is considered (Nyström et al 2003; Carlsson et al 2006). These studies, one in an emergency care unit (2003) and one in psychiatric care (2006), show that encounters with negative outcomes were found to be characterized by the nurses’ personally involvement, which originated in fear that they were unable to manage. This made them use a more forceful attitude with the patients. The positive outcome was characterized by the nurses’ presence in the encounter, by which, despite the feeling of fear, they remained close to the patient in wanting to show the patient respect and confidence. Challenges are the cultivation of self-awareness, and equanimity for self and others, in the caring encounter.

Constituting attributes in the outcome of completeness were open and accommodative awareness and embodied knowledge. Again, the increased awareness of self and others makes itself apparent. One might say that in this way the nurse is concerned with more seeking, lingering, and wondering forms of thought that can make her/him more sensible of this which lies beyond problem-solving thinking (Gadamer 1989; Hansen 2009). It also means that the patient senses this completeness and feels acknowledged. Arman et al (2008) found in a study of patients’ experience of anthroposophic health care that when patients encountered a pure and aesthetic inner and outer milieu together with true caring encounters, a sense of ‘homecoming’ was described. This homeliness or homecoming may relate to deeper existential sources inside a person. Embodied knowledge requires completeness, since it is the place where being and knowing meet. It has to do with the interface of being and knowing, letting the being expand sufficiently to take hold of a bigger whole. This state of being requires training and effort to expand and cultivate.
The outcomes of *contentedness* and *completeness* are related in caring; represented by the attribute of equanimity for self and others, but also by the attribute of enabling existential dimensions in being.

Sensing completeness in caring is not a static state that can be obtained for ever; it is a re-creative process. Embodied moments of presence are conceptualized and can bring forward an experience of nuances of embodied recognition as a growing awareness in which a sensitivity of the whole atmosphere of the patient is expanded via the body. A ‘widening’ of the senses enable an unreflected body of knowledge to become developed and reflected. Such embodied knowledge enables opening of existential dimensions in being and a more humanizing form of health care. Edvardsson (2003) shows in a study these transcending qualities in caring; where nurses caring for demented elderly by giving tactile touch experienced being able to transform their caring abilities by having a tool for easing the patients’ suffering. The perceived embodied knowledge enabled them to see the person behind the disease as a human being in a larger whole.

The outcome of *reflexivity* shows in an intricate way the intertwining of theory and practice in caring. Reflexivity requires an awareness of the contributions of meaning and of the ways in which our own values, aims, and experiences in life affect and shape our profession and us. Empirical studies show us that nurses’ relation to theoretical caring knowledge is ambiguous; theory can confirm practice, but in turn theory can be too narrow to have practical relevance. This depends on the apprehension of the theory in question and its relevance in the context. Nursing models as standardized checklists were acknowledged as tools, but had little to with caring for a patient. Even if the nurses understood that the aim of these systems was to make visible, describe, and structure the complex caring situation of the patient, they experienced them as being fragmentizing and trivializing in relation to the same context. It was even claimed that the system had a purpose of its own, creating a rift between what was documented and the lived experience of and with the patient. Theory thus created a different way of gaining knowledge that did not connect but collide.

On the other hand, theory also had the role of confirming what practice was about, confirming the caring processes, and confirming the teaching and learning relationships
within caring. Reflection on caring theory and its applicability to practice has been described both from an educational perspective as for example in Ekebergh et al (2004, 2009), and Rydlo (2010), and from clinical educative ones, as in Bulfin (2005). It has also been described in instrumentation and evidence-based practice from caring theory (cf. Sumner 2008; Watson 2002). Ekebergh et al (2009) emphasized the same characteristics of theory as came out of the empirical study with the nurses, namely that the theoretical knowledge must be meaningful to and address the practitioners. To accomplish such an understanding of theory Ekebergh et al. (2004, 2009) went further and tried methods of supervision in practice in which theoretical caring concepts could “come to life” and involve the practitioners. In those projects, the focus was upon the patients and their expressed experiences. The nurses or student nurses brought the cases and the stories to the supervision meetings. The supervisors contributed with educational tools, e.g. educational drama, and included theoretical concepts of caring in the reflections (ibid).

The analysis in study IV reveals that although caring theories are abstract or visionary and distant from their practical reality, the validation of the same theory contributed to reflection on fundamental caring questions and the basis for caring and confirmed the nurses’ caring intentionality from a larger perspective.

The outcome of intentionality has the attributes of cultivating caring, as well as equanimity for self and others. That is, in one meaning the expression of caring intention is conceptualized in an intention that comprises a health perspective. This salutogen perspective comprises existential needs and expressions of being, and thus requires caring for the whole human being. An obstacle is the drifting apart from the intentional caring mission as when pure problem-solving in medical caring takes over the caring intention. As a result of this, the cultivation of caring has a stronger medical magnitude. This would provide a sense of gap between caring intention and the organizational demands of caring.

Pearcy (2010) confirms in a study that nurses know what caring is or can be, and they know what obstructs it. They know that they cannot achieve what they want in terms of caring, because as expressed in the study: “Caring, it’s the things we are not supposed to do anymore”.

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Enns & Gregory (2007) minds this same gap as suggested by the nurses revealing a dichotomous tension between what caring should be in terms of intention and what actually occurred. This tension was impregnate and generated regret and loss on the ward.

Interdependence as an outcome is contemplated through the attributes of equanimity for self and others as well as transpersonal caring. Transpersonal caring is the mutual relationship, the intersubjective meaning of all participants in the encounter. These notions of connection and interdependence are consistent with the theoretical dimensions of a transpersonal relationship (Watson 2008). We are intersubjectively interdependent, and the nurse in a transpersonal caring relationship transcends the personal ego level of professional control and is able to enter into and stay within the others’ frame of reference. This is communicated in the empirical data as the promotion of an inner space of freedom for all parts in the caring relationship. Todres (2010) elaborates this in his theory of well-being where the deepest potential for existential well-being lies in the unity of dwelling and mobility. This is the dialectic movement of feeling at home, and moving forward; the creation of freedom as well as the feeling of acceptance, rootedness, and peace. Andersson et al (2007) revised similar results in a study on old people receiving municipal care and their experiences of what constitutes a good life. Focusing inwards, coming to peace with the past, present and future, and maintaining dignity as opposed to being in the hands of others and the feeling of being at home, were some of the elements of their experience. To achieve this inner space of freedom in all aspects of a caring relationship means that there is a possibility of obtaining equilibrium in the equanimity between the actors in that caring relationship.

DISCUSSIONS ON THE FINDINGS

Theory and Practice Intertwined

The findings of the studies show that the lived experience of caring as experienced by the participating nurses comprises both implicit and explicit theoretical foundations to existential caring theory. The explicit use of theory or certain theoretical affiliations was not obvious; rather what may be theoretical inputs was expressed as the importance of being present and the necessity of having a health perspective in caring (I, II & III). By illuminating caring and concepts from caring theory, the meaning of caring in their professional lived
experience, the primary intention or choice of working as nurses became apparent again for
the nurses. ‘The core motive of one’s intention in caring easily gets lost in everyday effort
and the administering of the work...’(III) ‘One should reflect more often on the reasons for
doing this ...the very foundations of caring in a deeper sense...’(I). The result shows that the
advanced outcome of mediating care (IV) can be seen as an ontic expression of the
understanding, interpretation, and application (the lived being) of caring in theory and
practice.

Figure 2. Theory and practice intertwined

![Figure 2](image-url)

The figure shows the interwoven dimensions of interaction; reflection on theory, reflection
on practice, and the expanding interspace that represents itself as mediating care - the form
of expression of caring. The interface centers and expands the movement that is the
reflection on theory and reflection on practice.

*Mediating care* comprises how caring is mediated in doing, being, and becoming, and it finds
expression in tentativeness, the creative use of self, efficacy, and the open awareness of the
caring encounter. As we can see from the results of the analysis, equanimity for self and
others was a critical attribute that manifested itself in several of the outcomes in the process model of mediating care. Equanimity means an evenness of mind. It is a concept of balance and centeredness that endures through possible changes in circumstances (Oxford Advanced Dictionary 2000, Merriam Webster online dictionary.). This is not an inactive state of being; rather it is a striving towards states of self-possessed watchfulness that is free from suppression. The mediated dimensions of a caring moment are affected by the awareness of the nurse. The Danish philosopher Lögstrup (1997) acknowledges that the ethical demands implicit in every encounter between persons is not vocal, but mediated and silent. He claims that it is in this third form (an extension of the two), in a kind of mediating, that we must meet as human beings if the encounter is to be helpful or liberating for the individual. As a consequence of this, the most professional relationship is always a personal one, as the professional and the personal are intertwined in the mediating of caring.

One might claim of caring theory that it is the caring nurses’ way of mediating this engrafted knowledge, that shows if this knowledge has become the nurses’ own understanding, in flesh and blood so to speak, as embodied knowledge (Todres 2009; Hansen 2009).

As human beings we are not in an immediate relation to ourselves and others, and we have to express ourselves through something intermediate (Lögstrup 1997). The mediating of caring becomes obvious in our work as nurses; the way we mediate our caring, our caring intention, becomes our caring efficacy. This is what the evidence of caring for the patient becomes, and the caring efficacy can only be evaluated by the patients.

Different ways of understanding professional roles and patient encounters in health care are related to different ways of formulating clinical care. Caring for the whole suffering human being, considering the entity of body, soul, and spirit, must be the foundation for clinical caring in both theory and practice. Attitudes, operations, and values are deeply immersed in and color the caring culture through steering documents, policy, and quality assurance systems (SFS 1982:763, SFS 2001:453, ICN 2000).

Through ‘caring practice-sensitive’ theories that are anchored in a humanistic phenomenological existential view, the nurses must face to what extent they have the courage to encounter and witness the situations of patients in a way that touches deeper layers and may lead to transformation in suffering. Caring embodies several dimensions that cannot be separated; instead, caring must be comprehended holistically. Each qualitative part is integrated into a whole and this may lead to an understanding of care that cannot be
understood as a dichotomy between theory and practice, but rather as a dynamic movement of all dimensions, interrelated and inseparable (Todres 2007). Following this, the choice of an epistemological starting point has consequences for the relationship between theory and practice. In a Gadamerian (1989) sense, understanding is the ontology of being in the world. It is an understanding that in a deeper meaning seeks possibilities of doing - it is intentional. Understanding is, as such, shackled to practice, to intention.

Caring; various dimensions of knowledge
In this way we may look upon theoretical knowledge as, on the one hand, a source or resonance bottom for our personal transformation or integration of it. To be able to take this knowledge inside, to incorporate it, and make it one’s own for the perspectives to enrich and expand. With an expansion of perspectives it is possible to achieve the possibility of relating more freely to demands in one’s own hour of time. Such caring cultivation (or expansion of caring), as an open awareness in dialogue with theoretical reflected knowledge, may give nurses the possibility of achieving an expanded existential caring consciousness, in which thoughts from the great theorists become embodied in everyone’s understanding of life and continuing contesting of the understanding of life itself. Knowledge that is not personally incorporated, and that has not led the nurse or human being to the experience or even the wish for insight and wisdom, has not become cultivated, but may at best be called information. What we have achieved theoretically and what deserves to be called the ‘being in caring’ is not evident in what we are able to inform our patient about; rather the evidence is in how we are able to understand what the patient has to tell us.

Reed (2004) says that an important tool for knowledge development in nursing and caring practice is the conceptualization of theory at all levels of abstraction. Practice-based knowledge must be reflected in theory–based knowledge to gain a sound and fundamental development in practice. This is also the argument of Parker (2006) who claims that practice must first be guided by theory, and then the theory can be studied and further developed as a result of expert practice. The intention is obvious, but seldom realized in everyday nursing care as nurses are usually guided by empirical generalizations primarily from medicine and pharmacology, from psychology, sociology and other disciplines, rather than by caring
theory. Caring theory has the intention and should have the power to function as a mirror of one’s caring experiences, and as the nurses in our studies (II, III) show, this is what happens when caring theory is seen as a guideline or a guiding light (inspiration) to reflect one’s own experiences in caring.

Caring is constituted of various dimensions and as such, it illustrates how we are to the world as embodied existence that comprises ethics and aesthetics in the lived experience of it (Merleau Ponty, 1995).

This embodied recognition is silent and often taken for granted, and as such, not often cultivated in terms of sensitively developing an ability to expand and inquire into these fields of knowledge. To get in touch with or in dialogue with caring, one must open for this which the methodological access is not capable of coming up with, and which the spoken and written word is not directly capable of saying (explicating), but which all the same makes itself valid as an impression in life - an impression of life seeking an expression. Hansen (2009) and Gadamer (1983) says that it is through this source that meaningfulness is derived. It is also this meaningfulness that we may come into contact with when we have an aesthetic experience or when we have an authentic caring encounter with someone. Gadamer(1989) names this excursion and return; the eternal movement of the human spirit. The crucial moment in this movement is for Gadamer the return - the engraftment of the unknown or making the unknown known, for example, through the dialogue being open to other interpretations. The presupposition for being able to engraft new interpretations is to put something ‘in play’. The phenomenon of putting something ‘at play’ or like a child, being totally absorbed in the play is to abandon the known – and at the same time make what is known alien. Hereby an interspace or a room occurs that is not a dispute or verification of one’s presuppositions, but is the predecessor for any reflection. Strictly speaking, it is the necessary creative impulse for anything to draw itself back and for something to rise. This movement or state of mind is the openness and vulnerability that is described in the studies as being a result of a caring encounter when the participant nurses describe the state of achieving an expanded awareness.

How can we develop such a mediating quality, such awareness? Findings from study II reveal that certain caring acts may have the ability to give access to the room of presence,
the expansion of senses in the ‘play’. The caring act may be a tool the nurse can use to develop access to this awareness that is a prerequisite for any sensation or reflection.

Other studies, for example de Vries (2004) and Edvardsson (2003), are in line with the findings above, as the nurses experienced a level of awareness being absorbed in the present situation. The experiences allowed for the occurrence of interconnectedness and changes in their relationship with the patients.

The perceptiveness, or open and listening awareness, is shaped in the metaphor of the play. The metaphor of the play can be used to make an image of the transcendence of the classical dualism between subject and object. The play itself is the crucial point; it does not hide any playing subject; rather the play itself is the accomplished movement.

What the nurses characterized as embodied moments of presence (II), is seen as a way of aesthetic knowledge; it gives rise to a concentration and a presence in the room or in the encounter that may lead to a change of horizon. The world becomes different, enlivened, and immediate. If the person you meet, the patient, shall be able to show all his/her individuality, that is if the person or patient can open up or develop for you, you will have to bring yourself into a state of mind of open wondering. If you, like the informed biologist, already know what this patient or person is or is about to express, then he/she cannot talk to you - you only have your preconceptions confirmed. To let the world become impressions, to sense it, by setting yourself aside to let someone or something appear and make impression - this is an effort and demands cultivation of self-awareness, reflexivity, and open awareness.

Philosophers try to describe or formulate the substance of such expressions, i.e. what this speech is. Gadamer (1989,) for example, explains that impressions withdraw from thinking (reflection) it is not catchable, and it is therefore not possible to comprehend and communicate this expanded state of mind in a direct manner. The exercise is, according to Gadamer, to try to endure or withstand the unconditional frustration that follows this endeavor.

To encounter patients in ways that give room for existence demands time, but also enough sensitive senses from nurses to recognize the “silent call”, and self-awareness and self-strength to deal with deeper lying concerns. One cannot expect a person who is unable to read Swedish to understand a text written in Swedish, and follow the intentions of that text.
Likewise, one cannot demand from nurses, if they are educated in a narrow-minded form of medicine, to recognize patients’ suffering in its entirety and their existential demands.

Reflection on one’s owns pre-understandings create a possible openness and pliability that is essential in a caring profession. Preconception and pre-understanding prejudice may be an inner guide that can make the dialogue with the patient fruitful and meaningful, but may also lead us the wrong way. The benefit of persistently challenging the movement between practice and the preconceived thought behind may represent a consciousness of why we act as we do, and what consequences our actions have on our patients, on our colleagues and on our milieu. Caring consciousness and intentionality is described by theorists as being the basis for an expanding ontology (Eriksson 2001; Watson 2008). Incorporating and reflecting on the dynamic between theory and practice means that we are caring for and cultivating our caring consciousness and the meaning and significance of our intentions. An assumption is that through this effort we are constantly challenged in our meaning and intention of why we act and think as we do, and in what basic values rule our intentions and the meaning of our caring actions from a deeper existential level. Extending this assumption into the research questions in this thesis was done through studies illuminating the dynamism of theory and practice in elderly care.

**Is there a gap?**

The findings do not reveal a determinant gap between caring theory and practice. Instead, they show that caring theory and practice are intertwined. However, the study confirms that the experienced theory–practice gap is more related to organizational constraints such as role constraints and time pressure than to the caring intention in theory and practice (study III). This gap can be verified in research such as Maben et al (2006), concluding in a longitudinal study from the UK which showed that although nurses emerged from their programs with a strong set of caring values, they were soon hindered by what they called organizational sabotage. The findings showed that the disparity may have profound implications for the future of the profession in terms of job-satisfaction, morale, and retention. In a follow-up study, Maben et al (2007) showed that after two years in practice the majority of the interviewed nurses in the study experienced
frustration and some level of burnout as a consequence of their caring ideals and values being restrained. This is in line with the findings of the studies in this thesis. The caring intention seemed distant in their everyday practice in elderly care, as their professional tasks were adjusted to the needs of the organization; that is working as medical consultants, addressing medical, technical, and physical issues, as well as administrating. They were confined to duties that took them away from working close to the patients in favor of paperwork and organizational tasks, leaving little time to connect with patients through being with them, having conversations, or doing those little things that make a person feel cared for.

**DISCUSSION ON METHODS**

From out of the thesis aim, an approach was chosen that enabled a narrative (description) and understanding of the meaning that nurses within municipal elderly care impute to their experiences of caring, the caring as such, and caring in theory and practice. Phenomenological and hermeneutic research may be seen as difficult and it has been a great challenge to make the results of the studies readable without renouncing the complexity that is involved in lifeworld research. The research demands knowledge of ontology and epistemology, which may not necessarily be a drawback.

Other aspects concerning the methodological approach are the challenges and contributions of the interview situation. This offers possibilities for confrontations with pre-understandings and taken-for-granted meanings, as it goes into deeper lying concerns through follow-up questions and exemplifications. The first opening question was important to set the scene in an open and not limiting atmosphere, as were as the subsequent questions that would give substance and nuance to the experiences.

The interview situation also touches on working through feelings and memories that are associated with earlier experiences. What became obvious was that many of the participating nurses were confronted with the choice they had made – to work with caring and especially caring for elderly and fragile human beings. As such, they reminded themselves why they had chosen this in the first place, what their caring intentionality had been, and how this motivation had slowly fallen into oblivion.
Evaluation of validity, reliability, or trustworthiness is carried out through the thesis - from planning the studies, the design and collection of data, during the analysis work, and the statement of the results. Validity is shown as transparency in the research process to clarify and make visible the epistemological and methodological principles (Kvale 1996) of the thesis. The chapter on method shows the procedure followed in the thesis and how the different studies’ research processes were coped with. This means that the selection of participant nurses attempted to ensure richness and variation of lived experiences in the given context.

The participant nurses in all three studies were mostly women. This may be a disadvantage, but is due to the fact that most nurses working in municipal elderly care actually are women. In the analysis process, discussions were held with supervisors to reinforce the interpretations. A challenging and cultivating aspect of the whole research process was to achieve openness in the analysis, to bridle one’s own pre understanding, i.e. to set aside one’s own understanding and let the texts speak.

Interviews were chosen as data sources for the studies. The possibilities of making observational studies as well as making a quantitative study based on a questionnaire was also considered, but was rejected due to the assumption that richness of data would be obtained through open-ended interviews. The access to the lifeworld of the other is not as obvious in observational studies or in a questionnaire-based study as in a successful interview study.

A weakness of the thesis may be the limited number of nurses that participated in the studies. However, the number represents the average of the employed nurses in two municipalities; that means half of the total number of nurses in the municipalities.

Working as a nurse in municipal elderly care myself may have influenced both the collection of data and the analysis. This led to a strenuous effort to bridle my own pre-understanding, reflection, closeness, and distance, and an attempt to ensure the participants provided rich narratives on both the phenomenon in question as well as the context; richness derived from their lived experiences.
Clinical Applications
The findings of this study contribute knowledge and possible new perspectives on the understanding of caring as a basic phenomenon in health care, and how caring in theory and practice is experienced in the context of municipal elderly care.

Theoretical reflection and developing sensitivity in clinical practice are intertwined and may lead to expansion of the caring consciousness, and as such will provide the base for the mediation of care. An application of the study is its contribution to directing attention to basic aspects of caring in theory and practice, and thereby it contributes to the possibility of a deeper understanding of existential dimensions in being and caring, particularly by raising awareness of the fact that as nurses we are tools in the caring process.

Clinical application is an incorporation of caring theory as a philosophical-ethical base that can offer a humanistic worldview and extended practices. This could constitute a possibility of transforming the nursing work from its ethical core, transforming practices by offering inspired theoretical philosophical visions in order to mediate high quality care.

Reflection on the existential aspects of caring phenomena may in itself provide for an expansion of caring consciousness, which again may affect the mediation of caring. This is perishable knowledge and as such has to be rediscovered.

Training of sensibility is the other great challenge that has to be intertwined with theoretical reflection; it is a continuous task to develop sensory-based, individual, and situation-determined awareness and attention to patients. Certain acts of caring have the potential to expand attentiveness, observation ability, awareness and creativity. Sensibility can favorably be developed through certain caring acts such as RE, tactile massage, washing feet or even everyday tasks such as feeding situations or hygiene. The caring consciousness is contained within the single caring moment. An attitude of increased closeness towards inner obligations in relation to the intention of care might show the development of caring theory in action.

The movements of sensibility and reflection must not be seen as opposites or as dualistic; rather they presuppose each other and are intertwined in the cultivation and opening up of expansion in caring.
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Wilkin


Svensk Sammanfattning

När högskoleverket granskade svenska universitets sjuksköterskeprogram (HSV2007;23), blev det klart att många av lärosättena gav en oklar definition av huvudämnet inom utbildningen. Utvärderingen visade indikationer på ökat fragmentariserings- olika tolkningar av ämnet omvårdnad/vårdvetenskap där den vid några lärosäten placerats i anknytning till medicin och vid andra i anknytning till humaniora och samhällsvetenskap. Brister fanns framförallt i ämnets teoretiska förankring och karakteristika. Osäkerhet råder om vårt ämne och vår disciplin.

Samtidigt finns det en unik vårdeutelisk grund som är väl förankrad filosofiskt och vetenskapsteoretiskt, och som ligger till grund för den autonoma akademiska disciplinen omvårdnad/vårdvetenskap. Avsikten med sjuksköterskeprogrammens utbildning är att ge en teoretisk förankring i huvudämnet som grund i arbetet. Efter en tid i klinisk praxis verkar sjuksköterskors teoretiska förankring klinga av; den blir vag eller obefintlig och uttrycks som ett gap mellan teori och praxis.

Forskningens övergripande syfte var att undersöka och belysa vårdandets mening hos sjuksköterskor, samt att belysa deras explicita och implicita förståelse för vårdvetenskaplig teori i den dagliga verksamheten. Avhandlingens kontext är inom den kommunala äldreomsorgen, där sjuksköterskor ofta arbetar med ett stort omvårdande ansvar, har en självständig administrerande och handledande roll i arbetet med ofta multisjuka äldre människor.


kultiverande av den vårdande närvaron, för öpphet och följsamhet. I denne studie var öppningen mellan teori och praxis utförandet av rytmiska insmörjningar (RE) tillsammans med dialoger och reflektion över vårdteoretiska bärande begrepp. Resultatet av studien visar en vidgad observationsförmåga, uppmärksamhet och känslighet i vårdmöten samt en ökat teoretisk anknytning genom reflektion.


Studie IV visade att vårdandet kan få ökad tydlighet och mening genom att sjuksköterskor medvetandegör vårdandets intention och verkan i klinisk praxis. Detta kan i sin tur generera förändringar i förhållande till vårdandets roll i professionen och i hälso- och sjukvården.

Studierna visar att det finns en svaghet i vårdandet som relaterar till ett gap mellan organisatoriska restriktioner, styrdokument och tidsfaktorer å ena sidan och sjuksköterskornas vårdande intention å andra sidan; snarare än ett gap mellan teori och praxis.

**Förmedlande vårdande** — är begreppet som omfattar och inkluderar de empiriska och teoretiska begrepp som identifierats. Förmedlande vårdande representerar uttryck för den livsförståelse, de värderingar och normer som präglar professionen. Detta begrepp innehar möjligheten att vara uttryck för både inneboende och överskridande dimensioner av vårdande. Det ger sig uttryck genom den insikt vi har om, och det sätt vi anknyter till varandra, vår förmåga som vårdare att nå fram till en annan i dennes varande, likaväl som förståelsen av vårt eget vara.

Teoretisk och praktisk reflektion och bildning av klinisk sensibilitet har förmågan att inspirera till ett vidgat vårdande medvetande, och förmedlandet av vårdandet vill vara dess manifestation.