GÖTEBORG STUDIES
IN EDUCATIONAL SCIENCES 139

Maja Söderbäck

Encountering Parents

Professional Action Styles among Nurses in Pediatric Care

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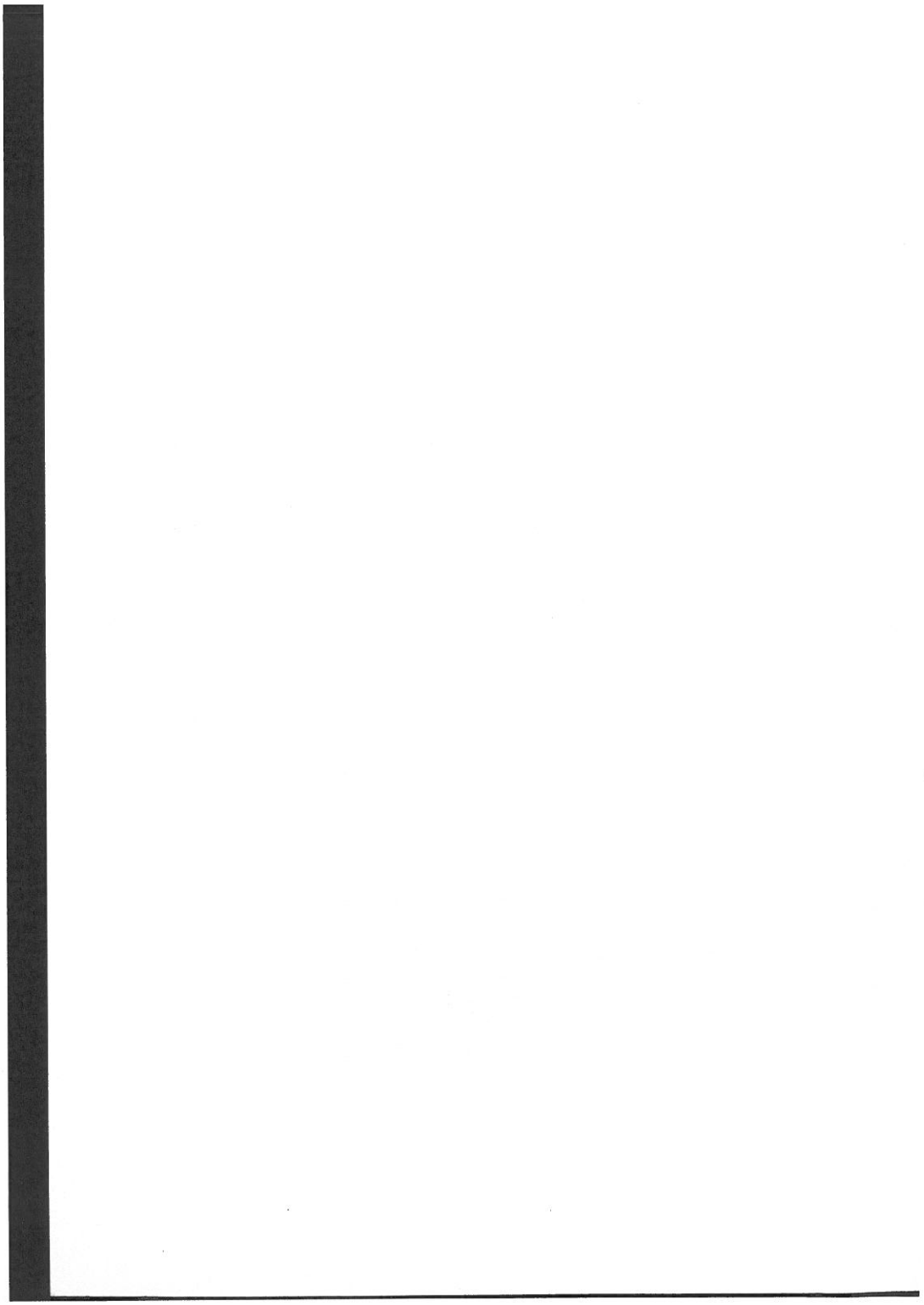

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To Anders, Johan and Petter

Two truths draw nearer each other.

One comes from inside, one comes from outside.

And where they meet we have a chance to see ourselves.

(fromTomas Tranströmer, Selected poems 1954-1986)

Abstract

Title: Encountering Parents. Professional Action Styles among Nurses in Pediatric Care

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Keywords: Pediatric nursing care, parents in pediatric care, stock of knowledge, encounters, practical knowing, action styles, social representations, ethnographic methods, hermeneutic interpretation process.

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The primary aim of the study was to provide insights in nurses' delivering of practical knowing in encounters with parents. Fieldwork went on during one year at a pediatric unit (0-18 year old children with various illnesses) in a middle-sized Swedish hospital, where most parents were living-in with their children. Ethnographic methods were used, including participant observations, interviews and collection of documents. Thirty nurses were observed during encounters with parents in different situations. Altogether 370 hours of observation were conducted. The observations were followed by interviews with the nurses, during which they were asked to reflect upon situations and events recorded during the observations. Official, local documents concerning policies and rules for interaction with parents in the care were collected and served as a third source of data. Data was analyzed according to a hermeneutic interpretation process.

The theoretical perspective was based on social philosophical and social constructivist traditions. A set of theoretical constructs (stock of knowledge, transformation of meanings, encounters in time and space, intersubjectivity, actions and socially constructed and shared knowledge) was defined as theoretical tools throughout the work.

The results showed that the nurses used differentiated patterns of actions when encountering parents. Through analyzing the observed actions and the nurses reflections on their actions in the encounter situations, a structure of four qualitatively different *action styles* were identified: assumptive style, demanding style, eliciting style, and collaborating style. In the assumptive and demanding styles, the nurses emphasized parental adaptation and accommodation, and their approaches in the encounters were task-oriented. In the eliciting and collaborating styles, the nurses focused on promoting parents' own resources and stressed mutuality in the joint care. The nurses' approach in the encounters were both task-oriented and parent-oriented.

Socially constructed and shared knowledge indicated social representations of parents and of the nursing profession.

The social complexity of encountering parents in nurses' practice is discussed, particularly issues related to the assymmetric relationship between nurses and parents. Ways of keeping a balance of power is pointed at and discussed in terms of the nurses' organizing, complying and enabling actions Finally, implications for practice and nursing education as well as future research are suggested.

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Arboga, November 1999

Maja Söderbäck

Lust är livets inkastare

(I. Sjöstrand, 1980)

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Introduction

Parental involvement in pediatric care has undergone great changes during the last decades. Knowledge of the importance of parental presence while a child is hospitalized has been generated. Children's stress when separated from their parents as the ordinary caregivers, and the importance of keeping a family intact during changed life circumstances is well documented in the literature (Spitz, 1945; Bowlby, 1953; Robertsson, 1970). In the recent decades the notion of parents and families being residents in their own right during hospital care has largely been accepted. Allowing parents access to their hospitalized child is viewed as a parental right. The present approach in pediatric nursing is that parents or a whole family might be involved and participate as much as they want in the care of a hospitalized child. These opportunities for parents to participate in hospital settings have connections with the increased consumer participation in health care on the whole, as well as in other social institutions in the Swedish society. The encouragement of consumers of health care to participate in decision making and collaboration is anchored in the Swedish Health and Medical Services Act (SFS1982:763) and is in line with interests in nursing ethics and humans' rights. Various codes for nursing ethics, the United Nation Convention on the Rights of the Child (Ministry of Foreign Affairs, Sweden, 1991) support these ideas.

Recommendations, standards and directions in Swedish health care use 'participation' and 'involvement' as watchwords. These watchwords put strong emphasis in carrying out nursing care. Nevertheless, involvement and participation are recognized as being complex issues in nursing. Combining professionalism and familiarity in health care settings and encouraging consumer participation at the same time is recognized as challenging (Sundström, 1996). A report on official power in the Swedish society (SOU 1990:44) portrays medical and health care settings as places where people, as consumers, feel most powerless. There seem to be contradictions between recommen-dations of consumer participation and involvement and how the phenomena are carried out in everyday health care practices.

In Swedish pediatric practice there are directions from laws, regulations, standards and policies, which are aimed to guide and encourage parental presence and involvement. Pediatric care offers open visiting and live-in facilities to support the opportunities for parents to share the care of their sick child during hospitalization (SOU 1975:87; Stenbak, 1986). Thus for nurses, parental presence means parental involvement in everyday care in hospital settings. However, reviewing earlier research, both Swedish and international, descriptions of how nurses actually deal with the encounters with parents during these premises, are lacking.

In pediatric care the implementation of parental participation and involvement is viewed as more challenging than was first imagined when the rights of parental presence were introduced (Darbyshire, 1993). Hospitals are complex contexts, and, for both parents and nurses, the implications of inviting parents to stay as residents with their child and be involved in the care tend to be underestimated. Nurses may experience the achievement of participation and involvement as conflicting with other ideas.

Nurses' professionalism and familiarity with the hospital context can create experiences of being 'strangers' among parents (Darbyshire, 1994a). In addition, through living-in as a resident with a child in the hospital, parenting becomes 'public' in hospital settings. Nurses' everyday activities also become 'public', in the sense that they are judged by families' observations. Furthermore, as they are expected to initiate and encourage involvement (Darbyshire, 1994a; Rowe, 1996; Sundström, 1996) the way encounters are carried out is likely to have pivotal meaning for parental participation.

The study, which is presented here, is aimed at bringing more knowledge about parental presence and involvement in pediatric hospital care. This has been done from the nurses' perspective, by careful observations of their mastering of everyday encounters with parents, in the context of three pediatric wards.

Before presenting the outline of the thesis, a brief overview of the present general policy for hospital care of children, primarily in Sweden, is presented.

Policies for Hospital Care of Children

Hospitalization of a child is expected to be as short as possible. Because of medical and technical innovations and increased efficiency in treatments, the number of admissions during the last twenty years has decreased. This reduction is due to the fact that children are admitted to hospital only if they require care that cannot be equally well provided at home or on out-patient basis.

In Sweden, children are hospitalized for an average of four days at a time (SPRI, 1997). Included in this average are children who are continually or frequently hospitalized because of chronic diseases or dangerous illnesses. An essential objective of minimized child hospitalization is the obtaining of optimal developmental conditions in a lifelong perspective. The goal is to keep child-ren's everyday living intact with family, friends, childcare, school, etc. Dealing with sick children requires institutionalized environments that are formed to accommodate and promote development. Environmental factors are fundamental for continuity in all children's lives and hospitalized children are no exceptions. Social relationships form a particularly important element in this continuity (Hägglund, 1999). Such a perspective implies that all activities and relationships in which children and their families are involved influence social realities and provide contexts for the child's development (Bronfenbrenner, 1979, 1989). From this perspective, all activities during a child's hospitalization are likely to influence the structure of a family life and thereby developmental conditions for the child. Research on hospitalization and children has shown that a combination of factors, such as kind of illness and disease, age, personality, and earlier experiences, influence experiences and outcomes of hospitalization. Also local circumstances in the setting, parents' presence and other situational factors during hospitalization are known as influencing children's development (Robertson, 1970; Lundgren, 1988; Eenfeldt, 1989; Carlberg, 1989).

Nursing knowledge concerning patients and families is based on a holistic perspective with normative implications to do something for others in practice (Kim, 1987, 1998). In Sweden, the Health and Medical Services Act (SFS 1982:763) and recommendations from the National Board of Health and Welfare (SOU 1975:87; SOFFS 1993:17), guide nurses' strategies to see to that patients' rights to be involved in their own care and participate in decision-making are met. The statutes of participation in care are of specific significance when patients are children and adolescents (SOFFS 1995:15).

The nurses are expected to create good relationships and collaborate with child-patients and their families to create optimal conditions during hospitalization. In order to meet children's rights to receive care directed at their specific needs, national regulations recommending pediatric hospitals or units with staff specifically trained in caring for sick children were formulated in the 1970s (SOU 1975:87). In the 1990s most children in need of hospital care (63 %) have been admitted to such hospitals or units. In middle-sized towns, regardless of diagnosis or illness, pediatric units offer combined care. Combined care means that all children with medical pediatric-, orthopedic-, surgical- or ophthalmologic diseases etc. are to be cared for at children's units. Pediatric medical care aims at serving children's specific developmental needs (SPRI, 1997). European recommendations for achieving general standards to ensure optimal developmental conditions for children during hospitalization have been agreed upon (NOBAB, 1992; EACH, 1993). These common general recom-mendations serve as regulations for local hospitals to improve children's situations. Among other things guiding principles in these documents reinforce parents' possibilities to stay with their children during hospitalization, preferably in the same room, and stress the importance of ensuring continuity in their presence by financial compensation (Alderson, 1993). Governmental policy in Sweden stipulates that small children shall not be left alone without their parents during hospitalization. The Swedish parental insurance system provides parents with economic compensation for loss of pay during a child's illness (SOFFS 1976:280). Since 1990, the policy allows parents to stay with a sick child for a total of 60 days per parent during a given year (if the child is under 16 years of age) while receiving compensation for loss of income. Another directive is to provide continuous information to parents in order to support their rights to exercise parental responsibility and their ability to participate in decision-making concerning treatment and care (Alderson, 1993). The Swedish legislation states that pediatric hospitals and pediatric units shall create opportunities for parental presence and support parent partici-pation in children's care in order to create a sense of well-being during hospitalization (SOU 1975:87).

Parents' involvement in the caring for their child may force nurses to mode-rate their activities towards them. It may be that normative directives and re-commendations concerning parental involvement do not always correspond with the diversity of everyday practice (Darbyshire, 1994a, 1994b).

The social and professional realities surrounding nurses' mastering of encounters with parents, where the actors may have different interests, are complex. The ambition of this thesis is to reveal some of the elements in nurses' mastering of this complexity.

Outline of the Thesis

The thesis is subdivided into six parts, each with several chapters and sections, arranged as follows:

Part 1 gives a review of the literature concerning parents, nurses, and pediatric nursing. Here, the first section presents a historical perspective on parental presence during children's hospitalization. The next section reviews common concepts and practical models for parental influences in pediatric nursing, and is followed by a section where empirical research of parents' and nurses' experiences and relationships in hospital care is presented. Finally, a section focuses on nurses' professional dominance in relation to issues of asymmetric relationships and social and ethical dimensions. The aim of the study is also presented.

Part 2 comprises methodological considerations. The design of the empirical study is described and issues of trustworthiness of the empirical study are discussed.

Part 3 consists of the theoretical perspective including the fundamental theoretical constructs, which have been guiding the procedures of analysis, interpretation and conceptualization of the empirical data.

In part 4 the analyses, interpretation and conceptualization process is described in detail.

In part 5 the results are presented. The structure of four qualitatively different action styles in the encountering situations is exhaustively described and illustrated from empirical data. Finally, common themes in the nurses' communication are presented and discussed as socially shared nursing knowledge in the pediatric context.

Part 6 consists of a discussion of the results and implications for nursing practice and education, the quality of the study is discussed followed by a conclusion and some final recommendations for further research.

PART 1

Background and Aim

Parents, Nurses, and Pediatric Care

Historical Context

The presence of parents in hospital care of sick children is a recent phenomenon. As mentioned in the introduction, the awareness of the importance of parental presence during the 20th century reflects social trends and an increased interest in ethics and humans' rights. In addition, medical traditions have influences on children's hospitalization. The attitudes in the beginning of the century consisted of stringent restrictions on parents' visiting rights. Now, in the last decade of this century, parents are recognized as residents who live-in with their children during hospitalization. Following a developmental line of medical and technical innovations and child-care ideologies some explicit steps toward parents' access to hospital settings are further described below.

A Closed World

During the first decades of this century, caring for Swedish children in hospitals took place in a closed world. The children were separated from their parents for long periods of time. Parents were expected to leave their children and the responsibility for their care to hospital staff. Visiting hours was non-existent or severely restricted. One reason for the long hospitalization of children was the lack of cure for many diseases, such as malnutrition, diabetes, and different kinds of infections. Tuberculosis was also widespread among the Swedish population (Köhler & Merrick, 1984; Bishofberger, Dahlqvist & Elander, 1991). To prevent infections from spreading, visiting was restricted. The struggle against infectious diseases and destructive illnesses in the beginning of the twentieth century helped to create a hospital system based upon asepsis and a rigid following of routines (Köhler et al., 1984; Erlöv & Petersson, 1992).

The absence of effective treatments meant that physical factors, such as fresh air, cleanliness, and a suitable diet were emphasized. Hospitalization could last for months. Hospitals were often located in healthy but remote places far from children's homes (Köhler et al., 1984). The children were cared for in a closed world with hardly any contact with their families. A review of literature from other Western countries shows similar patterns (Cleary, 1992; Young, 1992).

Since the 1920s, a large number of pharmacological and medical innovations, which are important with respect to children's therapy and recovery have taken place, giving children new chances for better lives (Köhler et al., 1984; Young, 1992). This development gradually required more trained and skilled nurses in the hospitals.

However, the ethics of childcare within hospitals was not shaped solely by physical and epidemiological factors. If that had been the case, separating children from their parents might have been expected to disappear with the decline in infectious diseases, the introduction of antibiotics, and the technological innovations that made restrictions less essential. But contemporary ideas on child rearing constituted and provided justifications for mechanistic and regimented care. Childcare experts of the 1920s and 1930s advocated strict adherence to 'by-the-clock' routines, and emotional interaction with children was viewed as sentimental. The prevailing orthodoxy of the time regarding relationships with children was one of firm, cold detachment. The nursing of children became a territory for professionals. Parents had to accept and trust that the sick children 'were in the best place' at the hospital (Cleary, 1992; Young, 1992).

Most nurses in hospitals during the 1920s, 1930s, and 1940s were unmarried. They had their homes at the hospital in which they worked. Rules and regulations governed both their working and social lives. The nurses' everyday life was devoted to child rearing and nursing and children's reactions of being separated from their families did not seem to be regarded as a problem. Visiting time was to be respected by parents. Through interviews Erlöv & Petersson (1992) have investigated retired nurses' experiences and found that they ignored parents' presence because parents were too emotional. Nurses recommended that parents visit their children as rarely as possible as they thought children felt distressed by meeting their families. Children should be cured without coddle. According to a retired nurse:

> We grew up thinking that anybody could take care of children, as long as they were fed and had diapers everything was fine. We didn't know that the relationship with one's parents was so important (Johansson, 1986-04-13).

This predominant belief is important to keep in mind in order to understand nurses' professional notions of parent participation in hospital care during several decades until the 1960-1970s. Children's isolated hospitalization, with the legacy of separating children from their parents and families, also influenced the absence of any relationships between nurses and parents (Young, 1992).

Towards Parental Entry

Though some discussion of parental access began early in the century, such access was not common until much later. A British pediatric surgeon, James Spence, advocated the idea of allowing mothers to stay at the hospital with their children already in the early 20th century. He called for a humane and satisfactory method of nursing sick children, particularly those under four years old (Spence, 1951). But his ideas never got published until later when other researchers gave them credibility. Cleary (1992) and Darbyshire (1993) argue that it was the pharmaceutical and medical innovations that initiated the ideas of changing norms concerning children's developmental and emotional needs. The development of powerful new medicines, such as sulfanilamides and antibiotics during the 1940-50s, made many diseases much less dangerous. In addition, psychological research in the 1940s provided powerful evidence of traumatic psychological experiences causing symptoms of emotional stress. Spitz (1945) used the term 'hospitalism' for a certain kind of emotional stress found in hospitalized children. Bowlby (1953) added further knowledge about children's experiences of maternal deprivation and several subsequent psychological effects. In addition, Robertson (1970) reported effects on children such as detachment, apathy, restlessness, and failure to thrive caused by separation from mothers during hospitalization. Although the psychological research provided strong reason for including families in the care of hospitalized children, change occurred slowly.

In 1959, the British Ministry of Health presented a report on welfare of children in hospitals (Platt, 1959). It was recommended that mothers of very young children requiring hospitalization should be allowed to stay with their children. Some principles were also formulated under which nurses should

care for children. This was the first guideline in British nursing for how nurses should attain a relationship with parents of hospitalized children. The report is frequently cited in British research (Cleary, 1992; Darbyshire, 1994a).

Still, opinions about parents' presence in hospital care fluctuated during this time among physicians and nurses in British pediatric care. According to Young (1992) one reason probably was that psychological re-search on hospitalization of children appeared to have little impact on the medical and nursing staff. The nurses were educated in rigid, procedure-oriented, routinized systems and were not easily willing to change their practice (Young, 1992; Darbyshire, 1993). But attention to children's needs and the knowledge of what stresses them gradually influenced hospital settings and nursing practice (Stenbak, 1986; Cleary, 1992). The emerging psychological research gradually made both nurses and parents aware of the risks involved in separating small children from their families.

In Sweden there was no public discussion about children in hospitals during the 1940-50s. However, during these decades the child's position in the society as a growing human being got more attention (Bischofberger et al., 1991). Because of attention to children's needs, parents' regular and frequent visits to their children were more and more accepted. During the 1950s parents could visit their children about one hour three times a week. During the 1960s visiting hours every day became increasingly common. In the 1970s most pediatric units in Sweden had open visiting times for parents and entire families (Johansson, 1986; Erlöv & Petersson, 1992). This meant that the nurses were forced to develop some kind of relationship with parents. But still parents were visitors and had few opportunities to influence or share the care of their child. However, it was regarded as a benefit if parents could relieve the pressure of the nurses' workload by, for example, feeding the small and disabled children during their visits (Erlöv & Petersson, 1992).

Parents as Residents

The psychological research on hospitalism and hospitalization (Spitz, 1945; Bowlby, 1953; Robertsson, 1970) was accompanied by pedagogical ideologies put forwards during the 1960-1970s and was inspired by, for example, Neill (1961), Jonsson (1969), Freire (1968), Köhler (1973), and Liljeström (1973).

They all spoke of deliberated children and their rights to be respected and listened to by parents, as well as other important adults in childcare, schools, and other institutions in the society. At the end of the 1970s the Swedish Government stated the right of parental influence in both childcare and schools (SFS 1976:381). Political opinion declared that it was up to parents themselves to obtain insights about and to influence and participate in their children's everyday life.

Knowledge about children's needs and what stresses them, and their rights to have parents present with them in hospitals gradually influenced the nurses' attitudes during the 1970s-1980s. Accommodation now was offered to all parents during children's hospitalization so they could participate in the care (SOU 1975:87). Parents were asked to remain during all kinds of hospitalization, either as 'long-term', regular visitors or as residents with their children. For the sake of the children parents' presence was accepted in hospital care. According to Brembeck (1995) the parental role since the 1970s is characterized by "being at their children's side" (p. 161). This attitude also seemed to have positively influenced the attitudes towards parents in pediatric care. In addition, children's need to play and to be prepared for treatments was increasingly accepted as essential (Lindqvist, 1973; Ljungström, 1985; Edvinsson, 1984).

The progress towards parental presence seems to be internationally similar in Europe and North America (Cleary, 1992; Young, 1992; Darbyshire, 1993; Dunst, Trivette & Deal, 1988). In North America, knowledge about the importance of contextual and ecological factors for child development particularly influenced a more family oriented care (Bronfenbrenner, 1979; Dunst et al., 1988, 1994).

As a consequence of the increased presence of parents during their children's hospitalization, the nurses had to encounter parents in their practice, and to interact with them in various kinds of daily settings. But hospital buildings and pediatric units were not built for parents staying during both days and nights. The wardrooms got crowded. Many parents and children shared the same room and parents slept on mattresses on the floor during the night (Johansson, 1986). Those problems were common up until the last decade. According to Darbyshire (1994a), what has not been considered in relation to the gradual implementation of parents' presence is in what way nurses and parents experience and manage to act in the same settings and to share the care of a child.

Taking parents' presence and interests seriously probably means an influence on several aspects of nurses' everyday practice, and it is likely that situations with conflicting interests occur (Bischofberger et al., 1991; Sundström, 1996).

In order to accomplish directives and regulations for parental presence and interests, several models based on various ideological and theoretical claims have been suggested for pediatric nursing practice. The most used concepts and models in the pediatric nursing literature for guiding parental presence will be described in the next section.

Models for Parental Influence

When parental presence became more common in pediatric practice, there arose many questions about nurses' relationships with parents and how to deal with parental interests and involvement in the hospital care. When reviewing literature in the area it was found that the implication of parents' presence in pediatric care asked for models to guide the everyday practice (Stenbak, 1986). Literature during the 1980-1990s, to a large extent dealt with models and concepts for parental presence in pediatric care. Particularly common terms were: 'care by parents', 'parental participation', 'partnership in care', 'parental involvement' and 'family centered care'. The review revealed differences in the use of concepts and models of nurses' perspective on parents to a hospitalized child.

In the care by parent model the nurses are regarded as situated in the periphery to assist parents (Cleary, 1992; Palmer, 1993). In the use of the other concepts and models two major viewpoints were possible to discern. First, in some models parents or a family is seen as the child-patient's environment in hospital settings. Secondly, in other models, a family is seen as a 'unit' for carrying out nursing activities.

In the first way of viewing parental influences, the parents are situated in the periphery during a child's hospitalization. Nurses' focus is expected to be on professional solutions directed towards the child, who belongs to a family, which influences the child and is therefore important as a participant in the care. Here, the concepts parental participation, and partnership in care tended to be more frequently used (Casey, 1988, 1995; Callery & Smith, 1991; Farrell, 1992; Nethercott, 1993; Kristensson Hallström, 1994, 1998; Coyne, 1995b; Tunstall & Prudhem, 1997).

The second way of viewing a family with a sick child is as a unit for carrying out nursing activities. The nurse's focus is expected to be directed towards 'the family', as a coherent system. Professional compensatory models of holistic helping are utilized here. Models, regarding the entire family as the focus, tend more frequently to use the concepts parental involvement and family-centered care (Dunst et al.,1988; Rushton, 1990; Stower, 1992; Ahmann, 1994a, 1994b; MacPhee, 1995; Coyne, 1996; Shelton, Jeppson, & Johnson, 1987; Shelton, 1995; Bradley, 1996).

However, the content in concepts and models lack in coherence, because different perspectives and definitions are used for the same term. In the sections below I will present some concepts and models in nursing practice as they have been described in Swedish and international literature.

Care by Parent

Care by parent, as a theoretical model for pediatric practice, is described in the literature as parents taking the overriding responsibility for basic care by living-in as residents with their sick child (Cleary, 1992; Palmer, 1993; Darbyshire, 1994a). Nursing models for 'care by parent' are used within specifically organized units where parents, almost always mothers, have an active participatory role in the hospital care. Within a context characterized by care by parent, parents have the vital role of comforting and supporting their children, thereby adding a dimension to the care that would otherwise be missing (Palmer, 1993). According to Palmer (1993) the parental role in care by parent units appears as "the role of provider of direct physical care, teaching the health care team about 'their' child's normal physical, psychological and social behavior, something about which they have intimate, personal knowledge". It appears also as the role of informer, "since parents often are the first to recognize deviations in these [children's] behaviors", and as the role of intervener, indicating that "parents must also be willing to be taught about their child's care by the staff" (Palmer, 1993, p. 187).

Cleary (1992) has conducted an empirical study following the establishment of a care by parent pediatric unit. She found that, according to such a model, parents had more confidence when dealing with their child's illness. She argued that when parents are given opportunities to gain understanding of their children over time, they ask for nurses only when they need support and

guidance. Both Cleary (1992) and Palmer (1993) found increased parental knowledge and efficiency in hospital care, as outcomes in care by parents units. Parents were seen to perceive themselves as "useful and important" (Palmer, 1993, p. 188). By using implications of the care by parents model in practice, parents may perceive increased responsibility for their children during hospitalization. Consequently it may also influence the nurse's role of serving and assisting parents, as parents are the primary care givers towards their child. Nurses' assisting of parents, is found to be based in beliefs and values of parents as the important caregiver for a child, with the nurses in the environmental periphery. However, Nethercott (1993) has formulated a critical objection because of the risk that when nurses view parents as the primary caregivers, and leave the basic care to them, they may abdicate from their nursing knowledge and avoid organizing activities.

Parental Participation and Partnership

In Sweden 'parental participation' has been frequently used. It was introduced by official recommendations to ensure parents' access and right to stay during hospitalization with economical compensation (SOU 1975:87; SOU 1976:280). Likewise, parental participation in other activities involving children and youth in the Swedish society, such as preschool and school, was strongly advocated (Stockfelt, 1975; Vi i förskolan, 1979; Ljungdahl, 1985; Flising, 1996). Along with the discussion of parental influence in official institutions, parents' interests and rights to have insight and influence by participating in children's everyday life in general became increasingly emphasized during the 1970s (Brembeck, 1995). However, since parental participation in hospital settings includes their presence during both days and nights, it is likely to influence contextual conditions and the relationships in hospitals in more profound ways than in other institutions.

Until the beginning of the 1990s research on parental participation in Swedish pediatric care was rare. Knowledge about parental participation was in many ways taken for granted in nurses' practice as mandated by state directives and regulations (SOU 1975:87) and by local polices and guidelines. Only recently a professional discussion among Swedish nurses concerning organization of parent participation in everyday practice has appeared. This lack of empirical research was the primary reason for conducting a previous study of nurses' conceptions of parental presence and participation in everyday practice

(Söderbäck, 1992). In this study, individual nurses' conceptions of parental participation in everyday practice were investigated by means of a phenomenographic approach (Larsson, 1986). The results showed that the nurses' conceptions of parent participation concerned making children feel safe by their parents' presence, and by the parents giving the basic care. A third dimension in the concept was that parents were regarded as advocating their children's autonomy and interests during hospitalization. Finally, either the parents were expected to serve the nurses by giving information about their child, or it was expected that the nurses had to serve and nurse both a child and its parents (Söderbäck, 1992).

A more recent study elucidated different aspects of parental participation in Swedish pediatric surgical care (Kristensson Hallström, 1998). Here, the understanding of parental participation was identified from the parents' perspective. Nurses' activities were regarded as the link between children and their parents. Kristensson Hallström proclaims that nurses are important actors in establishing parent participation, by, among other things, being responsible for taking initiatives in developing routines and guidelines for structuring parental participation.

Scholars in British pediatric nursing engaged themselves in public discussions and inquired about parental participation in pediatric care earlier than in Sweden. In the middle of 1980s Casey (1988, 1995) presented a model for developing 'partnership' with parents in practice by suggesting parental participation in caring for children. The model was based on a view of the family as the primary caregiver for a child: "the care of children, well or sick, is best carried out by their families, with varying degrees of assistance from members of a suitably qualified health care team whenever necessary" (1988, p. 8). A parent is the important environment for a child. Casey does not define the content of a partnership between a nurse and parents as this relationship may differ between different children, as well as over time. In order to establish the partnership however, a process of involvement of parents is recommended. The model constitutes a general description of how parental participation can be dealt with by nurses in pediatric practice.

According to Farrell (1992) the flexibility in nurse's roles in Casey's model, is a positive attribute in nursing practice. Through the model nurses can identify their role as encouraging parent participation within parti-cular situations. According to Lee (1998), Casey's notion of parental participation as partnership, and the implementation of the model have enabled nurses' work

during the 1990s in British pediatric care. The model has also been used in nursing education. However, this partnership model has also been criticized, and its implementation in practice has not yet been evaluated. Practitioners in British pediatric nursing have displayed conflicting attitudes in the use of the model. Tunstall and Prudhem (1997) argue that nurses find it difficult to translate partnership to an operational level. According to them there are no directives given as to how to create a 'partnership'. They are critical of that nurses' activities should only rely on parents' wishes and opinions. According to them, this is not a correct way of using professional nursing knowledge, which contains moral obligations of active acting towards parents.

Darbyshire (1994b) refers 'participation' to more functional engagement of parents in their child's care, as in the carrying out of everyday care. However, he also refers to 'parental involvement' as having a more holistic connotation, with a deeper sense of parents as being an integrated and essential part of a child's experiences in hospital care. Some additional definition and use of parental participation is found in the literature. Callery & Smith (1991) use the concept as outlining boundaries of partnership according to an amount of negotiated care. They argue that nursing knowledge requires negotiated skills, attached to nurses' and parents' different roles in sharing the care. The content of parental participation was also found in the literature as referring to the nurses' responsibility. For example, Nethercott (1993) has argued that because nurses are "experts by their nursing knowledge" (p. 794), they also are confident in recognizing the special knowledge and skill families have regarding their children's care.

Nethercott suggests that:

> The concept of parental involvement is to be seen as a hospital philosophy which acknowledges the rights of families to be present at all times, with nurses remaining the experts who control the family's involvement, while parent participation includes the features of parental involvement in participation, in order to differentiate between the types of relationships between parents and nurses (p. 794).

In a concept analysis conducted by Coyne (1996), she found that the use of concepts and models for parent participation has changed in British nursing over time. From a period in the 1980s, with mother's 'rooming-in' and 'care-by-parent units', there is a shift during the 1990s to use more 'family centered models'. According to her the meaning and implication of parental participation have changed from parental involvement, via partnership in care and care by parent to family centered care models.

Family Centered Care

The literature review indicated that the model for family centered care, developed in North America, was based on recognition of the family as the constant in a child's life (Dunst et al. 1988; Shelton et al., 1987, Shelton, 1995). This model was based on Bronfenbrenner's (1979, 1989) ecological perspective for human development, according to which the family constitutes the primary context for the child's growing understanding of the world and itself. A model for family centered care assumes a process of care where all families have "strengths and concerns beyond their need for and participation in specialized services and supports" (Shelton, 1995, p. 362). Children are to be focused upon in a way that is based on their potential for development. The implication of this perspective is that the family is the unit in nursing care for a sick child.

According to Shelton there are several characteristics that are recognized in family centered care with the family system as central during hospitalization. These characteristics address nurses' recognizing, respecting, and providing diverse strengths and needs within families, through appropriate, flexible, and accessible services and supports. The incorporation of a family in a central role and the enablement of a family's diversity are accomplished by nurses through the exchange of information with parents. The nurses' communication weaves the characteristics together in practice. According to Shelton, applying the characteristics of family centered care meant that the pivotal role of 'families' was recognized in policies, and respected in practices.

Stower (1992) writes that, as family centered care focuses on caring with the child and their family as a unit, nurses are expected to create the right environment for the child in hospital through as many normal, homelike activities as possible. Nurses "should be the facilitator for the parents to care; the enabler, not always the doer" (p. 68). In family centered care nurses are expected to recognize and strengthen families' special knowledge and skills regarding their children's care (Dunst, 1988; Rushton, 1990; Ahmann, 1994a, 1994b; Shelton 1995, 1996; Bradley, 1996). To practice family centered care is described in the American literature as a creative process that involves interchange between nurses, parents, and other family members.

A number of program-evaluations of family centered care have been conducted in the United States. They have provided some empirical support for benefits of using family centered care in practices (Rushton, 1990; Ahmann, 1994a,

1994b; MacPhee, 1995; Shelton, 1995, Bradley 1996; Trivette, Dunst, & Hamby). However, Darbyshire (1995) criticized a routine-like use of the term family centered care in British literature on pediatric practice. He argues that the use of 'parent' and 'family' only as words for an obvious kinship with a child is problematic as the implication of models for family centered care in practice risks becoming just a cliché:

> The concept of family-centered care is such a cherished tenet of pediatric nursing as to be almost above critique. Yet a close examination of the situation and meaning of the practice of family-centered care is long overdue if the term is not to lapse into being a mere cliché or slogan (p. 31).

Furthermore, Darbyshire argues that nurses who use the phrase family centered care when referring to families as "a physical and possibly metaphorical impediment between her [nurse] and the legitimate object of her nursing practices, the child" (1995 p. 51) are missing the idea of a family group as the center of caring contacts.

In conclusion, the review of the use of concepts and models for practice indicate that there is no real consistency in how to incorporate parental presence and support the involvement of parents during children's hospitalization. Different models are based on divergent beliefs and values about parents and families and how they should be professionally encountered. Divided beliefs and values of how to focus upon parents in practice point at distinctions in family oriented practices. It may be assumed that when nurses try to encourage parental participation in their everyday practice by using models that are more or less taken for granted, they do not analyze how values and beliefs are to be translated into particular activities (Coyne, 1995a; Darbyshire, 1995; Rowe, 1996). Variations in what nurses value and prioritize may imply different actions when encountering parents in practice. According to Kim (1998) it is the nurse's individual knowledge and moral obligation in a particular situation that determines what is socially recognized, and what activity that will be carried out.

Additionally, Peavy (1992) suggests that when nurses view parents as having shortcomings they place them in power-impaired relationships with service provided by professionals. When nurses focus upon parents' resources on the other hand they put themselves in a position of help-givers by enabling parents' and families' resources.

In the next section, a review of empirical research of parents' and nurses' experiences regarding their relationships in practice is presented.

Previous Research on Nurse-Parent Relationships

Early in the 1980s two Swedish pediatricians, Kjellman & Bourdin (1982), presented a minor study of experiences of parental participation in the care of hospitalized children. They found an unexpected sympathetic attitude on the part of parents towards the pediatric unit and the staff. However, apart from this study there has been scant Swedish, as well as international research before the 1990s, with focus on parents' experiences of staying with their hospitalized child and of pediatric nurses' experiences of working according to models for parental presence and participation in care.

Parental Experiences

To follow-up the quality of pediatric care in different regions, the Swedish Government (The National Board of Health and Welfare, Socialstyrelsen, 1991, 1992, 1993) has carried out some evaluation studies. These studies, among other things, investigated parents' experiences of hospital care of their children. The majority of parents were pleased with their children's care. But to a considerable extent they criticized their interactions with nurses and other professionals as lacking mutual communication. Parents' felt that their opinions were not listened to.

Other international empirical studies describe parents' experiences during their children's hospitalization as depending upon parental characteristics, including personality, emotional state, level of comfort in the provided care, and their familiarity with hospital environments. Parental uncertainty, regarding treatment and prognosis of their children, and a changed parental role during children's hospitalization were described as exacerbating anxiety (Brown & Ritchie, 1990; LaMontaigne & Pawlak, 1990; Darbyshire, 1994a; Evans, 1994; Kristensson Hallström, 1994). In several studies, parents' experiences signified a wish to participate in hospital care. Parents felt that they had the ability to participate if they were given instructions and guidance. The studies describe parents' need for trust and information (LaMontaigne & Pawlak, 1990; Deitz,

1991; Cleary, 1992; Evans, 1994; Melnyk, 1994; Kristjánsdóttir, 1992, 1995; Dixon, 1996; Kawik, 1996; Neill, 1996; Kristensson Hallström, 1998).

Kristjánsdóttir (1992) has suggested parental needs to be grouped into six categories: need to trust, need to be trusted, need for information, need for support and guidance, needs related to human and physical resources, and needs related to other family members. She concludes in another study, (Kristjánsdóttir, 1995), that there is a direction in parental needs that gives priority to the trusting of professionals and to the receiving of information. Melnyk (1994) specifies two forms of information that parents are particularly searching for; 'child behavioral information', focusing on the sick child, and 'parental role information', focusing on the parent. Other studies have emphasized discrepancy between nurses' expectations of parental participation and parents' actual experiences of participation in the hospital context (Callery & Smith, 1991; Coyne 1995b; Farrell, 1995; Evans 1996; Keatenge & Gilmore, 1996). Expectations, which are meant to influence and come to an agreement about the parental role, were identified as hidden and not spoken by nurses. Neill (1996) showed that parents experience problems with unsatisfactory communication of a 'paternalistic nature' on the part of professionals. Further, that there was a lack of agreement about the parental role in hospital settings. Parents experienced that they avoided asking nurses for clarifications because they did not know what questions to ask, or whom to ask.

Callery (1997) described mothers' with small children as experiencing conflicts between their parental knowledge of their child and the nurses' professional knowledge of conditions concerning the child. Parental knowledge was experienced as not fully respected by nurses.

In a Swedish study, Kristensson Hallström and Elander (1997) noted that many parents felt that their child's hospitalization was more demanding upon them than they expected. Hospitalization required extensive adaptation, due to insufficient facilities and problematic situations. Finding security in this environment was an unfamiliar undertaking for parents. There were various strategies of coping among the parents, and the level of anxiety determined the strategies they used for feeling secure. Three major strategies emerged regarding the manner in which parents tried to find security in the hospital. One strategy was to leave the care to the staff, another involved obtaining a measure of control over the care and the third was a strategy of depending on knowing one's child best. Additionally, Kristensson Hallström and Elander found that parents' varied in the extent to which they wished to participate.

Parents, who felt they lacked information and who were not secure in their parental role, were less disposed to participate in care. How individual parents viewed the hospital situation, and their available resources for dealing with different situations, depended upon to which extent they experienced stress. What might be stressful for one parent, however, might not be so for another, even if comparable situations.

Other studies, focusing on family members' coping with stress due to their children's hospitalization, indicated that if nurses can measure and recognize a family's needs and stress, they can provide care that encourages and supports strategies of coping (Dixon, 1996; Enskär, 1997).

Darbyshire (1994a) found that parents' experience of uncertainty, when living-in with their hospitalized children, was primarily about what was expected of them in relation to their child's care. This uncertainty, plus lack of information and conflicting advice, resulted in considerable anxiety and hampered parents ability to participate in sharing the care. He noted that although parents were uncertain, they felt under pressure to participate in the care in order to establish their identity as good, useful, and willing parents. Darbyshire also found that parents expected themselves to take an active part in the care and viewed themselves as providing physical childcare, play, and emotional support, performing the role of advocater and protector of their child. He found indications that parenting in public was frustrating and stressful for families due to their unfamiliarity with the hospital settings. Parents felt threatened when criteria for determining the quality of their child's care were set and controlled by professionals in the professionals own setting. Parenting was experienced as public, within an unfamiliar context. The parents' experiences represented an extension of the usual parenting role, in a territory where they interacted with strangers and were strangers themselves.

To summarize, recent research indicate that parents' experiences of being present during their children's hospitalization seem to include wishes to participate in the care on their own conditions. When entering a hospital ward, they are likely to perceive that their role as parent is changed, which rises their stress concerning how to cope and act in the unfamiliar hospital context. Uncertainty, questions concerning outcomes of medical treatment, lack of information, loss of parenting role, and inadequate facilities in the hospital settings seem to contribute to parent's experiences of stress. Nevertheless, they seem to express a need to trust the professionals.

Nurses' Experiences

A review of earlier research, on nurses' experiences of relationships with parents to hospitalized children, indicates that they seem, above all, to emphasize their function of transferring and exchanging information. Relationships are primarly regarded as ways for delivering nursing care to children, and for giving help to parents. For example, it has been shown that nurses use parents in order to get knowledge about the child to formulate a nursing care plan (Perkins, 1993). In another study, Brown & Ritchie (1990) found that nurses' experience of difficulties in fulfilling their duties toward parents was related to lack of trust in parents' ability to care for the sick children. Dearman (1992), on the other hand, found that nurses assumed parents to be involved in the care but without ascertaining their wishes. Still another study (Callery & Smith, 1991) reported that nurses seem to take parents' wishes to share the care with them for granted. They found that sometimes nurses' 'encouragement' consisted of expectations of how they wanted parents to behave. By giving explanations of caring events, parents were expected to behave in certain ways. In other cases, negotiations with parents resulted in agreements about the parental role. However, the nurses did not recognize this as a 'role-negotiation', but as a way of coming to an agreement (Callery & Smith, 1991).

These studies and Kawik (1996) showed that nurses have different conceptions of their roles in building relationships with parents conducive to involvement and participation in the care. Darbyshire (1994b) in addition, explains nurses' experiences of a "good parent" (p. 54) as someone who took her/his time to be with the child and relieved the pressure on the nurses by providing the basic care. A good parent was expected to understand that it was a child's degree of illness, which determined the level of nursing care. The nurses explained how they use social and moral criteria about what was expected of parents in the hospital context. The nurses experienced sharing of care as meeting their preconditions and demands in different situations.

According to Darbyshire (1994a) the dynamics of relationships and associated issues of responsibility, status, and power during hospitalization made clear that nurses were stressed and felt uncertain in the same settings as parents. The threat of loss of authority and a blurring role seemed to contribute to inconsistency in sharing the care of a child with the parents.

Rowe (1996) outlined in her study three themes of nurses' relationships with parents by the assignment of nursing activities in settings where both acted. First, there were relationships based on parallel activities. Nurses and parents occupied the same geographical space and moved in parallel motions. Relationships occurred because both nurses and parents had expectations towards each other. The second theme of relationships was based on cooperative connections. Here nurses, in the sharing of information, initiated negotiations with parents. The third theme of relationships constituted missed connections, or the excluding of experiences. Thus, relationships were structured by different qualities in nurses' actions.

To summarize, the review of the literature indicates that nurses experience role uncertainty in their activities towards parents. The discrepancy between parents' and nurses' familiarity with the hospital context, and implicit expectations of each other as actors in the same situations, appear to produce complex relationships. The social structure of pediatric nursing practice seem, by both parents and nurses, to be regarded as characterized by a professional dominance, despite the dependency on each other for carrying out care to a hospitalized child. Professional dominance in pediatric nursing care will be further described in next chapter.

Professional Dominance

Asymmetric Relationships

According to Sundström (1996), hospital settings are likely to create asymmetric relationships between professionals with authority, power, and control and uncertain and vulnerable clients. The professional actor dominates, and is explicitly or implicitly expected to take initiative in varied settings. Other scholars refer to this problem as an issue of asymmetric power balance in the relationships between helpers and clients, displayed in interactions where each professional action is inevitably connected with power (Cochran, 1992; Skau, 1993). Several empirical studies, relevant for the present one, have shown hospital settings as creating asymmetric relationships due to professionals' familiarity with the context and parents' or patients' dependency; children, adolescents and other sick persons (Silverman, 1987; Elander & Hermerén, 1989; Taylor, Pickens & Geden, 1989; Olin Lauritzen, 1990;

Darbyshire, 1994a; Thompson, Melia & Boyd, 1994; Wikander, 1995; Neill, 1996).

When discussing nurse-parent relationships, Darbyshire (1994a) referred to an earlier study by Silverman (1987), who stated that in pediatric settings, when parents perceive that functions and responsibilities are handed over to 'experts', the parents' sense of moral responsibility and competence may be threatened. However, according to Silverman, from a medical perspective there has to be an asymmetrical relationship in hospital settings, since parents with their children, and other clients, are the consumers or users of care. In his study, Silverman analyzed relationships between professional physicians and parents of sick children. He found that between the professional help-givers and parents, asymmetrical relationships were inevitable and essential for carrying out medical care, because settings were controlled by time, location, goals, and directed activities. There were routines for the actors to follow during the interactions, especially for the professional actors who initiated and completed events. He also found that help-givers, focusing on clients, could act in a way so as to let the patients think they influenced decisions. However, he also described relationships aiming at expanding the interest of clients as persons.

Obviously, when children are clients, the professional dominance had other qualities than with adults. There were more open questions as to whether the professional or the parents was the one to take initiatives. Both had an interest in the child and in sharing responsibility for the care. According to Silverman (1987) what actually happens in interactions between professionals and parents in health care has to do with the institutional context, which gives the space and sets the bounds for actions. However, the context does not solely determine the actions of the involved.

Olin Lauritzen (1990) has analyzed professionals in preventive child health services when encountering parents on routine basis and in establishing relationships. Her study concerned conditions for understanding encounters between maternity and child health services and immigrant families. The patterns of interactions during encounters in the health care settings were analyzed, among other things, in relation to the tasks of the health professionals. Based on her results, Olin Lauritzen proposed an overall structure for health care in terms of 'initiative' health care, initiated by the health services and 'receptive' health care initiated by the families. Initiative of health care was described as the checking-up of conditions according to a

program of health surveillance, while receptive health care was described as various forms of parents' search for advice. In the patterns of interaction Olin Lauritzen found that an initiative stance from the professionals was likely to involve a hidden agenda of health issues and medical doubt. When receptive health care was at hand, parents' ideas were uncovered, but only to the extent that was necessary for the professionals to make their assessment of the health problem and to give advice. However, when social interaction was intertwined with the task-oriented sequences, the families' view and ideas were more exposed.

In the light of these findings Olin Lauritzen (1990) argued that a professional dominance creates interactional dilemmas as the professional stance requires explanations, which imply superiority/inferiority. Further, parental participation might be interpreted in a passive way, where information is to be collec-ted by the parents without making their own understanding of the situation explicit. Finally, Olin Lauritzen's study indicated that, where there is asym-metry because of professional dominance, there is a need of social space for building relationships that can create mutuality.

Social and Ethical Dimensions

Issues of power and authority as dimensions of relationships in health care and hospitals have also been studied in relation to nursing ethics, and to questions of parents' well-being. According to Rowe (1996), professional dominance has the power to determine the direction parents take during a child's hospitalization. Subsequently, nurses' interactions with parents are to be viewed as taking place within power-dependent relationships. Nurses are understood as the initiators, who are expected to engage parents in the course of their practice and to determine the extent of parental involvement. Rowe further argues that nurse-parent relationships highlight an inherent paradox in the nurses' expectations of parents' roles, as the nurses describe parents as both visitors at the hospital and as partners in caring for their children.

The dynamics of interpersonal relationships and the social structure of an institution, i.e a hospital ward, give rise to questions about how nurses' master their professional dominance when sharing the care with parents in everyday pediatric nursing. Probably, as parents and nurses are increasingly acting side by side in caring for sick children during hospitalization, their relationships

are not free from difficulties, uncertainty, and stress. Dilemmas of power and dominance in relationships with parents are always present, regardless of the actors' awareness or will.

According to Skau (1993), the dualism in a professional relationship, i.e. helping or caring on one side and power dominance on the other side, has implications for building relationships and for the social structure of an institution.

Ethical issues in nursing, expressed by rules, guidelines, standards, principles, and ideals, are embedded in the organization of an everyday practice. Concepts and models, as reviewed above (p. 14), can be viewed as conceptualized norms for how parental issues should be dealt with in nursing practice. It is obvious that such reference frames will influence nurses' performance of care. For example, Andersson (1998) has suggested such written policies to influence nurses' perceptions of their moral obligations directing them to follow ideological objectives and principles written in laws, ethical rules, and different statutes.

Kim (1998), having declared nursing to be a normative discipline with intentions of doing something to change a situation for another person, also has pointed at the difficulties in transferring regulations, standards, and theoretical or applied models into practice. According to her, normative directives and obligations have no real capacity for carrying nurses' activities into the diversity of everyday practices. Further she argues, that since nurses' practice includes social dimensions, caring activities are likely to involve processes of transformed personal knowledge, which goes beyond theoretical models and moral obligations. A practitioner is involved in a set of actions encompassing aspects pertaining to the clients, the situation, and the nurse her/himself as the professional actor.

Additionally, Bäckman, Malmsten, and Olsson (1998) have suggested that ethical aspects of nursing care in interactions ultimately concern personal responsibility in situational relationships. They argue that the asymmetric relationships in nursing care, make it necessary for nurses to take a personal approach when encountering particular patients/clients. Written rules and codes are not sufficient to lean on in concrete situations. The individual nurse's ability to reflect on her own actions, alone and in dialogue with others in the same position is essential. Finally they argue that going beyond abstract, ethical principals constitutes a major element in a professional stance.

According to Darbyshire (1994a), the expectations to do things for each other to achieve good conditions in caring for a child are directed towards nurses, as well as parents. Nurses' expectations of parental involvement are likely to be related to ethical issues with professional and contextual relevance. Nurses have to consider contextual conditions and dynamic aspects of nursing children, in accordance with parents' wishes, opinions, and resources.

The existence of professional dominance, implying asymmetrical relationships to influence social and ethical dimensions in the encounters, was one important issue when planning and conducting the present study. Previous studies, such as those referred to here, indicated that nurses' knowledge and their own ambition in promoting parental interests may have bearing on how involvement of parents is carried out, and on how nurses master various encounters with parents in hospital settings. Questions, relevant for pediatric nursing practice, addressed by Kim (1994), were used as an early set of formulated research enquieries, namely why there are variations in activities and actions carried out in different situations, why intended actions are not carried out, and why what nurses' think they did is different from what they actually did.

To summarize, encountering parents in hospital contexts are events that occur frequently in nurses' pediatric practice. Taken for granted, socially embedded knowledge seems likely to be hidden in expectations, intentions, and actions. Social dimensions in mastering encountering situations are therefore expected to be associated with nurses' delivering of actions in their everyday nursing practice (Kim, 1987, 1994, 1998; Hartrick, 1995a, Hartrick & Lindsey, 1995b, Hartrick, 1998).

Aim

The aim of this study was to provide insights into nurses' mastering of everyday encounters with parents in a pediatric hospital. More specifically the study was aimed at:

- uncovering and describing nurses' actions,
- interpreting and describing nurses' perceived meanings of their actions,
- conceptualizing the content in and perceived meanings of nurses' actions in everyday encounters with parents as mediating practical knowing, and
- revealing indications of shared knowledge among the nurses about encountering parents in the hospital context.

PART 2

Methodology

Methodological Considerations

As the survey in the background indicates, nurses' practice in pediatric care is complex. Accordingly, hospital contexts of pediatric care, where nurses encounter parents in everyday occurrences, needed to be studied within its multiplicity. This implied a number of methodological considerations, which will be described in the chapters that follow.

Methodological Approach

The study is conducted within the domain of health care and nursing pedagogy. Within this research domain a naturalistic[1] approach has been useful in earlier empirical inquires of nurses' competencies in connection with nursing culture and organization (Johansson, 1989, 1995a, 1996a). Epistemologically, in the naturalistic approach, the researcher's relationship towards a field for investigation is inter-active. The research process is a transactional process where findings are created in close contact with the field and the informants (Lincoln & Guba, 1985; Guba & Lincoln, 1989, 1994).

A naturalistic approach has some implications for research. First, the research is carried out "in a natural setting or context of the entity" (Lincoln & Guba, 1985, p. 39). The objective is to obtain a contextual understanding by interpreting and describing what is going on in a natural setting without manipulation of the natural process.

Secondly, focusing on social processes in an institutionalized context assign the basic ontological assumption that realities are multiple constructions and holistic. Reality can be seen differently by each participant. The researcher is the human instrument who "elects to use herself as well as other humans as the primary data gathering instrument with sufficient adaptability to encompass and adjust to the variety of realities that will be encountered" (Lincoln & Guba, 1985, p. 39). Only a human instrument is appropriate for understanding

[1] Lincoln & Guba (1985) use 'naturalism' derived from the adjective 'natural'. In English 'naturalism' in addition can be derived from the substantive 'nature', and in this case the meaning is totally different.

and interpreting the meaning of varying interaction. Lincoln and Guba emphasize a conscious choice of perspective on the part of the researcher in search of the 'truth', to find 'a best formed understanding' of a social phenomenon (1985). A third characteristic is the utilization of tacit knowledge in natural settings. The researcher maintains:

> "... the legitimating of tacit (intuitive, felt) knowledge in addition to propositional knowledge (knowledge expressible in language from) because often the nuances of the multiple realities can be appreciated only in this way" (p. 40).

Fourthly, qualitative methods are preferable in studying natural settings:

> "... because they [qualitative methods] are more adaptable to dealing with multiple (and less aggregatable) realities; because such methods expose more directly the nature of the transaction between researcher and respondent and hence make easier an assessment of the extent to which the phenomenon is described in terms of (is biased by) the investigator's own posture; and because qualitative methods are more sensitive to and adaptable to the many mutually shaping influences and the value patterns that may be encountered" (Lincoln & Guba, 1985, p. 40).

The recommendation of qualitative methods is extensions of normal human activities: looking, listening, speaking, reading and the like. The researcher will therefore tend to use observing, interviewing, and mining available documents. Finally, a naturalistic approach prefers inductive data analysis because that process is more likely to identify the multiple realities to be found in those data. The nature of social processes can only be gained and refined through interaction between a researcher and respondents and through interpretations in a dialectical interchange. The analyses make the interaction between the researcher and informants explicit, recognizable, and accountable (Lincoln & Guba, 1985).

The characteristics above, grounded in the naturalistic approach, were useful in designing this study. The process of moving from specific observations of a specific phenomenon to analysis and interpretation involved different possible perspectives for attaining reasonable contextual understanding (Lincoln & Guba, 1985; Guba & Lincoln, 1989, 1994; Alvesson & Sköldberg, 1994; Johansson, 1989, 1995b).

In the characteristics of a naturalistic approach there are points of agreement with ethnographic research (Hammersley & Atkinsson, 1994). The present investigation of how nurses master encounters with parents in natural settings, was inspired by ethnographically oriented methods (Spradley, 1980; Hammersley & Atkinsson, 1983, 1994; Beach, 1995; Streubert & Carpenter, 1995; Pilhammar Andersson, 1996; Prus, 1996). The interpretative position, in search

of the nurses' meanings in their everyday world, was moreover inspired and influenced by an hermeneutic approach (Gadamer, 1975; Ödman, 1979, 1992; Sjöström, 1994; Gustavsson, 1996). The research interest focused on interpreting, visualizing, and elucidating individual nurses' meanings of their actions and of conditions in certain events and contexts. The hermeneutic approach offered possibilities to search these meanings for a fuller understanding and description. Here, pre-understanding was central. According to Ödman (1979), pre-understanding is a structure of personal feelings and thoughts, which is activated when we regard something as something. In addition, Gustavsson (1996) has suggested that a theoretical pre-understanding can assist in making systematic interpretations of empirical data.

Relations between relevant theory and empirical data were explicitly considered for this study, rooted as it was in a nursing everyday practice that was viewed as inexhaustible in its multiplicity. The analytical activities needed to involve a distanced position to the reality, and expressions in the empirical data needed to be transformed for theoretical understanding and construction. For this analytical work, it was important to find theoretical tools for the analyses and interpretation work.

Although Lincoln & Guba (1985) propose a conscious choice of perspective in searching for the understanding of empirical phenomena, they do not articulate any strategy for emerging conceptualization of an empirical field. To study action processes, in order to describe and understand them from certain actors' premises, this study took in abduction and retroduction in the processes of analysis and interpretation. Here, 'abduction' is defined as formations of assumptions drawing on observations and experiences of empirical data, and 'retroduction', is defined as verifying the assumptions in a reverse manner against new patterns of expressions in the empirical data (Kim, 1992; Qvarsell, 1996). In the subsequent sections the ethnographically oriented methods, the hermeneutic interpretation processes and abduction together with retroduction are further described.

Ethnographically Oriented Methods

Ethnographical methods have been evolved in the field of anthropology in order to study societies and cultures. The objects for ethnographic studies extend to all aspects of human life, including biological, social, and cultural

life. Thus ethnographically oriented methods sometimes are used synonymously with fieldwork (Morse, 1989; Ely, 1993; Merriam, 1994). The fundamental characteristics are that the researcher is the instrument in the field and that there is a cyclic nature of data collection and analysis. The methods fit with the expectations in interpretative approaches in which one strives to know and understand people in their natural settings. As Spradley remarks:

> The essential core of ethnography is this concern with the meaning of actions and events to the people ethnographers seek to understand (1980, p. 5).

Hammersley & Atkinson's define the ethnographic research method as:

> Ethnography (or participant observation, a cognate term) is simply one social research method, albeit a somewhat unusual one, drawing as it does on a wide range of sources of information. The ethnographer participates, overtly or covertly, in people's daily lives for an extended period of time, watching what happens, listening to what is said, asking questions; in fact collecting whatever data are available to throw light on the issues with which he or she is concerned (1983, p. 2).

The usual strategy in fieldwork is to get as much information as possible concerning the social phenomenon being studied. The researcher has the role of an open inquirer and participant who has the opportunity of grasping implicit and taken for granted contextual understanding. The researcher role is an outsider role with an interest in and respect for the informants' inside experience. The researcher observes actions and perceives possible motives and meanings to understand what is going on in various settings and situations (Robertson & Boyle, 1984). Reflective analysis and interpretations form patterns, or reconstruct puzzles, grounded in a translation of one setting into another, to generate comprehension of the group which is studied in a particular context. Selection and interpretation are always included in uncovering the nature of social phenomena. When exploring and interpreting natural settings, reflexivity is necessary for a critical view.

Although the performance of ethnographic studies varies depending on science traditions (Pilhammar Andersson, 1996), common in all ethnographic inspired research is that the researcher reflects over observations and talks with informants. Reflexivity refers to the movement back and forth between the researcher and participant roles, using this duality as a source of insight and to gain a critical distance in the fieldwork. These reflections are the foundation for theorizing about the collected data (Hammersley & Atkinsson, 1983; Beach, 1995).

In nursing science, Leininger (1991, 1992) has used anthropological techniques since the 1950s to carry out transcultural research of nurses in order to discover similarities and differences in health care services, with the purpose of guiding nursing practice. Through studies in medical and social anthropology, an increased interest has gradually been redirected towards conducting fieldwork in one's own culture of professional practices. Recently, ethnographic oriented nursing research has been conducted with the purpose of obtaining deeper understanding of oncological hospital settings (Ploug-Hansen, 1995), of clients in health practice (Haugen Bunch, 1983; Townsend, 1992; Connely, Keele, Kleinbeck, Schneider & Cobb, 1993), of nursing education and administration (Pilhammar Andersson, 1991; Streubert & Carpenter, 1995), and of clinical nursing training (Mogensen, 1994; Pilhammar Andersson, 1997).

According to Streubert & Carpenter (1995) the studying of natural settings in nurses' practice requires a familiarity with the settings and the participants. One of the goals, which they emphasize in ethnographic nursing studies, is making explicit what is implicit within a familiar context:

> Cultural knowledge requires an understanding of the people, what they do, what they say, how they relate to one another, what their customs and beliefs are and how they derive meaning from their experiences. (p. 91)

In addition, Streubert and Carpenter call attention to reflexivity. Both the participant and the investigator positions provide opportunities to explore contexts in nursing, and to reflect on both the affective and subjective nature of human beings' striving towards theorizing.

Prus (1996) calls attention to interactionistic ethnography and its focus on everyday life, as an approach to investigate experiences and activities of people. It attends to meanings and actions in encounters with others and offers an approach oriented towards exploration, understanding and conceptualization of social groups' interactions and is sensitive to particular contexts.

The ethnographically oriented methods used in this study involve a systematic process of observing, describing, documenting, and analyzing natural encountering situations in a particular context. The essence in collecting data was the observation of situations in nurses' everyday pediatric practice.

According to Pilhammar Andersson (1996), to 'be there', making continuous observations of events and to 'share' the informants' view on what is happening is central. In this study, the observations were followed by interviews where

the nurses reflected on their actions. In addition, written documents with relevance for the nursing practice were collected. (See page 55 for an overview description of the data production.)

The combination of data sources was helpful in grasping realities in the nurses' everyday practice and gave possibilities for systematic analysis and reflections during the fieldwork for as full comprehension as possible. As a researcher I tried to grasp the nurses' view of different aspects of particular situations and the larger context. At the same time, even though I was a participant in the situations, I always tried to keep a perspective from outside. Information was drawn both from an insider's view, using information from the group of nurses' experiences and beliefs, and an outsider's view when interpreting observed actions (Streubert & Carpenter, 1995). By drawing on comparisons across situations, it was possible to arrive at a richer understanding of each situation and of similarities or divergences between a range of situations. Conscious use of reflexivity supported in evaluations of both the intersubjective and the methodological levels of my researcher role in the nurses' practice. I will return to issues of maintaining the researcher role during the fieldwork when discussing issues of trustworthiness in the data production (p. 55).

Hermeneutic Interpretation Process

A hermeneutic stance was used in this study for interpretation of the nurses' actions and perceived meanings in encounters. Within the hermeneutic interpretation process, focus was concerned with interpretation of various transcribed texts, as 'marks' from the empirical field (Ödman, 1979; Sjöström, 1994; Gustavsson, 1998).

According to Gustavsson (1998) 'understanding' in a hermeneutic sense means to grasp and interpret marks from real situations and their meanings for those who made them. The researcher can be seen as a human instrument, who forms interpretation and understanding in confrontations with marks from the reality (Ödman 1979, 1992; Alvesson & Sköldberg, 1994). Ödman states:

> The interpretation of what the research object means in its existential world corresponds to what some authors call hermeneutical understanding. Ontologically, this type of understanding is experienced as a *meeting* or confrontation with something vivid and vital. It can also be compared with the phenomenon of *seeing* something more clearly (1992 p. 172).

An essence in the interpretational stance is that both personal and theoretical pre-understanding are necessary in order to attain understanding, of a transcribed text (Ödman, 1992). According to Ödman:

> To interpret is to decipher marks. We impute meanings by relating to something we see *as* something (1979, p. 44, my translation).

Personal pre-understanding is central in Gadamer's (1975) hermeneutic. Pre-understanding emanates from a tradition or context where the researcher is familiar, and it may facilitate as well as constrain understanding. Hence, interpretation emanates from a certain horizon. Gadamer talks about the essence of experience as "historically effected consciousness" (p. 346). To gain deepened understanding of certain phenomena, empirical data can be seen as asking questions to the interpreter. The task for the researcher, who wants to understand, is to answer what lies behind and beyond, through the horizon of the question. A horizon may include several possible answers. Considerations of sense-making of certain phenomena are focused on the asked question. According to Gadamer:

> ...the close relation between questioning and understanding is what gives the hermenutic experience its true dimension (1975 p. 374).

Continuous questioning of my interpretations was of considerable importance in this study. A dialectical stance towards the empirical data meant moving back and forth between my understanding, experiences and interpretations of the occurred and transcribed situations. During the fieldwork and the inductive research process a theoretical perspective was developed in order to systematically describe, understand and elucidate nurses' mastering of encounters.

Abduction and Retroduction

In interpretation processes 'abduction' can be used by adopting a theoretical perspective as a tool to re-construct and conceptualize empirical data. Abduction involves proposing theoretical assumptions by abstracting from observations and experiences in empirical data. It is a reflective activity. Similarly, retroduction involves reverse processes of using these inferences as tentative concepts to examine patterns of expressions in the empirical data. (Kim, 1992; Qvarsell, 1996).

Both Kim (1992), from a nursing perspective, and Qvarsell (1996), from a pedagogical perspective, are inspired by Pierce's (1990) alignment of actions

and the relation between marks, and the interpreter when proposing the concepts 'abduction' and 'retroduction' as useful in analytical work. According to Kim (1992), by applying abduction and retroduction, strategies for generating new knowledge of the nursing practical field are balanced. The process of explaining already existing theoretical constructs by reconfiguring findings in empirical data to challenge these constructs, finally arrives at a conceptualization in the studied practical field. Kim (1992) further argues, that as concepts are cognitive tools, they can be repeatedly used in constructing different social realities for deeper comprehension.

Additionally, Löfberg (1994) argues that 'abduction' is a way to understand how tentative theoretical concepts can evolve as a result of empirical observations. Also Prus (1996) states that in ethnographic studies the tension between tentative concepts, exploration and re-conceptualization constitutes conceptualization in hermeneutic sense. This is in line with Qvarsell (1996) notion that the process of 'retroduction' completes an emerging differentiation of concepts.

In this study, natural encountering situations were investigated from a theoretical perspective on the structure of everyday nursing actions. The theoretical frame assisted in making systematic use of the pre-understanding. In the abduction processes this led to concept development, in the retroduction processes it led to concept differentiation. The theoretical perspective is outlined in part 3 (p. 63).

To summarize the methodological considerations, a naturalistic approach encompassed ethnographic oriented methods in the collection and reflection of empirical data. Analyses, anchored in a hermeneutic, interpretative position,led to a conceptualization of nurses'mastering of encounters with parents in pediatric practice. The analyses and interpretation procedures are exhaustively described in part 4 (p. 81). In the next chapter the empirical study is thoroughly described.

Empirical Study

The methodological considerations, described above, were the basis upon which the empirical study was carried out and the analysis performed. The present chapter deals with the empirical study. After a short presentation of the pilot study, the main study is more exhaustively described. Subsequently, the field role and relations are described in a further chapter.

Pilot Study

A minor pilot study was carried out in order to create a basis for the design of the main field study. The pilot study aimed at getting an overview and making an inventory of natural settings where nurses' practice includes encounters with parents, and of testing observation and documentation techniques. Ethnographic techniques for data collection in a pediatric hospital context were also tried out.

The study took place in a pediatric ward in a middle-sized Swedish town during two months in 1994. In this general pediatric ward (which did not include neonatal care) children, from newborns up to 18 years of age, were cared for. These children had different kinds of illnesses and diagnosis. A considerable proportion of the parents lived-in with their children during the hospitalization period. During the pilot study, I spent two days a week conducting participant observations of nurses' activities with parents of the hospitalized children. Observations of nurses' encounters with parents took place in different kinds of situations. The nurses were observed in 6-8 hours in daytime as well as night work shifts.

Data was collected in field notes. Different kinds of written techniques were tested. Some informal talks in connection with the observations were tape recorded in an attempt to grasp nurses' view of their encounters with parents and of co-participation with myself as researcher. Two planned interviews with observed nurses were also recorded.

Conclusions and experiences, with implications for the main study drawn from the pilot study, are described in an earlier report (Söderbäck, 1994). The most important conclusions were related to issues concerning the nurses' workload and certain ethical questions, which were incorporated into the design of the main study.

Main Study

Selection and Access to Pediatric Settings

The primary objective was to gain access to a nursing pediatric practice which had 'combined care' in multiple settings. Such a 'combined care' unit cares for children from newborns to adolescents (0-18 years) with a wide variety of illnesses and injuries. This includes all children within the hospital's geographical region who need hospital care with the exception of those requiring intensive care. This means that nurses encounter parents with children in a great variety of situations, for example, from children under-going a minor tonsillectomy to children with leukemia. This also means that parents' presence can involve daily visits or live-in up to several weeks. In some cases, children can have a series of hospitalizations.

An important requirement was to have access to the hospital during all working hours, days, nights, and weekends, as experiences from the pilot study indicated that diversified activities appeared during different periods of nurses' working hours. It was also necessary that the setting to be studied was within a reasonable commuting distance for the researcher. This limited the choice to three middle-sized Swedish hospitals. A letter of invitation to be included in the study was sent to all three of these hospitals.

The hospital, where the head nurses for the wards in the pediatric unit first expressed willingness to be included in the inquiry, was selected.

This selected hospital had a pediatric unit with three wards accessible for the fieldwork. Negotiations for the entry into the wards started two months before beginning the data collection. During this time legitimization from the medical ethical committee for the actual hospital was applied for and received.

Initial Entry into the Field

In order to establish relationships with the nurses in the unit and to create a structure for observations and gathering of other data, a number of meetings were arranged. The head manager of all nurses in the unit was my initial contact and functioned as a confidant during the entire data collection period. She made the first agreements with both the medical manager and the head nurses of the three wards. These agreements were necessary in order to negotiate entrance into the nurses' everyday practice. I presented information about my study to all the staff at the pediatric unit. These information meetings included the aim of the inquiry, information about confidentiality, and an opportunity for the staff to ask questions.

The further negotiating of entry involved developing closer relationships with the nurses as well as other persons in the staff at the wards. The importance of being careful and sensitive in this step was clearly pointed out in the pilot study and concerned decisions about whom could, should, and needed to be informed about what in the project (Söderbäck, 1994). The obligation to protect families' integrity was taken into serious account as they were indirectly participating in the fieldwork. In order to establish important relationships at the wards, I spent a few days in the lunch rooms and reception areas, being generally available for casual conversation and information.

The Pediatric Unit

The pediatric unit consisted of four wards. One of these wards was excluded from the study since it carried out exclusively neonatal care. The other three wards were associated with other medical specialities in the hospital. The care was organized according to a model for 'combined care'. Regardless of what illnesses and injuries they had, children were admitted to the pediatric unit. Thus the nurses' practice was extremely varied, covering children with different medical and surgical diagnoses such as orthopedic, urology, ophthalmologic, oto- and pharynx diseases, and certain psychiatric problems such as anorexia.

The fundamental principle for the care in the pediatric unit was described as follows:

> Children's and adolescents' special needs for appropriate surroundings and professional knowledge are the basis for 'combined care' /.../

> The foundation for the care is knowledge about children, which means knowledge about children's development and needs. (From the Annual Report at the Pediatric unit, 1994-1996, my translation)

The building where the pediatric unit was located was separated from other buildings in the hospital area and was built in the middle of the 1980s. It was connected with the other buildings by a culvert system. All three wards had ample space for both children and their parents. In most cases a child with parents/family had a room of their own, or else they shared a room with one other child with parents. Parents and siblings, relatives and friends, could visit the wards as much as they wanted, and there were no restrictions on parents, or their substitutes, to live-in as residents with the sick children or adolescents.

The official policy for the pediatric unit stipulated a family oriented practice with parental participation in the care (Policy document, 1995). The principle of encouraging parental involvement and participation was formulated in a pamphlet, only in Swedish, placed in all ward rooms:

> Parents' participation in the care of their children is a way to continue improving care. By working as a team with children and parents, our service is to fulfil this. Our goal is to give good care, which provides a sense of security for the whole family (Pamphlet to parents at the Pediatric unit, 1995, my translation)

When starting a work shift the nurses got a report on the circumstances at the ward and were assigned particular children, whom they got necessary information about. The nurse manager usually was the one who decided about assignments of children during a work shift. However, the nurses themselves could also express opinions and reasons for caring for a particular child. Sometimes, continuity in care or relationships was given as a reason for an assignment. During a work shift the nurses documented their activities in casebooks for the sick children. The nurse receptions at the three wards served as places for co-ordination of their work.

Turnovers in work shifts and different employment conditions among the nurses sometimes led to a discontinuity in the nurses' relationships with children and their parents. One way to prevent lack of continuity in relationships with children and parents towards parents was to appoint a nurse as 'contact nurse' for a family. The nurse manager was responsible for such an arrangement when, for example, there was a need for a longer residence of a child and parents. Criteria for being appointed as a 'contact nurse' could be, for example, a nurse's competence in a certain disease, or of being the first nurse a family met when they arrived to the ward.

Nevertheless, the normal case among the studied nurses' was that they cared for new children and encountered new parents and also had recurrent encounters with familiar children and their parents.

The Nurses

The staff on the wards was composed of both registered nurses, mostly with special training for pediatric nursing care, and unregistered children's nurses. Besides, pediatricians and paramedical staff worked at the wards. This study embraces only the registered nurses[2] and their mastering of encounters with parents. Thirty registered nurses participated in the study. Two registered nurses did not agree to be observed in their work for 'personal reasons' but have contributed with other data. Two of the informants were males, which corresponds to the proportion of male nurses in Sweden as a whole (about 10 %). In order to protect the identities of the male nurses, all the nurses are referred to as female in the study and in quotations in the text.

The age of the nurses varied between 24 and 60 years, with an average of 38 years. Table I shows the distribution of age and the number of nurses with special pediatric training[3].

Table I. The nurses' age and pediatric training.

Age	Nurses without Pediatric training	Nurses with Pediatric training	Total
<30	3	4	7
30-40	2	8	10
41-50	0	10	10
>50	0	3	3
Total	5	25	30

One of the nurses had a diploma as a nursing instructor and two nurses had completed undergraduate studies in social sciences.

[2] The term 'informants' is used interchangeably with 'nurses' throughout the study.
[3] Special training for pediatric nurses has constituted an area of specialization for registered nurses in Sweden since the 1940s (Erlöv & Petersson, 1992). Since the 1980s registered nurses are trained in pediatric nursing in a supplementary course. For nurses working with children it is not necessary to have the supplementary courses. However, special training in pediatric nursing care is recommended by the National Board of Health and Welfare (1985, chap. 5).

Professional experience prior to the inquiry ranged from half a year to thirty years. The nurses' experiences within pediatric nursing also differed. Two of the nurses had half a year of pediatric nursing experience, while one of them had 30 years of experience. Caring for sick children according to a family oriented policy to a certain extent also means caring for adults. Experience of caring for adults differed as well. Fourteen of the 25 pediatric nurses had never cared for adult patients in hospital, except during their basic nursing training. Table II shows the distribution of length of experience of pediatric vs adult care.

Table II. Length of professional experience

Length (years)	Total experience as registrated nurse (i)	Experience of caring for sick children (ii)	Experience of caring for sick adults (iii)
<5	5	8	9
5-10	8	9	3
11-15	5	4	1
16-20	8	5	1
>20	4	4	0
Total	30	30	14

(i) Average =12,5 years, (ii) Average =10,7 years, (iii) Average =3,1 years

Eleven of the 30 nurses worked full-time. The other 19 worked at least half-time. The nurses' terms of employment were mostly related to their parenthood. Since it was possible to work part-time if one had small children, most nurses who had did not work full-time. Twenty-two of the nurses had children between 2 and 18 years old. Most of them had one or two children, but seven of the nurses had three children each. In addition, three of the nurses had grandchildren. Only five nurses had no experience of caring for their own children.

Four of the nurses worked only at night. These nurses worked with the same colleagues most of the time. But for the other nurses, with various terms of employment and distribution of working shifts (i.e. mornings, afternoons, nights and weekends), most of them worked with all the other nurses during some work shift during the year.

The nurses were not only collaborating with other nursing colleagues, but wor-ked in teams with the other staff at the ward: pediatricians, unregistered

child nurses, the social worker, the dietician, playground supervisors, and teachers. Because of the multiplicity in therapy, treatments, and interventions, the nurses also worked in teams with physicians from other units in the hospital and received instructions according to particular children and situations.

A conclusion of the demographic data was that most nurses participating in the study had extensive professional and private experience of caring for children, and to work in teams.

Ethical Considerations and Anonymity

Research in medical contexts requires particularly careful considerations concerning ethical rules. These must be taken into account, and serve as an ethical framework when conducting field research in nursing domains. More explicitly, medical ethical principles demand considerations of the impact of the study, on informants, or other persons who are directly or indirectly concerned with the study (Streubert & Carpenter, 1995). Prior to the inquiry, a customary ethical framework had to be formed in order to get permission for conducting the research (Medicinska Forskningsrådet [Swedish Medical Research Council], 1993). Such an ethical framework was developed, after which permission was applied for and obtained from the medical ethics committee in the region.

The design of the study was discussed with the staff, especially with the nurses as the informants. The most salient ethical issues here were those of informed consent, confidentiality, anonymity, and researcher-informant relationship (Streubert & Carpenter, 1995). The nurses were asked for informed consent for the periods of participant observation associated with reflecting interviews. This consent concerned an extension in time and had a processual character as recommended by Kvale (1996).

The informants were assured that the study had no covert purpose or hidden agenda, such as evaluating the nurses' performance. All informants were individually informed and signed a written consent form to confirm their willingness to be involved in the study.

During the fieldwork it was also made clear to the informants, that they could check field notes and interviews if they wished, and that any questions they had

in regard to the inquiry would be answered. At any time the nurses could decline from being observed. A few occasions of discussions of notes in relation to the reflective interviews occurred.

Ethical issues also concerned not to overload the nurses or to disturb their distribution of nursing care. For this reason some modifications in the ethnographic techniques were made, based on experiences from the pilot study (Söderbäck, 1994). Carrying out interviews in direct connection with participant observations was, in most cases, not possible. The nurses' workload and busy days did not allow for questions and talks during or immediately after the observed situations, unless the situation was at the end of the work shift. The reflective interviews with the nurses were instead carried out at a later point in another room, apart from the wards.

To protect the identity and confidentiality of the nurses certain measures were taken. To maintain their identities, but guarantee confidentiality in the study, the nurses were assigned capital letters (A-AE) in the transcribed data, which had nothing to do with their names. Nurses are referred to only as 'nurse', and sometimes also by their identifying letter, for example 'nurse G', in quotations in the presentation of results.

As described earlier, the children and parents were not directly involved in the study in that they were not the focus of observations, nor were they interviewed. Therefore they were not viewed as active informants for research purposes. However, they were important actors with respect to their actions towards the nurses and thus part of the intersubjectively constructed and shared experiences in encounters. To protect the children's and their families' identities they are described as anonymously as possible. All parents are referred to in the presentation of the result only as 'parent', or as the 'mother'/'father' to the children and the children have fictitious names. In descriptions of conditions in situations and contexts, minor modifications are made in order not to expose the identities of any family. Where a child had a particularly unusual illness or injury that could easily identify her/him, a change of gender was sometimes made along with other changes, while trying to retain the character of the disorder. However, short term acute illnesses and long term illnesses are kept intact. When children had previously received care in other hospitals and cities, these hospitals are referred to as 'large city hospitals'.

Given the aim of this study, detailed demographic information about children and parents was of minor importance as the interest in the analysis and interpretation process focused on the nurses' mastering of encounters as a professional group.

Data Production

The fieldwork and acquirement of data took approximately one year (1995), with a two-months break for reflection. The data is composed of field descriptions from notes taken during the fieldwork, transcribed reflective interviews, and documents concerning parents to admitted children at the wards. An overview of the data is shown in table III (p. 55).

The observations were made during 1 - 3 work shifts with each of the nurses. These work shifts, a total of 52, involved 6 - 8 hours 'shadowing' one nurse at a time in encounters with parents. A reflective interview was held afterwards. Some of the nurses were shadowed for one period, others for two periods, and still others for three periods, spread out over the year. As much variation as possible was strived at. Weekends, holidays, and vacation periods were expected to influence the nurses' practice, and was also taken into account when planning the observation periods. This approach is in line with Sanday's (1983) who recommends that to address 'normal' work shifts and periods, studies in institutional settings should at the very least span times of the daily and yearly rhythm. Observation periods therefore also encompassed morning, afternoon, and night shifts. Data was collected during the week and on weekends, as well as during the summer and Christmas period when only one of the wards was open for hospitalized children. During these vacation periods, nurses from all the wards worked together but with reduced staffing. Apart from covering the potential variation, this mixing and changing in the nurses' work was of interest because it was assumed to confront taken for granted actions and thoughts in the group, in turn regarded as important aspects of the nurses' knowledge and experiences.

The role of a participant observer was as a 'shadow', co-participating in the encounters but interacting as little as possible. The observations required about 370 hours. A multiplicity of situations was covered, common routine encounters with parents as well as problematic or critical encountering situations.

The reflective interviews, not included in the observation time, concerned events and actions in the observed situations. In this way the nurses' own retrospective reflections on their actions provided supplementary information to the observations and my understanding of the encounter situations. A total of 62 hours, distributed over 52 interviews, were carried out.

Field Descriptions

Short notes were written during the observation periods. Making the field-notes was the first level of 'marks' as textual reproduction of the observed situations. From these notes, more sequential descriptions of the encounters were written down. These 'field descriptions' transformed the content of the nurse's actions into ordered descriptions of sets of actions in a situation.

During the observations a scratch pad was used. When I had observed a situation I noted what had happened, who was involved, the surrounding conditions, and what I heard. The notes were written as detailed as possible in order to have the possibility of detecting slight differences later on. These notes thus contained information about time and place of situation, participants' position in the room, activities, talks (what about, who talked, and in what way), body-language, 'atmosphere', rhythm, and tempo. What the nurses articulated in the encounter towards the parent or a child was in some cases written down as a quotation. Quotation marks around the spoken words were used to make clear whether this was the case or not. I attempted to write notes on everything that happened. These field notes were made in as close conjunction to the corresponding occurrence as possible. Sometimes, for example, when a nurse made her round to assigned children and was writing notes during the encounter, then I, as 'the shadow', also could write notes. But mostly the notes of a situation or part of a situation were written retrospectively. The nursing reception was a common place for this.

My own reflections, about observed actions and encounter situations, were written in another section of the scratch pad. The field-notes were condensed and short and were, as mentioned earlier, re-written into field descriptions as soon as possible after the work shift where the observation was carried out. When the observation period took place during a nurse's evening shift or night shift, the field descriptions were made the next day.

One example of how a brief shorthand field-note of a nurse's encounter with a parent could be written was:

> Boy Victor 2 years old with his mother in a wardroom at night time ten o'clock. The nurse (AA) knocks ... know them before ... oesophagus atresi ... aid of syringe on the stomach ... mother in armchair with the boy ... feeding. Facing the mother ... asks about treatment, situation, needs, conditions ... mother dissatified ... could stay at home ... want to know what it is ... nurse doesn't answer ... shows the mother what to do ... turns the boy, smiles, plays ... wants the mother to call her if she wants something ... leaves

The information from the encounter was here condensed into a few impressions, which were written up as soon as possible. The field description transferred from these shorthand field-notes was:

> The nurse knocks on the door and enters Victor's room. Victor is two years old. The nurse has met him and his mother before. She acknowledges their acquaintance when she greets the mother who, in her turn, concurs by nodding. The nurse places herself facing the mother. The mother is sitting in an armchair by the window holding Victor in her lap. She is feeding him gruel with the aid of a syringe that is attached to the opening that has been made on his stomach.
>
> The nurse asks the mother if their visit to "the metropolis" has resulted in a date for surgery. The mother shakes her head. The nurse goes on and asks about the fistula for saliva on his throat, about how much it smears. "A great deal" the mother answers. "Have you got tissues?" the nurse asks. "Yes," the mother answers. They go on to talk about his present condition and the infection. "He's better now" the mother says. "He was worse last night when we were at home. I could just as well be at home. I can take care of an ordinary cold just as well when I'm at home with him, but I suppose we had better find out what it really is."
>
> The nurse does not supply an answer, but delivers syringes filled with medicine which the mother gives the boy. The nurse chats with the boy, smiles broadly at him and comments that he is such a good boy to his mother. She doesn't look at the mother any more but leaves after asking the mother to say if she needs anything (AA fd 1 p. 4).

The field descriptions were written in columns, which made it possible also to add reflective notes in the parallel column during the analysis and interpreting procedure.

Field-notes were also written on conversations about encountering parents, which occurred between the nurses. Informal talks during the observation periods were also noted as detailed as possible in field-notes and transferred into field descriptions. My subsequent reflections, interpretations and tentative conceptualization of empirical data were written down as separate documents.

Reflective Interviews

The reflective interviews were aimed at grasping the nurses' thoughts and meanings of their particular actions as well as of the entire situation. The nurses were usually free from duties during the interviews. But in a few cases when they left the ward for the interview, they knew that they would be contacted if anything important happened and they were needed. This occurred occasionally during interviews with nurses on the night shifts.

The interviews were based on the idea that the nurses' actions in particular situations were transformations of their perceived meanings of and what they wanted to achieve in the encounters. The interviews had the form of open-ended conversations. Using a conversational tune, I tried to be sensitive to what the nurses' wished to speak about concerning the encounters, and to act as a guide in the interviewing process. The objective was to get as much information as possible about the nurses' thoughts and meanings related to the encounter situation, including their views of the parents. As a co-participant I could confront the nurses with what had happened during the encounters and ask for their reflections. In this way the interviews can be regarded as co-constructed by the interviewer and the nurse (Ely 1993; Merriam, 1994; Kvale, 1996). My own interpretations and reflections, written down in the field-notes were confronted with the nurses' retrospective reflections on their actions in order to understand the meaning of the situation from the nurses' perspective.

The reflective interviews constituted a complementary tool to understand the observed actions by mirroring transformed meanings. In addition, it was found during the fieldwork that similar ideas and thoughts about how to deal with parents were expressed by individual nurses in the interviews. This was taken as indications of shared collective views in the group of nurses.

A systematic form of questioning was used, which carried the nurses' thoughts towards their intentions, intersubjective understanding, emotions, and relationships in the encounters. Spradley's (1980) suggestion on how to turn conversation into reflection inspired the framing of the questions that guided the interviews. He identifies five types of questions in interviews namely, descriptive, reflective, structural, and contrasting questions.

An interview guide was developed including question such as:

- Descriptive questions as

  "Tell me about how you acted in the situation?"
  "Tell me about your understanding of the parent?"

- Reflective questions as

  "What is your understanding of your actions in the situation?"
  "What do you think about your actions towards the parents in the situation?"
  "What do you think about encountering the parents of this child?"

- Structural questions as

  "Was the way you acted in the situation successful?"
  "Why was your action successful?"

- Contrast questions as

  "If you weren't successful, how would you act instead?"
  "What was the problem?"

Most of the questions were of this descriptive and reflective nature. They were always followed up by questions such as:

"What do you mean?"
"Can you tell more about that?"
"Do you mean that...?"

The interviews also included open, descriptive questions, which were aimed at encouraging the nurses to talk more freely about encountering parents and dealing with parental concerns, and to provide as much information as possible from their internal points of view. These questions were directed towards the nurses' general ideas about encountering parents in this particular pediatric context. Such questions were:

"What are your ideas about the nursing of families and parent participation on this ward?"
"What do you think about dealing with parents in caring for the child/children as a nurse?"

Altogether 52 reflective interviews with the nurses were carried out. They lasted 30 - 90 minutes each for a total of 61 hours. In the final part of the fieldwork, two pair interviews were conducted to search for additional information of shared experiences about how to deal with parental concerns in hospital

care. All interviews were tape-recorded and transcribed. These transcriptions were carefully made in order to be readable and usable in the further analysis and interpretation procedures. Either an assistant or myself made the transcription of an interview as soon as possible after it had been carried out. The transcribing was done verbatim, using as much notation as possibly to indicate tune, pauses, etc. The transcriptions were written in columns, making it possible to add notes in the parallel column during analysis and interpretation procedures.

Documents

Documents, which were collected during the fieldwork, were intended to inform about recommendations and rules for this group of nurses' practice in relation to resident or visiting parents and families. The nurse managers assisted in finding documents of interest for the study. Only formal and official documentation relevant for the pediatric unit was collected. This included annual information, booklets, and pamphlets containing official information for families receiving pediatric care, job descriptions for nurses, some standards for nursing procedures with respect to parental participation, and other less formal documents such as reports and notes found in the nursing offices.

After the year of fieldwork the collected information from documents consisted of 25 transcribed pages (A4). These documents were mostly included in the analysis and interpreting procedure to substantiate information of the pediatric context, conditions in the encounter situations, and content in the interviews.

Overview of the Data Production

In table III below, an overview of the different methods to collect information during the field work is presented.

Table III: Empirical data production

Type of data	Number	Duration	
		Each	Total
Observations	52	6-8 hours	370 hours
Interviews	52	30-90 minutes	61 hours
Documents			25 pages (A4)

Trustworthiness in Relation to the Data Production

Trustworthiness in relation to an empirical study and its findings may be questioned from several aspects. One general aspect concerns the internal logic of a study (Larsson, 1993), i.e. whether there is congruence between the research question, design of data production, and procedures of analysis. The processes of data production and analysis in this study are described as detailed as possible throughout the thesis. Hopefully, those descriptions offer enough information for the reader to judge about the internal logic of the study.

More specifically, trustworthiness can be discussed in terms of validity, reliability and generalization. Lincoln and Guba (1985) and Streubert and Carpenter (1995) have suggested other terms as being appropriate for qualitative and naturalistic studies.

Following their suggestions, *credibility* is here used for internal validity and concerns the degree to which the findings are based on 'true' data in relation to the studied context and phenomena. *Transferability* is used for external vali-

dity, and refers to whether the findings have relevance and significance in other, similar context. *Dependability* is related to reliability and concerns appropriateness of inquiry decisions. Finally, *confirmability* refers to the extent to which observed and reported phenomena are verifiable.

Below I will comment upon issues of trustworthiness in relation to data production during the field work period. Issues of trustworthiness in the pro-cedures of analyses and interpretation will be discussed in part 4 (p. 107). Finally, trustworthiness in relation to the findings will be discussed in part 6 (p. 197).

Concerning the data production in this study, issues of credibility are essential since this was the phase where the fundamental information about the nurses' ways of encounter parents was collected. The lengthy stay in the field, over a year, allowed extensive observations of encounter situations.

The careful and systematic documentation hopefully contributed to a 'true' description of what happened during the observations. Triangulation of data is crucially important in naturalistic studies according to Lincoln & Guba (1985). As this study unfolds, and information come to light, steps were taken to confront empirical data from the different sources. When confronting my descriptions of the situations with the nurses' reflections and images, a further step towards a 'true' picture of reality was taken. In addition comments, dialogues and conversations that occurred outside the observations and interviews continuously confronted, confirmed and verified data.

These procedures also influenced the dependability of data. As the observations took place during entire work shifts and were distributed over the 24 hours as well as over seasons, the potential variations of the nurses' actions in encounters with parents were likely to occur, and thereby observed and documented. In addition, the field role and relations were of essential importance for achieving credibility in the data production.

Field-role and Relations

In a field study, like the presented one, the researcher is the primary instrument for establishing necessary relationships with persons in the research settings. Of particular importance is to find means to balance research demands

against an understanding of needs of the persons with whom relationships are to be developed.

In such situations the researcher and the informants obviously have different positions and the researcher will never have the insider's view (Hammersley & Atkinson, 1983; Beach, 1995). Being a participant observer demands continous awareness of this and of the fact that the strength of this role is the contribution of an outsider's view in the processes of analysis and interpretation (Streubert & Carpenter, 1995).

In this study the researcher was familiar with the field being studied. Conducting research in the nursing field meant that I performed a study in a context where I was conversant with the discipline and the practical field. Although familiarity with a professional field may legitimize a researcher to conduct studies in certain sensitive settings, such as pediatric care, this does not mean neither that the researcher is familiar with the particular context being studied nor that she can act as a colleague. According to Morse and Field (1996) the most frequent mistake that researchers make when doing participant observation is to select a setting in which they already work, or have previously worked, to conduct observation. A strategy for making the researcher role distinguished and clear is necessary. Nevertheless, according to Kim (1998), personal pre-understanding, striving towards self-critique, can bring knowledge closer to what truly exists in a practice.

Being aware of the fact that I had to establish trustworthy relationships with the staff at the wards, particularly with the nurses who participated in the study, I also knew that I had to carry this out by explicitly position myself in the role of a researcher. Some steps in this strategy are described below.

Maintaining the Researcher Role in this Study

One purpose of the careful introduction of myself and my research, which were presented earlier, was to facilitate the establishment of relationships with the nurses and other professionals at the wards. The success of my fieldwork was dependent upon this. By being sympathetic and friendly, and by showing sensitivity to the conditions in the hospital, to the nurses as persons, the sick children, and the parents from a distanced position, I tried to maintain and make visible my research role at the same time as I showed concern for what was going on at the wards.

My familiarity with the field, and my professional experience as a registered pediatric nurse, probably facilitated the establishment of relationships with the nurses and legitimated my participation in the encounters with parents. One advantage might have been that it facilitated my reflections and interpretations of what actually happened in the encounters. However, my familiarity with this particularly field of nursing also made it difficult to maintain an outsider's view. I had to be aware of my personal pre-understanding during observations and interviews. My conscious and unconscious values concerning nurses' encounters with parents had to be critically kept in mind, in order to minimize inappropriate influence of hidden biases stemming from my own beliefs.

The researcher role involved the role of observer as well as the role of co-participant. Being a co-participant, close to the nurses in encounters with parents, was challenging. For the nurses and me to act as co-participants required trustworthy relationships with respect for one another's roles. Here, it was vital to form an accurate appraisal of the situations by observing closely and by trying to understand what was going on from the nurses' perspective.

In order not to appear differently and thereby cause unnecessary uncertainty among child-patients, parents and staff, I was dressed like the nurses. Co-participation by 'shadowing' with minimal interaction was a familiar phenomenon at the wards. The nurses commonly trained nursing students in this manner in all kinds of everyday activities. It seemed as if the co-participant researcher role during the observation periods was non-problematic for the nurses. It was likely that they forgot their 'shadow' as they were engaged in all kinds of 'doings'. According to Johansson (1989) one reason for why nurses seem to forget participant observers might be that they normally work together with other professionals. She further suggests that health care professionals, being intensively concentrated on their tasks, tend to forget what is happening around them.

During the interviews, following-up the participant observations, I always asked a question about the nurses' experiences of being 'shadowed' during their work to find out whether and how it had influenced their actions. Commonly they responded that they were not disturbed by being 'shadowed'. One of the nurses reflected:

> *"No, I was a little..., before, I thought about what it'd be like, but I don't think I've noticed you. You really have been quiet like a shadow, It wasn't like I'd thought it*

would be. Well, I thought, I don't know what I thought, but I didn't know what would happen". (T ri 1 p. 16)

Some of the nurses said that they had wondered how the co-participation would influence and alter their actions. But they had performed their activities in the same way as they normally did in their encounters with parents. Another nurse responded to the question of being shadowed:

Y It was fine. I've hardly noticed you. That's how I am.
I You haven't been influenced by my participation?
Y I haven't even thought about your participation during the shift (laughs). No, I really haven't. (Y ri 1 p. 21)

During the observation periods the nurses introduced me to the parents and children. Usually they made the presentation by saying "she is a researcher who is following me today". My researcher role, as a 'shadow', implied no actions of importance for the nursing care towards children or parents. But in acting as a human, it was necessary to have brief interactions with both children and their parents.

Neither parents nor children seemed to experience my co-participation as unusual. They showed a friendly acceptance. However, if I found a particular situation to be difficult or problematic with respect to my co-participation, I left. Such situations occurred within some encounters with adolescents and their parents.

The researcher role during the fieldwork also included the task to integrate theoretical reflections with the empirical observations. By exploring the nurses' actions and perceived meanings with my theoretical reflections, an emerging theoretical pre-understanding deepened my insights of the dynamic in the encounter situations. The theoretical frame as tool for further interpretation and conceptualization emerged during the fieldwork. In a way, the increased interaction between empirical observations and theoretical reflections facilitated the maintenance of distance and my role as researcher.

PART 3

Theoretical Perspective

Theoretical Constructs

The general assumption in this study is that when nurses encounter parents, they act according to their own views as to what is meaningful and efficient in the specific situation, something that in turn is assumed to be based on their professional experience and knowledge. As the focus of the study is encounter situations with parents, a limited field of nurses' daily professional activities is covered. Although regarded as included in their general professional nursing knowledge, the nurses' strategies to involve parents in the care of their child is assumed to concern a particular area of their professional knowledge.

Views of parents and of their involvement in relation to professional responsibilities and duties or commitments can, for example, be expected to play an important role for how encounters are carried out. By carefully observing what the nurses are doing in encounter situations and by relating this to their intentions, reasons and motives for acting, as well as to their perceptions of the whole situation, practical nursing knowing in a particular context is expected to be revealed. This means that neither nursing knowledge nor professional actions, *per se*, are of interest in this study. Rather, the approach is based on the assumption that there is a dynamic interplay between actions and intentions in the concrete encounters constituting a particular, unique, contextualized professional knowing.

In a general sense, this study is conducted within a tradition of nursing research where several studies have contributed to increased knowledge about the nursing profession (e.g. Carper, 1978; Kim, 1987, Kramer, & Chinn, 1988; Donaldson, & Crowley, 1992; Chinn, & Kramer, 1995, Silva, Sorrell, & Sorrell, 1995), involving practical knowledge (Benner, 1984; Johansson & Pilhammar Andersson, 1985; Johansson, 1995c; Benner, Tanner & Chesla, 1996; Rooke, 1994, Sjöström, 1995).

Concerning a theoretical perspective for this study, the fact that the empirical focus is on nurses' actions and intentions in complex and dynamic encounter situations, call for a frame which combines a broad perspective with relevant, specified concepts. Following the suggestion from McKenna (1997), new knowledge for nursing practice can be derived from other theoretical fields.

For this study a theoretical perspective is composed by theories and concepts, developed within social philosophical and social constructivist traditions (Schütz[4], 1962, 1967; Schütz & Luckmann, 1973, 1989; Blumer, 1969; Moscovici, 1984, 1998; Jodelet, 1991, 1995; Flick, 1998), and used to support analysis and interpretation. Although not identical, these traditions imply related approaches to the complexity and dynamics in situations of encounters between human beings. The theoretical perspective for the study has been developed gradually during the data production period and, particularly during the phases of analysis and interpretation of data where the theoretical constructs have been re-conceptualized on basis of empirical observations (see part 4, p. 81)

Schütz' (1962, 1967) theory for interpretation and understanding of the structure of everyday social life has been recognized as particularly relevant for the study, as it refers to phenomena which are likely to be present in nurses' encounters with parents. According to Schütz, human everyday knowledge mediates and organizes actions in and perceptions of the social world. 'Stock of knowledge', as presented by Schütz (1962, 1967), and by Schütz and Luckmann (1973, 1989), constitutes a key concept for the study. A stock of knowledge consists of a person's collected experiences, including knowledge and assumptions about other human beings. Here, intersubjective aspects of encounters are also regarded as having particular importance. A theoretical formulation of the nature and implications of individual interpretations of social interactions, based on a symbolic interactionist approach is therefore complementing (Blumer, 1969). According to this view, a person acts towards another person in accordance with how she or he perceives and interprets the meaning of a situation.

The above mentioned theoretical traditions emphasize the individual perspective in social interaction. An additional tradition that this study draws upon, supporting indications of social thinking in the empirical data, is the theory of social representations (Moscovici, 1984, 1998; Jodelet, 1995; Flick, 1998). This theory is based on a group perspective on social interactions and focuses on socially constructed and shared knowledge, relevant for everyday realities that a group has in common.

This brief outline of the theoretical perspective in the study will be elaborated upon in the following chapters.

[4] The German spelling is used for uniformity in the text. In the references American spelling, Schutz, is used.

The traditions and theories per se are not emphasized. Instead, the text is structured in a way that accents six basic, interrelated concepts. These concepts, which constitute the basic theoretical constructs for interpreting, understanding and conceptualizing the empirical data, are the following:

- stock of knowledge
- transformation of meanings
- encounters in time and space
- intersubjective understanding
- actions
- socially constructed and shared knowledge

Stock of Knowledge

This chapter introduces the theoretical concept 'stock of knowledge' and the way it has been utilized in the present study. It is assumed that nurses' stocks of knowledge contain elements of *everyday general and specific knowledge* and *nursing knowledge*. When acting in varied encounters with parents, content in stock of knowledge is assumed to be delivered through *practical knowing* in particular situations.

The nurses' encounters with parents can be understood in light of Schütz' (1962, 1967) general theory of the social structure of the everyday world as a world where individuals are face-to-face related and share social space, time and experiences. The world around is in potential reach and relations with other humans are distinguished by indirectness, but have consequences for understanding and interacting with other people.

According to Schütz, the everyday world is as a practical and social world in which an individual actor acquire experiences in interactions with other actors (1962, p. 208 ff). Schütz introduces the concept "stock of knowledge" (Schütz, 1962 p. xxv, 1967, p. 167) for the general and specific knowledge human beings acquire to interpret actions and experiences. The stock of knowledge is composed by own experiences, but also by experiences, which have been taken over from others, for example parents and teachers.

This reality encompasses not only the nature but also the social and cultural world. An individual, living in the everyday world, is an embodied and active practical human being. The everyday world is taken-for-granted and constitutes the foundation for all events, problems and mutual understanding that an actor is confronted with (Schütz, 1962, p. 227 ff). An individual's taken-for-granted knowledge of the everyday world and the human being, also provides specific taken-for-granted knowledge about other individuals in encounters, their way to understand, their habits, their way to express oneself etc.

Human beings "bring a whole stock of previously constituted knowledge" (Schütz, 1967, p. 169) into an encounter with another person.

In interactions, individuals stock of knowledge contribute to the interpretation of the situation by offering specific knowledge about the particular person as well as about individuals in general.

> This [a stock of knowledge] includes both general knowledge of what another person is as such and any specific knowledge I may have of the person in question. It includes knowledge of other people's interpretive schemes, their habits, and their language. It includes knowledge of the taken-for-granted in-order-to and because-motives of others as such and of this person in particular (Schütz, 1967, p. 169).

During interaction, by interpreting the other's actions, the conceptions of the other change and new knowledge about human beings in general, about this particular person, and about the particular situation develop. In this way an individual's stock of knowledge develops through interaction with other people. In any encounter, specific elements of a stock of knowledge come into use according to their relevance for mastering a particular situation (Schütz & Luckmann, 1973, p. 154).

The meaning a person gives to another actor in a given situation, derived from interests or commitments towards the other and from the other's actions, mediates the actions. The content in stocks of knowledge is socially rooted, socially formed and socially distributed in diverse situations of everyday life, thus constituting what is referred to as everyday knowledge. In the exchange of everyday knowledge, reciprocity of perspectives between actors is at hand. This implies that knowledge of the world is either taken for granted as known by the other, or is questioned if it means something different for another actor. Therefore, knowledge of and in everyday life is not a private but social affair and organizes everyday social experiences (Schütz, 1962, pp. 13-14).

According to Schütz (1967) and Schütz and Luckmann (1973) the activity of the body can be regarded as a dimension of the stock of knowledge. Activities such as speech, mimics, gestures and movements transform meaning into concrete actions. The body is also viewed as experiencing spatial arrangements in the social life. Schütz and Luckmann here refer to Merlau-Ponty's (1995) conception of human embodiment of perception. An 'embodied subject' is acting out meanings in relation to others, thereby occupying both a social and temporal space.

According to Schütz, influences from scientific knowledge can be incorporated as elements in stocks of knowledge (Schütz, 1962, p. 13 ff). This is of particular concern for this study as nurses' professional knowledge, based on scientific knowledge drawn from nursing science, medical science, and social

science, was assumed to be an important element in the nurses' stock of knowledge. Professional nursing knowledge, serving as a rationale for nursing practice, has been suggested to have a particular social emphasis on ways of thinking about humans (for example: Kim, 1987, 1998; Watson 1988; Chinn & Kramer, 1995; Dahlberg, 1994; McKenna, 1997; Andersson, 1998).

In the present study, it was assumed that nurses bring their stocks of knowledge, acquired through life-experiences, social habits, and professional knowledge, into situations where they encounter parents. Elements of general and specific knowledge about parents, included in the nurses' stocks of knowledge, were expected to be involved in their acting in the encounter situations.

Practical Knowing

Practical knowledge is sometimes perceived as applying theoretical, general knowledge. According to Schön (1983) practical knowledge has mostly been empirically studied as a process of problem solving in order to understand cause-effect relations. Professionalism has been viewed as "technical rationality" based on " specialized, firmly bound, scientific, and standardized knowledge" (Schön, 1983, p. 23). However, Schön argues that such a rational description of what professionals do is incomplete. Instead Schön (1983) introduces "knowing-in-action" and "reflection-in-action" as analytical tools to grasp what actually happens in situations. The 'knowing-in-action', or to 'know-how' in situations, is different from to 'know-that'.

Schön proposes that 'knowing-in-action' have distinctive characteristics in that a person knows the action but cannot describe the underlying knowledge. Professionals are likely to reflect in the midst of action. This 'reflection-in-action' occurs whenever questions at hand elude ordinary strategies and present a problematic situation. This is described as a reflective 'conversation with the situation', which makes experiences grow in a conscious way. Reflection-in-action is based on a repertoire of theoretical principles and life experiences and serves to generate new information about the situation and its conditions (Schön, 1983). During a professional life individual practitioners construct a repertoire of examples, pictures and actions. The result of every new action sequence is an extension of the repertoire and thereby it creates a readiness for an increased variety of actions. Theoretical knowledge is suggested to be incorporated in the practical repertoire of actions through reflections in different

situations. However, Schön (1983) argues, formulating of problems, or what conditions need to be reflected on, originates from the real situations.

Research in nursing, and health care pedagogic has showed that professional knowledge, although shared by a collective at a general level, to a large extent is individually constructed. How individual nurses act in particular situations and how they solve specific problems has largely been seen as based on their observations, conclusions and own experiences from earlier situations (Johansson, 1983, 1989, 1996a; Benner, 1984; Johansson & Pilhammar 1985; Benner et al., 1996; Sjöström, 1997).

In the nursing profession Chinn and Kramer (1995) differentiate between nursing knowledge, which refers to what can be shared and communicated within the discipline, and *practical knowing,* which refers to individual, dynamic acting. Compared to knowledge, which can be articulated and passed along to others, "knowing" refers to ways of thinking and acting in immediate situations. According to Chinn and Kramer (1995) nurses often have more 'knowing' than they can articulate to others.

Polanyi (1958) defines knowledge as related on the function it has in a practice. He emphasizes two different types of knowing in practice. These types consist of 'knowing how', which is known as procedural knowing in actions, and 'knowing that', which is explicit knowledge articulated by means of words. He states that it is essential that there are conditions where a practitioner 'know how' to act without to 'know that'. This type of knowledge Polanyi is denoted 'tacit knowledge'. However, when tacit knowledge is paid attention to, analyzed or criticized it can become explicit. In contrast, Josefsson (1988, 1991) proposes that some tacit knowledge probably is impossible to articulate. It is only in actions a nurse show if she has understood. It seems to be an open question how much of professional practical knowing can be articulated.

Molander (1993) has turned the interest of practical knowing towards how "attention-in-action" is structured. He argues that expressions of knowing are embodied, cultural, acted out and even visible in language and in articulation itself. Molander states that to know how to act in situations rests on a continuous dynamic in moving between insight and distance and between reliance on theories and criticism of the same.

Van Manen (1977) argues that 'knowing' can be viewed as a way of 'being practical'. By using the term 'practical orientation' he refers to ways in which individuals look at the world and define relevant actions for particular situations. Being practical, includes the notions of point of view, perspective, a person's way of looking at things, outlook, standpoint, and so on. The 'practical orientation' functions as a device for making visible how knowledge constitutes a way of making sense of situations. According to Van Manen, in order to get a deeper understanding of practical knowing in situations, hermeneutic approaches can make experiences, actions and perceptions of actors visible and understandable.

One further aspect of practical knowing is suggested by Kim (1994), who proposes that nurses in their practice are involved in situational actions, encompassing aspects pertaining to a client, a setting and the nurse-herself. Nurses in practice are "faced with facts of enactments that are time-bound, possibly have multiple meanings, and are fleeting" (Kim, 1994, p. 152). Therefore, Kim argues, nurses' everyday practices need to be studied by means of how professional enactments are carried out. Silva et al. (1995) call attention on questions concerning how nurses find meanings in what they know, perceive, and act in situations.

The theoretical suggestions that have been presented above indicate ways of interpreting practical knowing in everyday nursing practice. A working assumption for this study has been that nurses' individual stocks of knowledge, including general and specific everyday knowledge, and professional nursing knowledge, mediate personal practical knowing in encounters with parents. Practical knowing in turn has been seen as a collection of actions, delivered by the nurses in particular situations, representing both articulated knowledge and tacit knowledge.

Transformation of Meanings

According to Blumer (1969), encountering 'the other' is about interpretation and transformation of meaning. The fundamental link between social interaction and transformation of meaning is also expressed by Schütz as: "social interaction consists of a continuous series of acts of meaning-establishment and meaning-interpretation (Schütz, 1967, p. 169). Stocks of knowledge include meaningful experiences from earlier situations and mediate interpretations of meanings into new situations. Meanings are transformed and delivered through intentional actions. Schütz states that to address oneself in a situation and transform meaning is a fundamental human activity. Spatial and temporal space, along with other elements in a situation, contribute to processes of creating meaning in an encounter (Schütz, 1967). The range of possible actions in a particular situation is decided by the meaning perceived by the actor in this very situation. Such a range of actions "point to a particular style of lived experience" (Schütz & Luckmann, 1973, p. 23). Spatial and temporal space, structuring the interactions in a situation, is a given element in such an experiential style.

In the present study, these notions implied that the nurses transform their meaning in encounters with parents into intentional actions. This view of transformations of meaning, emphasizing embodied actions, is in line with Benner et al., (1996), who states that in nursing practice, nurses' social embodiments are means through which meanings, expectations, skillfulness, styles, and habits are expressed in courses of actions. One aim for the present study, was to search for nurses' perceived meanings of their actions, by means of examining their attentions and intentions when encountering parents. In accordance with the perspective presented here nurses' reflections on their concrete actions were assumed to give insights into their meanings, and grounds on which they decided to act. The working assumption has been that nurses transform their meanings by a range of actions perceived as relevant in encounters with parents. Schütz' and Luckmann's (1973) concept experiential style, as an expression for a range of actions, has inspired the search for 'professional styles' among the nurses, and was an important tool in the process of conceptualizing nurses' actions and perceived meanings in encountering situations.

Encounters in Time and Space

In nursing practice, interactions and encounters with patients and their relatives are central. Different theoretical approaches and perspectives have been used in research to study aspects of encounters in nursing. Theories, generated from research on interaction, concern content and quality aspects. Scholars such as Peplau (1952), Orlando (1961), Travelbee, (1971), and Peterzon and Zerad (1976), describe the content in interpersonal processes and the establishment of relationships, when conducted through 'right' manners. Quality in encounters has been described as the essence of caring by nursing theorists such as Watson (1988) and Benner and Wrubel (1989). Halldorsdottir (1996) calls attention to certain nursing competencies in encounters with patients, such as ability to "connect with people and to take actions on behalf of them in order to promote life-sustaining and life-giving care" (1996, p. 88). Additionally, as has been reviewed earlier in models for practice (p. 14), quality aspects of encounters were of central interest when involving parents in hospital care (Casey, 1988; Cleary, 1992; Dunst et al., 1988; Rushton, 1990; Shelton, 1995). For this study, it was important to exhibit the nurses' encounters with parents on premises which focused on the nurses' own interpretations and meaning in the encounter situations, as taking place within situations limited by time and space.

According to Schütz (1962, 1967), an encounter between human beings is socially constructed in a face-to-face situation. It creates a community of space and time where actors can physically reach each other (Schütz, 1967; Schütz & Luckmann, 1973). Further, the face-to-face relationship is fundamental for the structuring of interactions through a series of acts. Experiences of each other increase from moment to moment, and ideas about the other undergo continuous revisions. Thus an encounter can be regarded as a series of situation-bound interpretations of relatedness. Limited social space and time however make an encounter 'finite' and limits the opportunities for recognition and actions (Schütz & Luckmann, 1973, p. 65-66).

A finite encounter situation, can be looked upon as a social space, demanding priority of actions within a limited temporal space. Temporal space is suggested to direct duration and intensity in the actions (Schütz & Luckmann, 1973, p. 45-64), and to determine procedures of making arrangements and rea-lization of concrete projects. Schütz and Luckmann have suggested a structure of time by identifying different time dimensions, limited to particular types of events and acts. "World time" stands for actions which have a fixed, irreversible course for actions in a situation. World time refers to the fundamental motive for action in a situation and can be understood as the outer limit for someone's action. "Subjective time" is the second dimension and refers to an inner duration of personal thoughts, which are articulated and transferred to particular actions by the use of 'own time'. Considering the fact that encounters are intersubjective, they are experienced through the social space created with other actors. The term used by Schütz and Luckmann for this intersection between world time and inner time, is "social time", the third dimension. Social time refers to events with relevance for several actors where modifications are motivated from all those involved in the encounters. Although all three dimensions of time occur together, there is no absolute balance between them.

Referring to this study, duration of time in an encounter situation has been assumed to include considerations of conditions for delivering actions. The working assumption for the nurses' face-to-face encounters with parents has been that their interpretations of conditions for actions in particular encounters, embrace considerations of temporal, spatial and social space.

Intersubjective Understanding

Intersubjectivity can be regarded as essential for creating common experiences among humans. According to Schütz everyday life is intersubjective because we live in it as [wo]men among other [wo]men, bound to them through common influence and work, understanding others and being understood by them (1962, p. 10). The requirement to understand others is by inter-actions.

Blumer (1969), from a symbolic interactionistic approach, views encounters in a similar way. He proposes that the foundation for intersubjectivity is that persons act toward objects on the basis of their meanings, derived from social interaction and modified by both actors' interpretative processes. This involves mutual transformation of meanings.

According to Schütz and Luckmann (1973, p. 67) the development of a relationship, from one actor's point of view, consists of intentional social acts towards another person. Mirroring self in the experience of the other is a constitutive element of a relationship, and of intersubjective understanding. The inter-looking of expressions are attributes of the face-to-face situation in a common environment. Furthermore, the fact that an encounter occurs in a context, with a certain intention, influences the social orientation towards another person (Schütz & Luckmann 1989, p. 67 ff).

The presence of intersubjectivity in the situations where nurses encounter parents has been regarded as essential for the nurses judgement of situational conditions and experiences. *Social orientation* and *typifications* of others are important elements of intersubjectivity and will be further outlined below.

Social Orientation

According to Schütz (1967), social orientation towards a person includes motive and intentions in a particular situation and therefore affects the other. The primary way of affecting the other is by verbal and non-verbal communication. Schütz and Luckmann (1989, p. 70 ff) define social action as

"action whose meaning relates to the other by its very project". The motive for interaction is important, for it indicates the actions which are used. Any "affection" of the other within a relationship presupposes that an actor is oriented in a special way (Schütz, 1967, p. 162).

Important for the course of action is the 'sidedness' of the orientation, i.e. whether an act is *unilateral* or *reciprocal.* Even if boundaries toward each other may not be clearly recognizable in concrete cases, social actions can be either the one or the other. An action where the other person does not 'respond' is defined as unilateral. Only when actions are responded to is there reciprocity. Courses of actions aimed at unilaterally influencing others can be differentiated from courses of actions with reciprocal orientation, aimed at searching the other's response.

The principle of reciprocity implies each person to 'see' the other act as she does and to 'see' that the other treats her as an actor. Regardless of motives and intentions in an encounter, actions that are not intended to be unilateral may still be unilateral, and actions designed to be unilateral can become reciprocal. During interactions, perceptions of the other person undergo continuous revisions. Actions immediately affect the other and intentional motives towards each other are complemented and validated by reciprocal attention. Additionally, depending on whether an action is reflected upon in advance or afterwards, "in-order-to motives" vs "because-motives" for the actions are present (Schütz's, 1967, (p. 169). These motives are linked with the actions and whether they are intended to be delivered or have been delivered, and concern the interpretation of the entire encounter situation.

Social orientation has been of interest in this study as nurses were expected to achieve intersubjective understanding on conditions given by their professional interests. The motives 'in-order-to' and 'because of' in their actions as how they oriented themselves towards parents was used for interpreting the nurses' motives and intentions towards parents; i.e. whether their orientation revealed a wish to achieve something or a response to parents' actions.

The working assumption of social orientation has been that any attempt to affect parents presupposed that a nurse is oriented toward a parent. Differentiating nurses' unilateral actions from their reciprocal actions were assumed to be essential for interpretations of nurses' understanding of themselves and the parents, and for conceptualizing intersubjectivity from the nurses' positions in the encounters.

Typifications of Others

Social relationships in the everyday world vary in terms of anonymity and closeness, and have consequences for receptivity of each other and actions toward others. According to Schütz (1962, p. 15) "typifications" of others are based on earlier experiences, which tend to be used as schemes for interpretation of others. Stocks of knowledge contain typifications in the form of general and specific knowledge about how to interpret others and their actions. If experiences of other actors in encounters become taken-for-granted knowledge, specific taken-for-granted understanding of the other's thinking, habits, and expressions of themselves follows. In interactions, an individual's stock of knowledge contributes to interpreting other's actions, because of experiences of other persons in general and of this particular person.

Crossley (1996), referring to Schütz' concepts 'types' and 'typification', suggests that everyday social life is a construction of routinized life. Situations are approached as replications of earlier experiences. In encounters the acting partners tend to rely upon habits and pre-judgments of each other. Attention is directed towards the other person as a bearer of a particular social role, of a 'type', rather than being a particular person. Persons can be apprehended as 'types' also when they are well-known and familiar in a certain context. As 'types' they are predictable, taken-for-granted and their actions are expected. If a person is perceived primarly as a 'type' s/he is likely to be seen and referred to as a 'they'. Eventually, a relationship may be developed into a 'thou-orientation'. A 'thou-orientation' occurs when the actor is directing the attention to a particular person as unique (Schütz, 1967). Applied in the present study, this may imply 'parents' to be recognized by the nurses as 'typifications'.

Encounters characterized by a social orientation towards a particular parent in a particular situation are assumed to differ from encounters with a 'type' of parent. Even though a nurse initially may perceive a parent as a 'type', she could change her orientation towards the parent into a particular and known person later on. The working assumption here has been that nurses' stocks of knowledge contain expectations of 'types' and 'typifications' with significance for their understanding of parents and of themselves as professionals.

To summarize, the working assumption of intersubjective understanding in this study has been that nurses and parents act towards each other on the basis of

their meanings, derived during social interaction and modified by both actors in interpretative processes. Further, the nurses' have been assumed to have differentiated social orientation towards parents; i.e. unilateral or reciprocal actions. Finally, taken-for-granted knowledge about parents in general has been assumed to generate expectations of parents as 'types', with significance for the nurses' understanding of parents and of themselves as professionals.

Actions

According to Schütz (1967) actions have the character of mastering a situation to achieve something. As an undertaking, actions consist of a past and a future. An individual interprets a situation in relation to previous experiences, considers various conditions and acts according to what is perceived as meaningful and possible to achieve. Schütz and Luckmann (1973, p. 114), propose that in order to act, the actor must consider the conditions of a situation. This relates actions to some kind of planning, where images 'in the mind' direct the actor's attention to particular circumstances, which call for a choice of actions. Performed actions thus involve the interaction of the actors' intentions and transformed meanings mediated by stocks of knowledge as they occur in a particular situation.

The concept of action is, in a way, embracing the concepts introduced in the previous chapters. As was mentioned in the description of practical knowing (p. 68), the delivery of 'knowing' is presumed to be individually included in actions. It has also been suggested (p. 77) that encounters consist of actions conducted within spatial and temporal space limits. Further, it has been proposed (p. 74) that the actors' interests and intentions in a particular situation contribute to the social orientation towards the other.

According to Schütz and Luckmann (1973), "to be able to act in the situation I must determine it" (p. 114). Such an act of determination requires more or less consciousness by the actors in choosing concrete actions. More conscious use of a stock of know-ledge is required in situations with more problematic, unusual conditions (Schütz & Luckmann, 1973, p. 115).

In this study, the nurse's actions were assumed to be coordinated with a parent's actions, and to be related to how the nurse perceived the parent as a person. Verbal and non-verbal communication was expected to be a central element in the nurses' actions. Embodied actions, such as movements, facial expressions, gestures, rhythm and intonation of speech, were regarded as particularly important when interpreting the nurses' transformation of meanings.

The working assumption has been that the grounds for the nurses' decisions to act in a certain way mediate practical knowing as displayed in concrete actions. Apart from earlier experiences, stored in stock of knowledge, the nurses' attention and intentions in a particular situation have been regarded as important directors for actions.

Socially Constructed and Shared Knowledge

According to Schütz' (1967), members of social groups are likely to share representations of certain phenomena which are collectively perceived by the group members. According to Flick (1998) this perspective is similar to one of the fundamental ideas behind the theory of social representations (Moscovici, 1984, 1998), which is based on the idea of shared knowledge as a form of social thinking. The development of socially shared knowledge requires a shared cultural or social context, e.g. profession, a working team or a neighborhood. Social representations are defined as shared sets of knowledge, beliefs, norms, ideas, images, and actions in a group where the members' interests and intentions are developed within shared contextual conditions (Moscovici, 1998, p. 243). Social representations appear as thoughts and premises, which enable persons or things to be classified, and expressions and actions to be predicted and explained. Social representations thus concern implicit and explicit forms of socially shared everyday knowledge.

This study concerns a particular professional group in a particular, shared professional context. Indications of common patterns in the individual nurses' actions and reflections in the empirical data called for interpretations and descriptions at a group level. The theory of social representations offers a perspective on the social construction of professional knowledge, which was useful in the steps of the research process. Its approach implies a dynamic view of shared knowledge where social representations are assumed to constitute practical and communicable ways of thinking and acting, oriented towards understanding and mastering the environment:

> [Social representations on] ... forms of social thinking used to communicate, understand, and master the social, material, and intelligent environment. (Jodelet, 1991, p. 184)

A professional practice such as pediatric nursing can be regarded as an occupational field in which a group of nurses deliver a variety of actions based on the content and meaning of individual as well as shared stock of knowledge.

In the present study, an earlier presented, working assumption has been that nurses' stocks of knowledge mediate practical knowing (p. 70). Practical knowing in a particular encounter situation, is however also regarded as socially embedded. By adding a theoretical perspective, according to which shared professional knowledge constitutes a dynamic contextual dimension in the nurses' practical knowing, the notion of social embeddedness was possible to explore more explicitly in the empirical data. The main purpose of using the theory of social representations in this study was to shed some light on the social dimension in the nurses' practical knowing. The working assumption has been that the nurses developed social representations of parental involvement, which consti-tuted an essential element in their professional knowledge and a social dimension in their practical knowing.

Summary of the Theoretical Perspective

The six theoretical constructs presented above have been used as tools for conceptualization of nurses' encounters with parents, as displayed in actions and reflective interviews. Practical knowing in the encounter situations was assumed to be mediated through individual stocks of knowledge (Schütz, 1962, 1967; Schütz & Luckmann, 1973, 1989). The nurses' concrete actions in encounter situations were expected to involve elements of intersubjectivity and situation bound conditions, particularly social and temporal space. In addition, socially shared knowledge was assumed to be at hand among the nurses in this particular context (Farr & Moscovici, 1984; Jodelet, 1991; Flick, 1998).

The theoretical perspective has been central for the analysis, interpretation and conceptualization of the empirical data. However, it should not be regarded as a fixed 'theoretical model' for the investigation. Rather it has been developed during the working process and gradually increased the understanding of the complexity in the data.

In the next part of this thesis the interpretation and conceptualization procedures are more thoroughly described.

PART 4

Analysis, Interpretation and Conceptualization

Overview of the Procedure

The research process did not follow a linear pattern. Rather, the procedure was a back and forth process of observing, recording, analyzing and interpreting the empirical data. This process involved comparing and contras-ting contents in the nurses' actions and meanings. Repeated acts of judgement within and across different situations were made. An emerging theoretical perspective supported this inductive process. One essential element in the analytical proceedings was identification and examination of empirically derived, tentative abstractions as expressions of the content of actions and the nurses' perceived meanings of actions.

During the analysis and interpretation processes, abduction and retroduction were used as analytical tools to develop, refine, differentiate and structure the empirical data (Kim, 1992; Löfgren, 1994; Qvarsell, 1996).

The analysis procedures finally arrived at a conceptualization of nurses' actions and perceived meanings in the encounter situations with parents. Although the process of analysis was dialectical, circular, and recursive, various steps in the interpretations and conceptualizations of the encounter situations can be distinguished.

These steps are presented below as six sequential phases in the process of analysis.

Phase 1: Defining situations where encounters occurred.

Phase 2: Identifying preliminary patterns of actions as tentative 'styles'.

Phase 3: Interpreting and differentiating actions by verifying and refining tentative concepts with support from theoretical constructs.

Phase 4: Interpreting and differentiating perceived meanings of actions by verifying and refining tentative concepts with support from theoretical constructs.

Phase 5: Searching for correspondence between content in actions and perceived meanings in actions. Developing, structuring and conceptualizing nurses' 'action styles'.

Phase 6: Finding indications of socially shared knowledge among the nurses.

Phases 1 and 2 occurred during the fieldwork and phases 3 - 6 after leaving the field.

The entire research process can be described as the spiral on the next page, which illustrates how the empirical data was systematically described, interpreted, analyzed and conceptualized.

A detailed description of each phase in the research process follows.

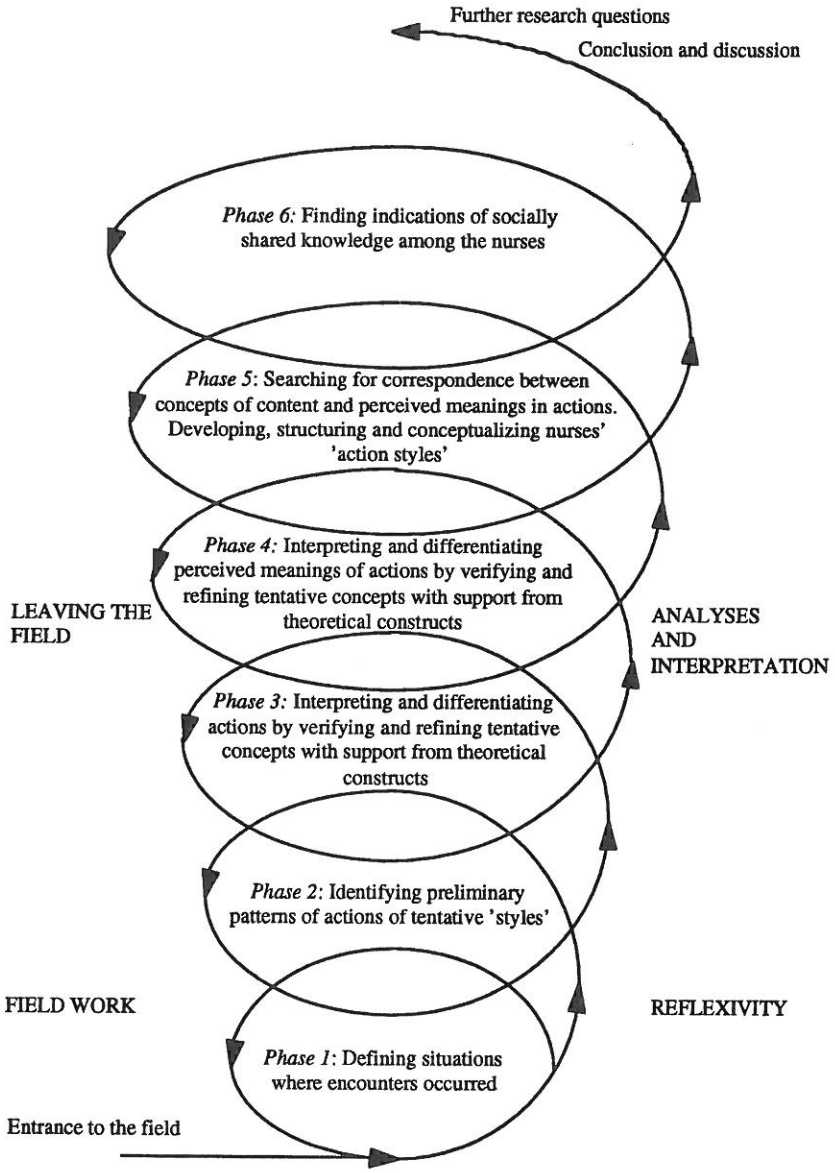

Figure 1. Conceptualization process

Conceptualization Process

Defining Situations in the Pediatric Context

From the beginning of my fieldwork I made complete observations, trying to note down exactly what took place in nurses' encounters with parents. Defining when and where encounters occurred was the first analytical step in the field. In accordance with Schütz and Luckmann (1973, p. 113) an encounter situation was defined as a "face-to-face situation", limited in time and space and delimited by a beginning and an end. The criteria for defining a beginning and an end of a situation were the following. A situation could start when a nurse openly called for a parent's attention, or when a parent called for a nurse. The situation ended when the nurse or parent left the common space.

A situation could also start with a nurse trying indirectly to get a parent's attention, or vice versa. Such a situation ended when either the initiator gave up trying to get attention or after attention had been gained, and one of the actors left the common space. If the breaks were only temporary within an ongoing series of encounters between a nurse and a parent, as for example when a nurse left to get a syringe, this was still defined as a single situation. As the study proceeded, a set of different kinds of encounters was defined.

The encountering situations occurred in different locations at the pediatric wards and varied in terms of content and meaning. It was recognized that the nurses settled routine situations in another way than problematic situations. Routine situations were defined as those where the nurses seemed to be familiar with their functions and tasks. In problematic situations unfamiliar components entered into a situation. However, it was obvious that routine situations and problematic situations were frequently intertwined. Both planned and unplanned actions occurred during the observed situations.

The nurses' were usually involved in situations with partly unpredictable conditions and were more or less prepared for new circumstances to occur and to act accordingly. During the interviews, after the observation periods, the nurses added information about the encounter situations. Their interest, motive and intention in a situation seemed to determine not only what they had paid attention to, but also the point at which the encounter was interrupted, and thus the situation was ended.

Five distinguished kinds of encounter situations were defined. Largely, they cover the range of situational variation in the observed encounters. The types of encounter situations were:

- Entrance to the wards/admissions: nurses encountered parents accompanying their children during admission to the hospital. These encounters took place in the reception area, a waiting room, a play room, a ward room, or the ward's hallway.
- Leaving the ward/turnover: nurses encountered parents in conjunction with the children's leaving the hospital. These encounters took place in the reception area, a waiting room, a play room, a ward room or the ward's hallway.
- Taking of specimens: parents were usually with their children when different kinds of specimens were taken. Different kinds of specimens were taken in the ward room, a treatment room or another place in the hospital.
- Treatments: parents normally were with their children when different kinds of treatments were carried out. Treatments of different kinds took place in a special treatment room or another place in the hospital.
- General and specific nursing care: encounters with parents were associated with nursing activities towards children or parents. These usually took place in a ward-room, dining-room, or in a playroom.

Within each type of encounter situation a number of finite situations were defined. The observations during the fieldwork were categorized into 186 finite encounter situations. The 186 situations were the basic units for further analyses and interpretations. The length of the situations varied from 2-5 minutes to about two hours. No attempt has been made to have equal numbers of each type of situation in the collection of data, neither has the analyses been

systematically conducted according to type of situation. All encounters, regardless of type of encounter situation, had several conditions in common with regards to how the nurses mastered parental interests and involvement in the care. Common for all situations was that a nurse had to pay attention to and determine the situational conditions in order to be able to deliver any action.

Identifying Patterns of Actions as 'Styles'

Having defined the 'finite situations' in the field descriptions the analyses concentrated on the nurses' social actions, i.e. actions, which were directed towards parents or responding to parents' actions. This step in the analysis process, still during the fieldwork, focused on actions, or combinations of actions and on similarities and diversities across encountering situations. My written reflections in the field-notes guided the transforming of data and the emergence of preliminary ideas for identifying range and combinations of actions. In addition, the reflective interviews gave further opportunities to come closer to the nurses' intentions, what they paid attention to, and how they understood themselves as professional actors, the parents as responding actors, and the nurse-parent relationships.

The theoretical constructs, guiding the interpretation of social dimensions in the encounters, emerged during this inductive procedure. The 'affecting' (Schütz, 1967, p. 162) of parents, as being oriented towards them in a special way, was actualized as it seemed to correspond to a professional stance in the nurses' actions. This was particularly clear in the nurses' general view of involving parents:

> *"The fact that parents are here implies an interest to involve them". (B fd 1 p. 4)*

A frequently expressed idea was that parents were oriented towards the nurse through the hospitalized child. Indications of nurses' social positioning towards parents, led to a search for their intentions in the encounter situations by explicitly paying attention to articulated and hidden meanings in reflections on situational conditions and their motives for action. This in turn, led to an awareness of the nurses' use of 'typifications' of parents.

The explorative use of theoretical constructs for interpreting social processes led to the 'working assumptions' (see part 3) which allowed for developing

tentative abstractions and concepts for the content and perceived meanings in the nurses' actions and reflections. The tentative concepts were used to exhibit, verify and differentiate how activities were carried out in terms of communication, arrangement, use of time, and sociality towards parents. Intensified and selective observations in order to identify combinations of actions, by contrasting and verifying the nurses' distinguished actions were carried out during this phase. By contrasting actions, as well as the nurses' reflections about their actions, a more complete view of the encounters emerged, which gave important insights as to how the actions and perceived meanings were related to each other. The balancing between openness toward the nurses' articulated intention, meaning, and ideas in certain situations, and of my detailed notes from the observations demanded continuous reflecting. As the amount of data increased, the nurses' actions gradually appeared as more authenticated and distinguished.

During this period of the field work, a conceptual analyses of the empowerment concept was made (Söderbäck, 1996). Other concepts, relevant to different aspects of the nurses' actions, e.g. assimilation, integration and collaboration, were also worked through. The concept analyses were based on a literature review of the use of the concepts in other contexts, and a comparison with the data from my field descriptions (Schwartz-Barcott & Kim, 1986). These analyses were carried out to verify, distinguish and differentiate combinations of actions in the encountering situations.

During the final period of field work, the analysis led to an emerging synthesis of range of actions, where particular patterns were identified as constituting an 'experiential style' in encounter situations (Schütz & Luckmann, 1973). An experiential style was interpreted as carrying content from a nurse's stock of knowledge, exhibiting her sociality towards the parent.

The 'styles' seemed to contain a distinguishing range of actions according to suggested tentative concepts as; communication, arrangement, use of time, and social positions. In the nurses' reflections on their actions, 'attentions/ intentions', 'choice of actions', and 'understanding of nurse-parent relationships' were discerned as tentative concepts differentiating their perceived meanings. At this stage tentative categories of 'styles' were explored. These were termed according to the main orientation in the actions: 'implying', 'interfering' and 'empowering' actions.

This categorization was more expounded, verified, or exchanged later on, during the conceptualization process.

During the fieldwork, indications of socially shared knowledge among the nurses were observed, particularly in conversations and during interviews. Of particular interest were indications of shared views on parents and the nursing profession. Such 'shared knowledge' seemed to be present in the nurses' actions. Here, the theory of social representations (Moscovici, 1984; Jodelet, 1991; Flick, 1998) contributed with a useful perspective on the social dynamics in the nurses' actions and reflections. Some questions were added in the interviews during the end of the field work, in order to further reveal shared ideas and beliefs. The nurses seemingly agreed upon ideas and beliefs of parents, of relationships between nurses and parents and of nursing. Themes were revealed which were more thoroughly analyzed later on in the analysis procedure.

After one year I had reached the point in the field work where no new events and situations which added any additional information to the collected data seemed to appear in the nurses' encounters with parents. The produced data signified saturation according to this criteria proposed by Streubert and Carpenter (1995, p. 24). At this stage the production of empirical data was viewed as 'marks' from a pediatric nursing practice for describing nurses' actions and perceived meanings in encounters with parents.

To sum up, the two phases of interpretations and analyses, which have been described above, constituted a basis for the subsequent work. The preliminary categorization of combinations of actions and perceived meanings in encounter situations into implying, interfering and empowering styles served as a first step towards a refined and more complete description of content and structure in the data.

The two phases that followed the field work encompassed analyses and interpretation, focusing on differentiation of actions and perceived meanings.

Interpreting and Differentiating Actions

The field descriptions contained close descriptions of nurses' actions towards parents and their responding to parents' actions in the encounters. As a first step, in the further analyses and interpretation procedure, it was necessary to identify the qualities in the actions in order to verify and refine differences in the nurses' range of actions in a situation. Each encounter situation was analyzed by using a matrix, structured according to the tentative concepts of the content in actions, which had been developed during the field work: communication, arrangement, use of time and social position towards parents. Each situation was analyzed with respect to what characterized the range of actions in the situation for each concept. Verifications, refinements and differentiation were made by comparing content in the action between and within the tentative concepts. The dynamic way in the delivery of actions was taken into account by following the nurses' actions from one situation to another in the field descriptions. Actions were also compared within and between encounter situations. The interpretations were based on the assumption that if a range of actions occurred in one situation, then they would probably occur in other situations and with other nurses. These procedures led to the insight that the nurses' actions were altered and changed when the grounds for acting changed.

This search for various details and differences in the nurses' actions led to a description and understanding of how they structured the encounters. A final identification and verification of content related concepts led to differentiation of the actions, namely: *verbal and non-verbal communication, arrangement, use of time, social orientation* and *atmosphere.* The main features in the proceedings that led to differentiation of the concepts are described in the sections that follow.

Communication

A first concept to be identified, verified and differentiated was communication. It was primarily recognized as *verbal communication.* Using words, e.g. giving information, instructions, or in order to search information about the situation, was a frequent element in the nurses' actions. Sentences, identified in different situations, were here contrasted with one another and verified in

order to refine 'descriptors', as distinguished expressions representative for the verbal communication in defined encounter situations. For example verbal commu-nication, which indicated various kinds of directing and informing, were cate-gorized in a 'descriptor' formulated as:

> 'Answering and directing. Making instrumental information and task-related talks'.

in contrast to a 'descriptor' that labeled more elaborated verbal commu-nication:

> 'Exchange of questions and comprehensible answers. Concerns for shared under-standing and choice of alternative'.

These descriptors illustrate that in some encounters the nurses passed on information or gave instructions seemingly without taking notice of the particular parent, while in other situations, they made efforts to listen and create a dialogue with the parent. Other descriptors were formulated, distin-guishing, for example between verbal messages, containing formal information vs. informal social talks, *"to learn to know each other"* (L fd 1 p. 6).

As the encounter situations were defined as face-to-face events, the nurses 'stood bodily before a parent', in a position that could be described as from above or below, to the right or the left, behind, beside or in front of the parents. Body movements were interpreted as important in the nurses' actions. They used their bodies as a center of coordination in all actions. In addition, sounds and noise of different kinds emphasized or undermined verbal expressions of communication. Such *non-verbal communication* seemed to help the nurses to regulate the flow of verbal communication towards parents. In the reflective interviews the nurses' indicated that movements of both their own and the parents' bodies directed turns in their dialogues with parents. Non-verbal communication seemed to be an integrated dimension of their actions by underlining verbal messages. This kind of communication was interpreted as co-created actions or 'joint actions'. In addition, the nurses seemed to evaluate parents' actions through their body movements. Finally, non-verbal communication served as cues for initiating interaction between the nurse and a parent. In the field descriptions, non-verbal communication in the actions was identified for example, through a descriptor as:

> 'Distanced outlook and occasional brief eye contacts'.

in contrast with:

> 'Close body positions and frequent sustained eye contact'.

There were several occasions when the nurses used particular non-verbal communication to strengthening or illustrating a message more expressively. For example, some nurses *"squat down in front of a sitting parent"* (P fd 2 p. 15) while talking. This particular kind of non-verbal communication was interpreted as a conscious act to balance the professional dominance with parents' opinions and thoughts and as an expression for emphasizing equality in the nurse-parent relationship.

In addition, non-verbal communication seemed to be helpful in the nurses' conveying of codes to parents about what to do or not to do in particular situations. If, for example, parents portrayed an unexpected behavior, the nurses' directed them by non-verbally *"putting a communicative brake"* (AA fd 1 p. 8).

The nurses' embodied communicative actions, such as words, mimics, gestures and movements, were found so integrated and intertwined in the encounter situations that they seemed to be taken for granted in transforming meanings.

Arrangement

The nurses' determination of particular conditions in a situation implied relevant actions. Therefore, all activities in an encounter situation were interpreted as particular arrangements for the concrete situation and were identified as concerned with all measures, both task related and social ones, that were taken by the nurses. Some arrangements were based on routine duties in nursing care, such as admitting new children and their parents, presenting different kinds of information and preparing treatments. Other arrangements were organized around less familiar or unexpected events, such as a very ill child and worried parents, a situation in question and critical incidents. When conducting arrangements for a particular situation, the nurses took into account various directives embodied by regulations at the pediatric unit, the children's care plans or ordinations given by physicians as well as other considerations.

Types of encounter situations, as defined earlier (p. 86), and location influenced the organization of arrangement to a large extent. The spatial limitation of a ward room displayed different arrangements compared to situations that occurred in the ward corridor or in the children's playroom. In a wardroom,

arrangements were likely to include medical treatment, injections, information, advice or other kinds of prepared activities.

In the ward corridor, unplanned arrangements were created when, for example, the nurse or a parent asked for information or advice. In situations in the children's playroom, arrangements typically involved informal social communication *"to get to know each other"*(L fd 1 p. 6).

Differentiation of actions, based on variations in activities as arrangement, rested on descriptors such as:

'Actions of effecting tasks'.

in contrast with:

'Creating a structure of activities which encourage parents to act by themselves'.

Discerning various content and structure in the nurses' arrangements, interpreted as a quality aspect of the actions, contributed to a deeper understanding of their complexity.

Use of time

The nurses' ways of organizing arrangement of the encounter situations were closely linked with their use of time. The nurses' use of time was easier to identify than to refine and differentiate. Guided by Schütz and Luckmann (1973) and their suggestions concerning temporal space in finite situations, I found a way to describe the nurses' use of time in particular encounters. While the nurses' use of time at a general level was identified as following the regular course of events at the pediatric wards, the structuring of time in particular encounters differed. By using Schütz' and Luckmann's terms 'world time' 'subjective time' and 'social time' (1973, p. 45 ff), the organization of arrangements could be identified according to the nurses' use of temporal space in concrete activities in the encounter situations.

Routine activities and tasks were identified as using *world time* implying that the time needed for the nurses to complete what was to be accomplished in terms of particular tasks. The nurses' use of *subjective time* or *inner time* was interpreted and refined as the personal or 'own' time that they used, for example, in searching and considering conditions in a particular situation, including different actions along with the interaction with a particular parent.

The *social time*, was interpreted and refined as used when nurses' and parents' joint actions for building or keeping a relationship were at hand. As social time was identified as the intersection of inner time and world time in the encounters, the extent to which it was used indicated a particular social quality in the encounter situation.

Differentiation of the nurses' use of time in encounter situations can be illustrated by the descriptor:

'Time together is determined by time required to complete tasks and arrangements'.

in contrast with:

'More time is spent with parents than what is required simply to complete tasks'.

To a large extent world-time, inner time and social time were used in the same situation. The nurses' use of space of time in the encounters was closely connected with their use of spatial space in their social orientation towards parent, which will be further described in the subsection that follows.

Social Orientation

The nurses acted towards parents with various forms of sociality. As mentioned earlier, the nurses were assumed to affect a parent in an encounter situation as they were professionally motivated to deal with parental concerns in the hospital context. Nurses' 'social orientation' was refined and differentiated through interpretations of the extent to which the nurses related to parents and how they used 'typifications' of them.

A typification of parents, which were used by the nurses, was 'parents in general'. This social *they-orientation* was verified in nurses' actions towards parents as similar in different encounters, distinguished from a *thou-relation*, verified in encounters where the nurses showed more concern for the parent as a particular person. A 'typified' parent could become a 'particular parent' during an encounter situation when there was a motive 'to learn to know each other'. The nurses' social orientation towards a parent, as a typification of parents in general or as a particular parent, seemed to be fundamental for what situational conditions the nurses paid attention to in the encounters.

However, it was also obvious that when relating to a parent as a particular person, the nurses also used typifications of parents in general, based on views

of parents in relation to, for example, a child's diagnosis or whether they were short or long-term resident parents.

Furthermore, a differentiation was based on whether the nurses' social position toward a parent was characterized as unilateral or reciprocal (Schütz, 1967; Schütz & Luckmann, 1973). A nurse's social orientation was defined as unilateral when she did not follow up parents' thoughts or ideas but showed a distanced position, or show no interest in a parent's responses as a particular person. The social orientation was defined as reciprocal when a nurse oriented herself closer to a particular parent by listening to and reflecting upon the parent as a particular person with own opinions and wishes. Situations with a reciprocal orientation were likely to coincide with a social thou-relation. In such a situation a nurse and a particular parent also constituted an 'Us' in a reciprocal and mutual relationship.

Differentiation in the nurses' social orientation in encounter situations can be illustrated by the descriptor:

'Assimilating by a forcing unilateral position'.

in contrast with:

'Reflecting and enabling in a reciprocal position'.

The nurses' social orientation towards parents was identified as an important element in the actions as it 'set the stage' for the encounters. The nurses' social position transferred their motives and intentions toward parents and what they wanted to achieve in professional terms. In the process of discerning various qualities in the nurses' social orientation, the concepts 'in-order-to and because-motives of others' (Schütz's (1967, p. 169) were helpful as they indicate two main orientations toward parents: to achieve something in contrast to responding to parents' actions.

Nurses' social orientation as social positions seemed to influence the atmosphere in the encountering situation, which will be further described in the subsection that follows.

Atmosphere

Identifying and differentiating the atmosphere during the encounter situations concerned the entirety of the situation. The atmosphere was identified and

differentiated through a combination of all identified elements in the content of actions. Emotions and affections in the encounters were interpreted as a major constituent in the social dimensions of the actions. The nurses' cognitive processes seemed to play a crucial part in their emotional and affective experiences of parents. Affective and thinking processes, along with time and spatial space were intertwined, constituting a particular atmosphere in the social space that an encounter constitute.

The atmosphere was interpreted as being closely related to the nurses' sociality towards parents and was identified by descriptors which recognized two major dimensions. One concerned distance vs. closeness, the other concerned whether the nurse showed a positive, sympathetic or a negative, reluctant approach to a parent. Examples of descriptors were:

'Professional cold kindness'.

in contrast with:

'Interest in parents as individual persons'.

To summarize, this phase of interpreting and differentiating actions was characterized by the repeating exposition of all the situations, relating parts of expressions in particular actions to the wholeness in the range of actions, using support from reflections written down during the field work. The descriptive concepts, presented in this section, served as tools for identification and differentiation of actions conducted by the nurses during the observed encountering situations. At this stage they offered a reasonable understanding of the nurses' encounters with parents. When leaving the observational data and turning to the reflective interviews, I knew that this was only the first step towards a complete picture and that the content in actions had to be further analyzed in a later phase.

Interpreting and Differentiating Perceived Meanings of Actions

During the interviews in close connection with the observations, the nurses had reflected upon the meanings of their actions in the encounters. Transcriptions of these interviews were used in this phase of interpretation and conceptual differentiation of data. All verbalizations, which concerned parents were taken as articulated 'marks' from the field, and were interpreted as relevant for the

nurses' perceived meanings and for the grounds on which they decided to act upon in the particular encounter situations.

As a first step, in the analyses and interpretations, it was necessary to identify the essence in the nurses' expressions of their perceived meanings in particular encounters for verification and refinement of differences. The theoretical perspective, proposing stock of knowledge as mediating practical knowing, transformation of intentions into actions and intersubjectivity as present in the encounter situation, guided the interpretation process.

The nurses' reflections were analyzed by using a matrix based on the tentative concepts, developed during the field work, i.e. *atttention/intentions, choice of actions and intersubjective understanding.* Verbal expressions were identified, verified, refined and differentiated according to the concepts. The procedure was similar to the one used for the observation data, i.e. expressions of perceived meanings concerning particular actions were contrasted with the totality of the situation. By confronting perceived meanings, as interpreted in one nurse's reflections with other nurses' perceived meanings of other situations, a differentiation gradually emerged. Verbal cues such as the use of a certain terminology or metaphors were paid attention to in particular.

Attention and Intention in Actions

The nurses' intentions were interpreted by focusing on what they said they wanted to achieve in an encounter.

Following Schütz (1967), specific elements in the nurses' stocks of knowledge were assumed to come into use in the encounters according to the particular situation. According to the content in their reflections, the nurses acted on basis of their interests, intentions, and perceived duties or commitments towards parents. Far-reaching intentions, directing the nursing care in a general sense, were referred to in terms of visionary intentions. When referring to written prescriptions in a child's care plan, as goals and interventions, the nurses more easy could verbally express what they wanted to achieve in a situation. However, how they transformed the written prescriptions and its intentions into actions seemed to be more complicated to formulate. When the nurses were asked what they paid attention to, focused on and had in mind in a particular situation they used expressions which indicated that implicit intentions and motives, or even feelings, rather than explicitly formulated

strategies were directing their actions. Metaphors such as, *"I can feel it in the air"* (Y ri 1 p. 7) or *"I feel it in my body"* (A ri 2 p. 5) were frequently used. These and similar expressions for attention and intentions in the encounter situations were interpreted as embodied experiences of how conditions and actions were determined.

The nurses' attention and intentions in routinized situations were referred to as a *"habitual knowing"* (U ri 1 p. 11). Here, the nurses' intentions were to make regular interventions by, for example, checking meals and sleep, despite expectations of parental involvement. These kinds of intentions were identified as mediating standardized elements in the stocks of knowledge, along with Schütz' and Luckmann's (1973) thoughts.

Concerning attention and intentions in problematic, non-routine situations, some nurses described how they determined the conditions by *"reading the situation"* (J ri 2 p. 9), or by *"reading the needs in a parent's face"* (R ri 1 p. 11). In addition, these expressions were identified and interpreted as illustrations of embodied experiences of the situation as determining conditions and choice of actions. The nurses' reflections on their attentions and intentions also involved a temporal component. They frequently referred to the encounters with parents as a matter of using adequate time, both to carry out tasks and in giving parents of their own time. Thus the nurses' use of time was verified both in the observational data and in the reflecting interviews.

It was articulated, as:

> *"I just did what I had to do in the situation". (C ri 2 p. 6)*

in contrast with:

> *"I took of my own time to achieve what I wanted". (T ri 2 p. 21).*

As a consequence of how the nurses used social space and performed activities the differentiation of their intentions were interpreted through their perceived meanings of the whole encounter situation, as well as of certain actions.

Perceived meanings of intentions were differentiated through, for example, descriptors, as:

> 'Inviting parents as residents and get the job done'.

in contrast with:

> 'Familiarizing and associating parents. Enabling and empowering'.

In some encounters, a nurse's intentions were understood as a receptivity to carry out particular actions. In these situations the nurses' reflections revealed considerations of readiness and timing as *"a kind of tacit practical knowing"* (A ri 1 p. 5). In other encounters the nurses had difficulties in making their attentions and intentions explicit. It was difficult for them to articulate what they paid attention to and what they intended in a situation. It was fairly common that the nurses described their intentions in the encounters as: *"I just act"* (D ri 1 p. 12).

Choice of Actions

The reflective interviews were also used for identifying how the nurses decided to act in an encounter situation. The nurses' appraisal of their actions was identified through their conscious articulations of recognition of a situation, what they paid attention to and why they delivered certain actions. Following Schütz (1967), determination of conditions and choice of actions in an encounter was interpreted as being dependent upon a combination of two circumstances. The first concerned what importance the consequences of the nurses' actions had in the actual encounter, as "in-order-to motives" (p. 169). The second concerned whether the actions were routinely oriented, demanding habitual skills, or if they were more diffuse or problematic. In case of the latter the nurses were likely to choose actions step by step to arrive at a fuller understanding of what a situation was about. Such "because-motives" (Schütz, 1967, p. 169), seemed mostly to occur as a response to parents' actions.

Two specific verbal metaphors, in the nurses' articulations, were identified as being of particular interest. One of them was interpreted as carrying an interest in trying to understand a particular parent or family. Here a nurse acted in order *"to see the lay of the land"* (K ri 1 p. 19). This and similar expressions were used in the reflections when the nurses articulated a particular intention to involve a parent or a family in the care. The other metaphor was interpreted as an expression for how the nurses' perceived non-verbal communication, such as frequent eye contact and approval nods:

> *"We [the nurse and a parent] are on the same wavelength". (K ri 1 p. 4)*

Through verifications of the nurses' choice of actions, through the content in the reflections, descriptors was discerned and differentiated as:

> 'To serve and help'.

in contrast with:

'Interested in parents' opinions and wishes'.

This differentiation of the nurses' articulated reflections brought their perceived meanings and the observed actions together. At this stage of the analysis, the interpretations of the nurses' reflections proposed a distinction between actions perceived as focusing on establishment of a relationship with a parent, while others did not.

Intersubjective Understanding

Reflections on the nurse-parent communication in the encounter situations were interpreted as identifying the nurses' perceptions of parents and themselves. Here the nurses expressed their views of a parent in an encounter, and of themselves as professionals in the same situation. This made it possible for me to identify and differentiate their intersubjective understanding.

When the nurses were asked as to their view of a parent in a particular encounter, they used expressions that indicated that the way they looked at a parent, listened to a parent and how they felt in a particular encounter, made them attuned to what they could expect of a parent, who the parent was, and what they expected of themselves as professionals in this particular situation.

This interpretation led to the insight that the way nurses understood parents were linked to their views of themselves. Here, the nurses' qualitatively different way of viewing parents in particular encounters mirrored their understanding of themselves as professionals towards parents. For example, in some situations, the nurses' descriptions of parents as users of help and consumers were linked to an understanding of themselves as professional nurses that are to be accountable.

Identified and differentiated expressions of how the nurses understood parents in different situations, were formulated in descriptors such as:

'Parents take own initiatives and want an own territory'.

in contrast with:

'Parents want to comply through directives'.

The differentiating expressions for how the nurses' understanding of themselves as professionals were based on descriptors such as:

> 'Being superior as a professional in the situation'.

in contrast with:

> 'Being a facilitator in the situation, the professional knowledge is used to enable parental knowledge'.

To summarize, the phase of interpreting and differentiating the nurses' intentions, attentions, choice of actions and intersubjective understanding gradually led to a reasonable understanding of the nurses' perceived meanings of their actions in mastering the encounters with parents. Further verification and refinement of the content in the nurses' reflections on their actions was however needed in order to confirm and further develop the tentative identification of distinguished patterns of actions in encounters as described in a previous analysis phase, which occured during the field work.

In the subsequent phase, a deeper analysis of data aimed at identifying and verifying the correspondence between content and perceived meanings in the nurses' actions.

Correspondence between Content and Perceived Meanings in Actions

The purpose of this phase was to verify the correspondence between observed content in and reflected meanings of actions in order to gain a more holistic and contextually based comprehension of nurses' mastering of the encounters, as well as refine the conceptualization.

A re-analysis of all empirical data was made by critically reviewing the field descriptions and by re-listening to the interviews and re-reading the transcribed texts. By listening to the tape-recorded interviews again, additional information about nurses' perceived meanings and intentions, in connection to the observed situations was attained. The information in its entirety was examined in relation to parts of information from particular situations. This analytical step was largely concerned with a critical examination of all earlier interpretations and the correspondence between content of actions and perceived meanings of actions. The abduction and retroduction processes (see p. 39) sup-

ported confirmation, verification and refinement of the conceptualization. All the encountering situations were elucidated by critically re-viewing expressions, which had been differentiated according to the concepts, tentatively suggested in the previous phases. Actions and perceived meanings in particular encounters were compared and contrasted with all the other situations in the data, in order to further explore the structure of variation in the range of actions, tentatively identified earlier, as a 'pattern of actions' in an encounter situation.

These procedures revealed dimensions in the empirical data, indicating interpretations beyond what was earlier identified. These dimensions, which will be presented below, concerned the nurses' foci and their social approach during the encounter. Finally, a description of distinguished 'patterns of actions' in encounter situations, where different 'styles' were identified, was arrived at. These styles, with particular range and combinations of actions and perceived meanings of the actions were possible to categorize as a structure of different *action styles.* Thereby, a long process of interpretation had reached a stage where the revealing of how nurses mastered the encounter situations was possible to describe.

Overall Focus and Relationships with Parents in Encounter Situations

When interpreting and defining the correspondence between range of actions and perceived meanings in the encounters, some dimensions were identified which deepened the understanding of the nurses' actions. There seemed to be an overall focus for each encounter, displayed in a range of actions combined with the perceived meaning of the actions. While some encounters were interpreted as having an overall focus on 'parental maintenance', others were interpreted as focusing on 'integration of families by promoting own resources' or on 'collaboration in a partnership' with parents.

Apart from a general focus, the encounter situations also were interpreted as displaying a general social approach to parents as revealed in the complex totality of content in actions and perceived meanings. The presence of unilateral vs reciprocal approaches to parents, as were earlier defined in the data, seemed to be related to the nurses' views on how important it was to learn to know the parent.

If there was a conscious wish to affect parents, this obviosly implied a conscious choice of actions, which were embodied in a particular manner. But even non-conscious actions seemed to imply actions to establish relationships. These insights led to a verification of the nurses' affecting orientation as being unilateral or reciprocal.

In unilateral affecting orientation the nurses did not show an interest of parents as particular 'persons'. this orientation was characterized by descriptors as:

'Organizing their [child and parent/s] existence on the wards'.

or

'To look after them [child and parent/s]'.

In reciprocal affecting orientation the nurses turned to parents with more conscious attention to their existence, and parents turned to nurses in the same way. These relationships were characterized by descriptors as:

'Showing interest of parents as persons and to enable them [child and parent/s]'.

or

'Share the care with parents as equal persons with different kinds of knowledge of the child'.

Further, unilateral orientation was interpreted as more likely being linked with a formal, *task-oriented* approach, while reciprocal orientation rather was connected with an informal, *parent-oriented* approach.

Identifying Action Styles

During the analyses, divergences between the nurses' range and combinations of actions and perceived meanings were found to constitute different 'patterns of actions' in the encounter situations. These originated from the tentative idea of different professional 'styles' (see p. 88), indicating "particular styles of lived experience" (Schütz & Luckmann, 1973, p. 23). Repeated use of the empirical data in a holistic interpretative way, challenged the earlier developed concepts for describing content in actions and reflections (see p. 91 and 97).

In this final conceptualization of encounter situations, summarized in Tableau A, the concepts for content of actions and the concepts for perceived meanings

of actions were constructed on basis of their correspondence in the empirical data.

Tableau A. Conceptualization of the encountering situations

Observed Content of Actions	**Perceived Meanings of Actions**
Communication: Verbal and Non-verbal	Intention
Arrangements	Definition
Atmosphere	Attention
Time	Intersubjectivity: as understanding of self as understanding of parents
Social Orientation	Relationships
Focus	

The theoretical constructs guided the continuous differentiation of the empirical developed concepts. Starting from details in the actions and reflections, the encounter situations were contrasted with each other to gain a comprehension of how nurses' professional styles were mediated from individual stocks of knowledge, and revealed as practical knowing.

In this search, for a complete picture of what 'patterns of actions' could be distinguished in the encounters, the conceptualization process generated a construction of four qualitatively different *action styles.*

The differences between these action styles were defined according to four different scopes of characteristics, identified in the patterns of actions. These action styles, *assumptive, demanding, eliciting* and *collaborating styles*, will be exhaustively described in the result chapters.

To summarize, the conceptualization process was carried out through examination of all information in the empirical data. Identified and differentiated content in the observed actions was compared with the content in the nurses' reflections during the interviews. First, the focus of analyses and interpretations alternated between the observed actions as the outer reality and the reflecting interviews as the inner reality of the encounter situations.

Thereafter the interchange between these two realities was focused upon, in order to conceptualize an empirical structure of the nurses' mastering of the encounters.

Finally, by recognizing distinguished scopes of characteristics among the actions and perceived meanings of actions, as patterns of actions, a repertoire of four qualitatively different action styles was identified. Here, the analysis and interpretation process led to a differentiated conceptualization of particular action styles, forming a more contextualized understanding of nurses' encounters with parents.

Indications of Socially Shared Knowledge

During the process of analyses and interpretations that have been described in previous sections, indications of shared knowledge among the nurses, preliminary noticed during the fieldwork, were paid attention to and to some extent confirmed. Attentions, intentions and actions conducted by individual nurses revealed themes which were similarly repeated among the other nurses in the group. Drawing on the assumption that social representations of parents and nursing practice constituted an essential dimension in the nurses' practical knowing, some common themes in their actions and reflections were identified.

Although these analyses were not as carefully conducted as the earlier described procedures, they contributed to a deeper understanding of the data. When communicating with each other at the wards, the nurses expressed ideas about parents and about encountering them, which they seemed largely to agree upon. In their reflections during the interviews, they also frequently mirrored each others' thinking about encountering parents.

Particularly common were ideas of what parents could be expected to do or not to do during their child's hospitalization, and of different parental types, such as 'excellent', 'disinterested' or 'extraordinary' parents.

Further, the nurses' use of "we" [as a professional group] when responding to questions about their own ideas, thoughts and reflections during the interviews, indicated that they perceived themselves as belonging to a professional collective with shared views of parents and themselves as professionals. Concerning views of themselves as professionals, the nurses commonly expressed that in the everyday practice the children always came first. A final

theme that was identified as a shared idea was that the nurses regarded each other as being 'interchangeable'.

These indications of socially shared knowledge among the nurses will be described in the final result chapter (p. 169).

Trustworthiness in Relation to Interpretation and Conceptualization

In order to comment on issues of trustworthiness in the analysis and interpretation process, a brief review of the methods and procedures, as documented in the descriptions of the analytical steps towards conceptualization, is needed. The terms related to trustworthiness (Lincoln & Guba, 1985; Streubert & Carpenter, 1995) have been described earlier when discussing issues of trustworthiness in relation to data production (see p. 55).

A major condition for judging the confirmability of this study concerns the fact that the analysis and interpretation procedures were grounded in the empirical data. Confirmability refers to establishing verifiability of the studied phenomena. Both the collection and analyses of data were to a great extent dependent upon what I myself brought to the study, and how I carried out the treatment of data. The acceptance of pre-understanding provided opportunities to gain insights into the nurses' practice. Interpretations were made in dialectical confrontation with the encountering situations.

But how then can I know that my interpretations of what manifests nurses' delivering of practical knowing in encounters with parents correspond to what is true?

One approach here is to acknowledge that the nurses' mastering of encounters can be described and understood in more than one way. According to Kim (1992), applying analytic rigor assures confirmability and comprehensiveness in developing arguments and making inferences of findings as well as awareness of theoretical concepts applied to a new context. The term credibility here stands for trustworthiness of the findings related to what have been established by me as the researcher and refers to the truth-in-context (Lincoln & Guba, 1985).

My familiarity with and personal experiences of pediatric contexts largely contributed to making this study possible. Hopefully by thoroughly describing the analytical and interpretation procedures in identifying and differentiating the nurses' actions and perceived meanings in actions, I have documented a process which fulfills the criteria of analytical rigor.

Further, I have tried to follow two essential principles in the interpretation process (Ödman, 1979). First, internal logic required that the interpretations were not contradictory and that the parts confirmed interpretation of the entirety. Secondly, the principle of external logic demanded my findings and conclusions to be grounded in the empirical data.

The research process of this study was characterized by ongoing reflections and interpretations during the fieldwork and, later on, of the transcribed data. Development, verifications, differentiation and refinements of theoretical concepts were grounded in the empirical data. Through continuous critical elaboration of concepts and expressions for conceptualizing the nurses' encounters with parents, efforts were made to reach credible interpretations and conclusions. Dependability, as the stability in the interpretations, was met through securing the credibility. It has been suggested that if a study demonstrates credibility and appropriateness, it also has confirmability (Lincoln & Guba 1985; Guba & Lincoln, 1989; Streubert & Carpenter, 1995). However, according to Robertsson & Boyle (1984), confirmability is more difficult to establish than credibility.

The conceptualized structure of various 'action styles' was developed to provide insights into a group of nurses' mastering of encounters with parents. The identification of these 'action styles' relied not only on the nature of correspondence between actions and perceived meanings that emerged from the empirical field work, but also on the theoretical constructs which were successively decided upon to serve as a frame for the analysis, interpretation and conceptualization. All these procedures had a dialectic character and were based on a holistic view, implying that all information was important.

The result was based on 186 identified situations and the nurses' reflections connected to these situations. The approach was explicitly inductive. Observed actions and reflected meanings were largely documented 'in the field'. The interpretations of field descriptions and transcripts focused on the entire situations.

Differences and similarities in the totality of empirical data gradually led to the establishment and confirmation of the qualitatively different action styles. The content and structure of these styles are presented as the result of this study. In line with the methodological approach, the way they are described was regarded as the best formed understanding of nurses' delivering of practical knowing in mastering of encounters with parents in pediatric hospital care.

PART 5

Results

Structure and Content of Action Styles

As was showen in the previous chapter, the outcome of the conceptualization process is formulated as a repertoire of four distinguished action styles:

- *Assumptive Style*. Actions characterized by intentions to invite parents' to take their own initiatives in undertaking of the basic care of their child. Focus in encounters is on parenting maintenance.
- *Demanding Style*. Actions characterized by intentions to assimilate parents into the hospital care. Focus in encounters is on parental accommodation.
- *Eliciting Style*. Actions characterized by intentions to enable parents' own wishes and resources in the care of their child. Focus in encounters is on parental integration.
- *Collaborating Style*. Actions characterized by intentions to cooperate with parents from their knowing of caring the child. Focus in encounters is on active collaboration with parents.

In the following sections exhaustive descriptions of each action style with illustrations from the empirical situations will be presented. Extracts from field descriptions, interview transcripts and documents will be used. Attempts are made to quote from purposeful and explicit occurrences in the empirical data to verify the justification of the differentiated patterns of actions delivered by the nurses.

The extracts and quotations from empirical situations vary in length because of fair description of the action styles. The extracts from field descriptions are marked with (fd). The capital letter of the nurse, number of observation period, and page in the field description are denoted.

A selection from field descriptions denoted as (R fd 2 p. 23) means the nurse, assigned the capital letter R in the transcribed data, second observation period, on page 23. Quotations obtained from the reflective interviews that are used in the result presentation are denoted (ri). The capital letter of the nurse, number of observation periods, and the page in the transcribed interview, are denoted as (R ri 2 p. 16). The interviewer is assigned the capital letter I.

Sensitizing sentences are cited, and so are phrases from everyday language, for example as metaphors for essential expressions of transforming meanings into actions. Some words and sentences are excluded because they are not relevant. Such exclusions are marked /.../. Exclusions within extracts from field descriptions are marked in the same way.

The description of an action style concludes with a summary of the essential elements and an overview of the characteristics in content and perceived meanings of actions.

Assumptive Style

The first action style is identified as the assumptive style. Here, the nurses' actions are interpreted as assumptive, as they are linked with the intention to invite parents to take their own initiative in caring for their child. The nurses take the parents' presence, beliefs, and wish to care for their children for granted. The main theme of the assumptive style is the nurses' focus on parenting maintenance. After inviting for questions and giving information, they expect parents to take their own initiatives in caring for their child as residents in the ward. Their verbalized meanings of the actions contain attempts to please parents, effectuate wishes, and legitimate their requests. Their intentions are to achieve a good practice by 'organizing the care' and 'doing what they have to do' towards parents.

The following illustration is from an encounter with the mother of a baby. The nurse has been told before that the mother thinks that her baby has difficulties in breathing.

> The mother is sitting on her bed, crocheting. The baby is sleeping in a little bed beside. The nurse walks to the baby's bed, looks at the baby and asks the mother how it is going. The mother answers that now she (the baby) has been sleeping for a while, but she coughs sometimes.
>
> The nurse, still looking at the baby, asks if she (the baby) has thrown up. No, the mother answers, but I have a child at home who also has got a cold and has croup. The mother lifts up the baby and starts breast-feeding. The nurse doesn't say anything more, just leaves the room. (B fd 2 p. 1)

Two hours later the nurse returns to the room because the mother has asked another nurse to help her to give the baby nose drops. Since it is 'nurse B' who organizes the care of this baby and her mother, she is the one who responds to the request.

> The nurse returns to the room. She directly asks the mother to take the baby in her arms, so she (the nurse) can help the mother to manage the nose drops.
>
> The nurse reads the instruction on the package of the nose drops. The mother holds the baby and the nurse gives the drops in the nose. Afterwards the nurse says to the mother that next time she (the mother) can manage it herself. The mother is quiet and the nurse leaves the room. (B fd 2 p. 5)

Typical in the assumptive style is that the nurses indirectly suggest parental participation in the care rather than mentioning it directly. They also anticipate

parents to be interested and engaged and to wish to perform the basic care of the child and participate in the treatment:

> *"The fact that parents are here assures a degree of interest and involvement".*
> *(B ri 2 p. 3)*

Among the analyzed situations there are a number of entrance situations where nurses show the assumptive style. However, the style does not characterize all entrance situations. Nor does the assumptive style occur only in entrance situations. Arrangements concerning parental care upon their arrival on the ward involve mainly actions of instrumental information. In such situations the nurses' actions sometimes indirectly expect parents to carry out the basic daily care without explicitly talk about it with the parents. Instead verbal communications are limited to answering and directing parents, mostly as routine and task-oriented information. The nurses have a distanced outlook with distanced body positions where eye contacts are brief and occasional. A nurse describes:

> *B /.../ I have no real picture of her. She is a little bit negative.*
> *I How can you see that?*
> *B Well, I don't know. She acts like 'don't come too close here' in some way.*
> *(B ri 2 p. 17)*

Also typical for this style is that the nurses' organize the care and their serving of parents' wishes by carrying out instrumental tasks. The nurses' intentions are to please parents by inviting them to participate in the care of their child and have the parents think of them as nice nurses:

> *"That you try to make things as good as possible, that you feel like you're needed. Yes. That, well, you make things as nice, make it as nice as possible for the kids and parents, to organize the care". (D ri 1 p. 21)*

The nurses talk about their relationships with parents in terms of 'organizing them', perceiving an obligation to organize the admission to hospital care of the sick children with their parents as enclosures. The focus is on maintaining parenthood during the hospitalization. The intention is outspoken as to 'please parents' in the daily life at the hospital by handing over initiative to parents as a way to define their relationship. The nurses' expect parents to take their own initiative for getting help, if they give them essential information and invite them to ask questions. A common statement among the nurses towards parents in the encounters is to be available:

> *"They (the parents) know we're here, that they can call and ask if there's something they want or need, that we tell them that we're here, don't hesitate to call if you wonder about anything or want to know something". (B ri 2 p. 11)*

The nurses think that parents' participation in the care of their child is a logical consequence of parenthood By reading parental cues and habits they determine the parental willingness to undertake basic care of their child. If they recognize a *"normal parent - child relation"*, they choose to *"leave the basic care to the parents"* (U ri 1 p. 9) and just organize the care at the ward.

Parents' presence as residents at the ward is legitimated by offering a room for both the child and the parent. This room is viewed as the family's own territory. The nurses almost always knock on the door before entering wardrooms, as the families are respected and expected to carry out *"the parenting in their own way"* (Q ri 1 p. 5). In her report, when changing work-shifts, a nurse describes the importance of the wardroom as parents' territory. She talks about an 11-year-old girl who has been hospitalized for a month because of a fracture of her leg:

> *"They have to take care of themselves, they seem to enjoy each other's company. They're content". (L fd 1 p. 3)*

Another nurse talks about her understanding of the family's situation as:

> *"We soon won't be able to see them. There are so many belongings and other things in the room. One parent, sometimes two, have lived there for a month now!" (F fd 1 p. 11)*

Still another nurse expresses her understanding of parents' residence on the ward:

> *"I mean just because they are in the hospital doesn't in any way mean that we can just tramp right in any old way. It's their room. We can't just rush right in. I don't think so". (D ri 1 p. 9)*

The nurses' assumption of parents' involvement in the care and the right to live with their child in the hospital is expressed in this way:

> *"I don't think you should direct parents in that way. You shouldnt take anything away from them, how can I put it? They're responsible for their children and as a caregiver I shouldn't have that, they have to take responsibility for their children themselves. I think we took over a little too much before. I think so, that's what I think". (Q ri 1 p. 12)*

Parents thus are perceived as 'experts' on their own children and therefore left in charge of them. However, parents are not only valued by the nurses as experts in caring for their own child, but also as persons who reduce their

workload; parents' residence seem to be perceived as a guarantee to carry out their professional actions.

The atmosphere in encounters performed by actions according ti the assumptive style is well-meant, but has a streak of professional coldness. A distanced social position towards parents, as showed in the nurses' body positions and brief eye contacts, makes clear that they are going to leave the situation as soon as possible. Typical descriptions of the nurses' body positions in relation to parents are: 'standing beside', 'in front of' or 'sitting in the reception area'. The time that is used in typical assumptive style encounters is limited to 'world time' (see p. 73). The length of the encounters depends upon how much time is required to effect the task, mostly recognized as routine tasks by the nurses, such as giving of information, taking measurements, checking things, or just demonstrating their 'good will' by being available.

A more extensive illustration of the assumptive style is illustrated below. After giving a specimen in a treatment room a nurse and the mother carry Anne, 5 years old, back to her bed.

> The nurse follows the mother into Anne's room. The mother is red-eyed from crying. She is busy with Anne. The nurse doesn't say anything while she observes the mother cover the girl with a blanket. The mother busies herself with the child.
>
> The nurse stands at the bottom of the bed. She is quiet.
>
> After a little while the father arrives. After he takes off his coat he lies down on the adult bed which is right next to Anne's bed. He pats her. Asks the girl and mother how it went. They talk quietly and calmly to each other. Anne dozes. The mother goes to the bathroom. The father looks at a newspaper.
>
> The nurse is still standing quietly at the bottom of the bed. When the mother comes back from the bathroom the nurse asks if it is okay if she leaves. She encourages the parents to let her know if they need or want anything. The parents nod and the nurse leaves the room. (G fd 2 p. 3)

In the nurse's reflection about this situation she says that her intention was to be available for the mother. The nurse just wanted to be present in the room because she thought the parents might need her for something. She describes:

> *" Well, I didn't think I needed to talk, just that I should be available because the mother was a little uneasy, and then when the father came I felt superfluous because it seemed like things were stable. It's so phony when you just stand there and watch. ... She didn't dare tell the father how frightful and horrible she thought it was and that they stuck her in the back, but that Anne was a good girl. The feeling*

in the room sort of seemed to change when the father came. They needed to talk, since he thought that it hadn't been done". (G ri 2 p. 11)

Nurses' mastering of situations by the assumptive style anticipates understanding of themselves as someone whom parents are 'in need of, just as a professional'. It is a request towards parents to be used as a complement regarding nursing of the children. The nurses' opinion is that a balance between parents' will and wishes and the nurses will to carry out tasks by their professional knowing is most beneficial:

"But I (if I was the parent) see to what's best for my child and if the staff also does so then things usually function. Then there's a harmony between the parents' will and our will. That's why we're here, so they do well". (F ri 1 p. 13)

There are both expressed and unexpressed expectations that parents' reside on the ward and are involved in the daily caring of their children. The nurses' focus is on organizing the hospital care and maintaining the parenting role, both of which facilitate the nurses' workload. In a short report talk in the hallway, a nurse asks a colleague about the caring situation of a three years old disabled girl who is admitted to the ward because of an infection:

"She (the mother) knows very well that this ward is not like the relief ward with all the resources they have there for parents". (X fd 3 p. 8)

To sum up, the nurses' actions within the assumptive style are concentrated on delivering instrumental tasks related to the nursing care of the children. The effectuating of nursing tasks gives them authority and reasons for entering and leaving situations. Moreover, the actions express a distanced sociality towards parents, where the relationship is based on the nurses' responsibility to organize the care to parents and children. The nurses reflect on their intentions in the encounters as to just 'get their job done' and 'to do what you have to do' as authoritative professionals. When the nurses perceive situations as "getting their job done", they have, however, slightly divergent social position towards parents. In one situation they want parents to be their supervisor in caring for a child. In another situation the nurses avoid encountering parents. In still other situations they say that they wish parents to take all the initiatives and matters into their own hands, but when parents act in this way, the nurses sometimes act resolutely as someone who know what is best. Hence, within the assumptive style, the nurses' sociality show slightly distinguished forms defined as *acquiescent, evasive* and *resolute*. They will be further described in the subsections that follow.

Acquiescent Actions

It is common that parents and their children use their own territory in the wardrooms and live *"as if they were at home"* (F ri 1 p. 3). The nurses legitimate this type of residence life if it does not disturb the nursing care and the routines on the wards. They want parents to *"manage themselves* and *"do as they usually do at home"* (B ri 2 p. 6). The nurses therefore emphasize their availability and invite parents to call on them if they want help, as has already been described. Some parents do as they are invited to do.

There are a number of encounter situations where parents ask for services of diverse kinds. Some parents are very forward in requesting service and the nurses do as requested by serving them. An illustration of nurses' actions in these situations can be illustrated by an encounter with the parents to Aron, 2 years old. The boy is isolated in a wardroom because of the risk of transmission of infection.

> It is 10.30 on a Tuesday morning. The call-light goes on from one of the patient's rooms. The nurse goes to the room. Aron's parents have rung. The parents are reclining on two beds, with Aron between them.
>
> They say they have been asked to remain in the room because of a contagion on the ward and ask that food be brought in for their son. The nurse stands at the door and asks what they want him to have. After the given directive she goes directly out to the kitchen to prepare it.
>
> When she returns to the wardroom with the boy's food, the father asks if the restrictions of isolation also include the parents. "They probably do," answers the nurse and laugh (in an unsteady voice?). "In that case, may we have some coffee?" asks the father. The parents joke about ordering something good with the coffee. The nurse is quiet, leaves the room, and enters the kitchen to prepare a tray with coffee and a few cookies which she takes back to the parents and hands over at the door. (B fd 1 p. 4)

The distanced body position of the nurse, by her just standing at the door and talking, is typical in these encounters. The nurse serves and effects the task. She does not use many words while standing at the door and she uses only those minutes that are necessary to give the parents what they want. The nurse agrees with the parents without questioning or bargaining:

> *"It's best to do what the parents want us as nurses to do. Then there won't be any conflicts". (B ri 2 p. 12)*

The nurse relate that they ("we nurses") perceive parents as being *"experts on their child"* (B ri 2 p. 12). Parents also are expected to know the situation best.

By standing beside their child in the care they are expected to know what is best for the child and what they want to request as parents. Familiar with the hospital context, the nurses are 'willing to help and serve them':

I You were really obliging, a little like a waitress.

B Well that's how it is with those who are here a long time, you want to try to be that way. /.../

I Making things easier for the parents, being service-minded, are these things important?

B Yes, Because that's what they need help with, /.../

I On the whole, is being willing to help important in your contacts with parents?

B Sometimes it's hard when there are many of them. If you have many of them to organize it's really hard. (B ri 2 p. 6)

The nurses' social position appears as a major wish to assist and please parents. Their intention is 'to be asked for'. Parents' requests are seen as evidence that they are fulfilling the nurses' obligations to inform parents that it is their duty to be available, serve, and effect wishes on the wards. But, in turn the nurses point out that receiving requests from parents also gives them the possibility to get in touch with the parents in their territory in the wardrooms. A nurse describes:

"You have a natural reason for going in, you could say, not going in and disturbing them but going in and asking if they want anything". (B ri 1 p. 21)

Evasive Actions

The nurses' wish to be a professional complement to the parents' general parenting and to prepare them before treatments is not free from conflicts. The imparting of routine and task-oriented information, answering questions and 'doing what they have to do' towards parents are described earlier. However, in some encounters, where the actions constitute the assumptive style, the nurses' show great uncertainty. The atmosphere reflects an unassertive distanced manner and an evasive position towards parents.

An example is when a nurse has to prepare Anders, an eight-year-old boy, for a planned operation. The boy has an undescended testicle that will be operated upon the next day. He has been called to the ward today from the waiting list. A health care assistant has guided the parent and child around the ward. Informing the boy and his mother is a routine situation for the nurse.

> The nurse has the task of informing the boy about what will take place during the rest of the day. She goes to the playroom and meets the boy and his mother. They are sitting on a sofa in the playroom. The nurse sits down on a chair beside them, looking in the chart. She first asks the mother's whether the surgeon has seen them. The mother says yes. The nurse informs them that the anesthetist will come in the afternoon. She informs Anders that he should take a shower tonight and that he is not allowed to eat anything after midnight. The talk is short, and she has been looking at the chart in her lap the whole time. She finishes the communication by saying, "After that nothing will happen, so you can go home this evening."
>
> It is quiet for a moment. "That's tough," the mother responds. She says that they live too far away to go home this evening and come back tomorrow morning.
>
> "Oh, no, of course you shouldn't. It's too far" the nurse excuses herself. "I didn't notice that you live so far from here," the nurse says. Then she is quiet again.
>
> The mother again says: "It's difficult". No more is said and the nurse hurries to the nursing office and writes in the chart. (D fd 1 p. 2)

Providing information in preparation for surgery is a routine situation for the nurses when they follow a pattern of acting which is in accord with the policy of the ward. The nurse, in the illustrated situation above, uses a pamphlet when giving the information. When the talk progressed in another direction than the nurse expected she became quiet, make no eye contact with the mother and leave the situation as soon as possible in an evasive manner. In reflection she describes feelings of uncertainty. She reflects on her difficulties to talk with the parent and refers to feelings of insecurity because she does not have anything to say, only the memorized information. The nurse describes her uncertainty towards parents in general as caused by her lack of interest in talking more than necessary to parents:

I *What is it that makes it difficult to talk with parents?*

D *If they're a bit quiet and don't say very much then I think it's so hard to just pull something out of the air and talk about it. I'm not all that talkative myself, and don't talk just for the sake of talking. (D ri 1 p. 4)*

This nurse is aware of her reasons for showing an evasive position and why she waits for the parent to take initiatives for her continuing actions. She describes difficulties in talking with parents and lack of time as the causes of her failure:

I *Do you think you got your message over the way you wanted when You informed them about what would happen during the day?*

D *No, it didn't really work out that way. It was so abrupt because then I had to leave. Something else happened.*

I *What wasn't good?*

D I think it was that I didn't talk with them properly. (D ri 1 p. 11)

In similar encounters, where the nurses perceive that they failed to perform the encounters properly, they reflect on their actions with feelings of distrust.

An evasive orientation is tend to be speechless. The nurses avoid verbal communication with parents unless the parents themselves take initiative and call for them in some way. Further, there is a general willingness to please parents, but when this fails there is always an excuse to avoid further contact because of the nurses' busy workload. If there is any *'social time'* it is handed over to parents:

"If a parent is 'special' in some way, one avoids contact. /../
They [parents] don't want contact, and we [nurses] don't have so much time to spend with them", (X ri 1 p. 5)

In encounter situations with an evasive position the nurses seem to perceive their relationships with parents as not being especially important. Instead they emphasize their relationships with the children, as their patients; parents are just accompanying them. A nurse describes it as:

"If it doesn't work with the parents, the children always come in the first place in any way". (N ri 1 p. 17)

Combined Acquiescent and Evasive Actions

An even more complex differentiation of nurses' assumptive style is when a combination of actions makes their sociality towards parents both acquiescent and evasive. This will be illustrated by an encounter with a parent in a treatment situation where a small child needs inhalation therapy. During a coffee break on the night shift, a nurse talks about a parent she will meet who always is *"dominating"* and *"demanding in a strange manner"* (AE fd 1 p. 4). This mother always wants to have everyone follow her commands, and, according to the nurses, she orders people around. The nurse thinks that it is easier to "let this mother continue" with her own way of handling situations. She decides *"just to do what she has to do and not be attacked by the parent"* (AA fd 1 p. 6).

Before the encounter with the parent the nurse decided to use the action of distancing and *"keep a low profile"*, because her intention was to attune herself

to the situation and only serve the parent and *"do what she has to do"* (AA fd 1 p. 6).

> At 11.30 pm the nurse is called to the emergency ward. She is expected to give the daughter of the mother in question an inhalation treatment with Ventoline.
>
> She greets the mother and they both confirm that they know each other since before. The nurse starts the inhalation treatment of the child.
>
> The first thing the mother says during the treatment situation is that she has called the father of the child and asked him to pick them up within half an hour. "If I'm not ready by then, one of you must go and tell him or he'll leave again" she says.
>
> "You'll probably be ready," the nurse says evasively. She does not look at the mother, but just at the child.
>
> During the entire treatment, while the child is half-asleep, the mother keeps talking about her children and her job at the day care center. She says that she always tells the children that the nurses at the hospital are nice.
>
> The nurse is quiet and makes few comments during the whole situation.
>
> The mother asks for "stickers" for the children. She tells the nurse where to find them. She knows where they are and which ones she wants, both for this child and the sister at home.
>
> The nurse is impassive and vague and lets the mother find the stickers by herself. The nurse writes in the chart.
>
> The mother hurries away with her child when everything is finished at the emergency ward. The nurse makes no further comment concerning the incident. She just sighs and goes to another situation. (AA fd 1 p. 7)

The nurse's position, in this encounter, not only has the acquiescent orientation, but is also evasive to avoid getting herself hurt, as she has told in her planning of the encounter. She describes her actions by relating to her knowledge of the conditions and her intention to make it easier for herself and preferably "ignore the parent and let her behave in this way".

The nurse states, however, that if this situation had arisen at another time and in another setting at the hospital she would have "put a brake" (AA ri 1 p. 10) on the parent's actions and chosen other actions instead. This kind of comments, that other kinds of actions might have been decided upon if conditions were otherwise, is fairly common in the nurses' reflections.

Resolute Actions

Although having invited the parents to take own initiative in the care of their children, the nurses sometimes, when parents do so, act resolute from a superior position.

An illustration of this is a nurse's encounter with the mother of a one-year-old boy, Adam, who has been on the ward since the previous day because of gastroenteritis, and received IV fluids[5] during the night.

> The nurse knocks on the door and goes through the sluice system into the room. She greets the mother, who is sitting on a chair by the window. The TV is on. The boy is playing on the floor. The nurse tells the mother she wants to see what the boy has had to drink and also what his temperature is.
>
> The mother comes over to the changing table where the intake list is. Fluids that have been taken into the room have been written on the list. "I haven't been able to write because I don't have a pen," says the mother in broken Swedish.
>
> The nurse says that she'll leave one of her pens so that the mother can make notations on the list herself. The nurse goes over how much of the fluids Adam has drunken. "He doesn't want to eat," says the mother. The nurse says several times that what is most important is that the child drinks. Then the mother says that she also breast-feeds him. The first time the mother says this, the nurse does not indicate that she has heard. The second time the mother says the same thing, the nurse asks how much milk she has, "or maybe it's just a few drops." The mother nods.
>
> The nurse says that they may have to put in an IV during this night too. The mother doesn't say anything in response, but looks hesitant. "Maybe I can get more into him," she says. "We'll wait and see until this evening," nurse says. Before she goes she comments that she is leaving a pen for the mother. (C fd p. 8)

The nurse acts as taking the parent's engagement in the care of the child for granted but at the same time she resolutely determines activities:

C *I want to show the mother which one of us who has the knowing to determine what kind of activities, related to the child's illness, which can be considered later on. /.../*

I *How do you think she reacted when you said we might have to give him IV fluids during the coming night?*

C *Well, you know... No, she definitely didn't want that, or I don't know. Some parents want it and some don't, and sometimes it can be good to say it, because then maybe they'll really work at it, because it's hard to sit in a room and try to force fluids into someone the whole time /.../*

[5] IV fluids = intra veoese treatment because of dehydration.

> *I said it simply as information, so that she wouldn't be shocked if I go in at 8 pm and say that now we're going to put in an IV. I think... I think it's good that you can check a little and see what she thinks about this issue. (C ri 2 pp. 11-15)*

By her authority the nurse wants and expects the parent to care for her child during certain activities, decided by her.

Another nurse reflects over her using of a resolute orientation in a similar situation:

> *"One insists that more professional care should be given by you (a nurse) yourself to be available. You want to know more then them (parents). It can hurt sometimes when they know more about their child's treatment and care". (AE ri 1 p. 18)*

Assumptive Style: Summary and Overview

The assumptive style focuses on parental maintenance. The nurses' intention is to be available and identify themselves as professionals who are needed. They act by inviting, serving and helping. Typically, the sociality towards parents is distanced and unilateral. The amount of time in encounters is limited to the time required to effect the task. It is significant for the nurses' relationship with parents that they just organize the care. Within the assumptive style the approach towards parents is task oriented and can include acquiescent, evasive, or resolute actions, or combinations of these.

Content in actions and perceived meanings of actions categorized as belonging to the assumptive style are outlined in tableau B.

Tableau B. Assumptive style: Content and Meaning

Content of Actions		**Perceived Meanings of Actions**	
Verbal Communication	Answering and directing Task-oriented information	Intention	Please parents as residents 'To get job done and do what you have to do'
Non-verbal Communication	Distanced outlook Occasional and brief eye contact	Attention	Inaugurating and effectuating 'To be available'
Arrangements	Effectuating work tasks	Definition	To serve and help Inviting
Atmosphere	Kind but cool	Intersubjectivity: Understanding of self	Being needed as a professional
Time	Time together determined by time required to effect a task	Understanding of parents	Take own initiative and want own territory
Social Orientation	Distanced: acquiescent evasive resolute	Relationship	'Organizing them' (child and parents)
Focus	Parenting maintenance		

Demanding Style

The second action style is the demanding style, where the nurses actively aim at coercing the parents to participate in the care of their child and the everyday life on the wards. Here, the nurses describe an obligation to prepare and instruct the parents to follow plans and procedures involved in the caring for their children. Routines in encounters and arrangements are typically referred to, as in the following interview transcript concerning preparing for a planned surgery:

> G *The parents of "ear children" whom I admit so often, with them I don't plan what I'm going to say....I'm so used to admitting them.*
>
> I *What is it you want to say when you admit these children?*
>
> G *First and foremost to tell them what's going to happen during the day, a little bit, so they also have a chance to ask questions, who they're going to meet and why they're going to meet them, and then I think it's important to show the children that, for example, here's where you can lie down when they're going to put in an IV needle[6], because this sounds very frightening, that they have a chance to see what it's like and... ... So I think especially to show them the ward and tell them a little about who we are and what's going to happen and that they have a chance to ask questions /.../ and I usually tell them that they can go home and sleep, but the mother had already decided that they were going to do this, so therefore I didn't talk about how they could also stay on the ward, that they could choose, because otherwise you can choose.*
>
> *(G ri 1 p. 5)*

Typical actions in the demanding style is illustrated in the following situation.

> The nurse goes up to a mother who sits in one of the sofas in the playroom. Her son is driving around in a toy car in the corridor. The nurse asks the boy if he wants to come and hear her talk to his mother. He shows no interest.
>
> The nurse squats in front of the mother. She informs her that the boy and his mother will meet two doctors, the ear doctor and the anesthetist. /.../ She also asks the mother if there is anything particular about food. The mother answers that David has a bit of a cold and wonders whether he can have the operation.
>
> The anesthetist will have to decide about that, the nurse answers. She asks whether the boy has fever. The mother answers that she has not checked but /.../ The nurse also informs the mother that they can go home when they have met both doctors.

[6] IV needle = needle for intra veoese treatment.

/.../ In any case, the operation will not take place before 9.00 am. "Good, then we can sleep a little longer," the mother answers.

The nurse then informs that she will show them what things will be like tomorrow so "let's go into the surgery room." /.../The nurse pulls out a chair and asks the mother to sit down with David in her lap. She sits down on the bunk next to them. Facing the boy the nurse now informs the boy that he is to take a shower and is not allowed to eat anything after tonight. She shows him that tomorrow an anesthetic lotion will be put on his hand because a little plastic tube will be placed there to give him medicine and "soda pop."

The nurse takes a needle from the table beside them which is filled with articles for blood sampling and infusion injections. David observes closely. The nurse asks if they wonder about anything. She looks briefly on them. The mother shakes her head. The nurse then wants to prick David's finger. He folds his arms, puts a piece of paper in his lap. "Here's an apron," she says. "We'd better fetch the teddy-bear," the mother exclaims. The nurse leaves her chair and goes to the playroom to fetch David's small backpack and gives it to mother. The mother takes out a teddy-bear and a pacifier. "Let's prick the teddy-bear first," the nurse says. She pricks the teddy-bear and puts on a Band-Aid.

She pricks the boy and say "But you have red blood" she says to the boy. "I'll give each of you a bookmark from the little black box on the counter. You are so brave!"

She holds out the box to him. The boy quickly selects two bookmarks. Then he wants to go out and play in the playroom. His mother accompanies him and the nurse stays. (G fd 1 p. 7)

In this example the demanding style is illustrated by the nurses' verbal communication in information of the overall planning about the care. There are questions and answers from both parties. This kind of interaction, when the nurse asks questions about the child, and answers parents' questions about her child and how to act on the ward, is typical for the demanding style .

Nevertheless, the dominating social orientation in the demanding style is unilateral, because it is more of a one-way dialogue where the nurse informs the mother, asks questions, gives answers, and gives instructions. The non-verbal communication contains frequent eye contact. Nurses are likely to turn towards parents, to point and show. They come to parents' assistance by 'standing in front of parents', 'sitting on a chair beside parent or child' or 'sitting on the bedside'. In situations of instructing, leaning towards the parents is common.

In the demanding style, parental participation is typically encouraged through actions of giving information and preparing for treatments. The intention is to assimilate parents and their children into the hospital care through well-organized actions to influence for parental participation. Among the analyzed situations where nurses show the demanding style, many concern preparation

of particular activities, as taken of specimen or treatments. But the demanding style does occur in all types of situations.

Another situation is the following where a nurse in the recovery room calls the nurse to say that 8-year-old Dick can be picked up and taken to the ward. The nurse receives information about the boy's condition over the phone and goes to the recovery room to admit him to the ward.

> The nurse greets the boy lying in the bed and the mother sitting next to him. She pushes the bed through the corridors to the ward. On the way to the ward she asks the mother how the day has been. How they came in acute to the hospital.
>
> She shows them into the ward and pushes the bed into a large room with four patient beds and beds alongside for parents. Dick's bed is placed right next to a window. There is an adult-sized bed next to it intended for a parent.
>
> There is a curtain that can be pulled in order to partition these two beds from the other beds. The nurse looks at the boy's wound. Then she asks the mother about staying. The mother asks how long the nurse thinks Dick will be staying at the ward. The nurse responds that she doesn't know. It can be one or two nights. The mother answers that she'll be working tomorrow afternoon. She needs to phone home and talk to the father about plans for tomorrow.
>
> The nurse shows her the telephone out in the hall. At the same time the nurse shows the kitchen for parents and explains about available food. She also shows the nursing office and tells the mother that she can find her there. (T fd 1 pp. 10-11)

This nurse defines her choice of actions as one of surveying the situation:

> *"... to make a survey, and arrange activity and give information in the most practical way in order for the parent to participate in the care". (T ri 1 p. 5)*

Nurses' arrangements in the encounter situations meet parents' needs and requests. They seek opportunities to inform and arrange for parents as well as to support them whenever they call for help. However, giving assistance, helping, comforting and instructing parents and children are managed and controlled by the nurses. Their actions do not involve asking for any permission from parents. The nurses' attention in these encounters is directed towards to have control of the care. Parents are viewed as capable and the nurses expect them to be active, to comply and to assist the nurses in the care for the children as well as to assist and advocate their children during the during the hospital care.

The time the nurses spend with parents correspond to what is required for completing tasks, giving information, or making arrangements, i.e. 'world time'. Depending on the nursing activity, however, it can also involve 'social time'. In these cases, the interaction has the structure of 'businesslike' exchange

of information. While the nurses tend to actively encourage parents to go along with them, they make clear what they as professionals are doing and why they make different kinds of interventions. The relationship is characterized by a professional responsibility for children and parents by *"looking after and taking care of them" (U ri 1 p. 8).*

The nurses consciously seek to involve parents actively in the care. The focus on accommodation of both parents and children into the ward creates relationships which are indicative of the nurses' authority to demand parental participation. There is an expectation towards both parties, themselves and the parent, to make demands on each other. Parents are expected to ask and search for information, to learn new skills, and attune themselves to the new conditions. In the care of the children there is an alliance, while the nurses still keep a distance from the parents. They are telling, advising, inviting, teaching, coaching, explaining, suggesting, assigning, refusing, confirming, and guiding parents to attune to the circumstances of their child and on the ward. In the situation illustrated earlier (p. 128) , the nurse describes her intention to *"talk them over to my side" (G ri 1 p. 5).* This phrase is commonly used within the demanding style.

While the nurses' describe their relationships in these encounters by using expressions such as 'looking after and taking care of them' (parents), they use either confirming actions by 'getting them on the same wavelength' or forcing actions by 'struggling for parental compliance'. Hence, within the demanding style two kinds of social orientation towards parents are found, namely in *confirming actions* or in *forcing actions.* These will be further described below.

Confirming Actions

In encounters where the demanding style has a confirming orientation the nurses' actions establish ways of maintaining parents' wish to be engaged and to actively assimilate them to participate by *"getting them on the same wavelength"* (N ri 1 p. 15) as the nurses activities.

An illustration of a confirming orientation is shown by a nurse preparing Daniel (seven years of age) for surgery.

> The nurse knocks on the door to the room before entering. Daniel is sitting on his bed with a game of Memory spread out in front of him. His father is sitting on the edge of the bed next to him. They joke about who the winner will be.
>
> (Commentary: The family is immigrants. They speak Swedish with the nurse but communicate between themselves in their native tongue).
>
> While holding the plastic ID band with the boy's name and birth date, which is to be put around Daniel's wrist, the nurse asks the father if the facts are correct. She puts the ID band around his wrist and places a name tag on the bed, "So that they'll send the right bed back with you to the ward." The nurse gives Daniel a pill and tells him to drink as little water as possible. The boy has difficulty swallowing it. The father says that he has difficulty taking pills. Eventually he swallows his pill and the father stops him from drinking too much. The nurse tells the father that when Daniel is tired he can crawl back to bed. The nurse leaves the room and says that she will come back when there is a call from the surgery ward. (Commentary: In the office I read in the files: "Do not understand much Swedish. Make sure they have understood the information").
>
> /.../ At 10.40 there is a call from the surgery room saying that Daniel may come. The nurse once again knocks on the door, enters, and says that now it is time. Daniel has crawled into bed. The father says that Daniel is feeling tired now. Together they pull out the bed and walk along the corridor towards the elevators to the operating rooms. The father walks next to the bed. No one talks. Outside the operating department the nurse shows the father into a small room where he can change into clean "surgical clothes". She waits outside while the father changes. When he comes out in the green clothes, the nurse says to Daniel that his father looks like the doctor Daniel met yesterday (the anesthetist).
>
> They enter the operating area. The father puts on a surgical cap and slippers. The nurse shows him where he can put them to be sent to the laundry when he leaves. "You can be here until Daniel has fallen asleep. When you come back to the ward, one of those green coats will be enough". The nurse informs and points at the same time. Then they stand quietly for a while and when the operating room personnel come to get the boy and his father, the nurse returns to her ward. (R fd 1 pp.5-7)

The nurse in this situation acts according to the parent's capability, and she confirms the father's participation by showing things and giving instructions. When reflecting on this and similar situations she refers to her intention of *"getting the parent on my side"* (R ri 1 p. 18), as a strategy to influence parents in the right direction:

> *"Of course the children are so little that you don't really know, maybe you don't really feel you're dealing with the children in this respect, but then I've shown the parents anyway, and then the parents have seen it and become part of it too. And then at least I've done what I could and at least I've shown it to them".*
>
> *(R ri 1 p. 20)*

This nurse's arrangements in the encounter situation is also associated with a confirming orientation towards the parent's actions as a result of her instructions:

I Did you think the father got involved in what you did?

R Yes, I think he was. He also told me that the boy had trouble swallowing pills and tried to help. He also watched how much water he drank, so it wouldn't be too much. So then I felt that he understood about fasting and what the boy should drink. So I felt that, but then when I had to ask the father then, he was a little, you know, he wasn't really prepared for the question, but he answered anyway. (R ri 1 p. 21)

It is obvious that by confirming parents' active participation in caring for their children, the nurses' workload becomes less heavy, as what parents do for their children might be more difficult and time-consuming for the nurses. The nurses intentions are recognized as if they can tell and learn parents what is going on and what to do, they can be helpful and assist the nurses in their work. There seems to be a wish to achieve benefits in terms of a reduced workload during their shift.

The following situation illustrates a nurse's actions when giving information about clinical conditions, and wishing for parental activity to thereby save her time. Dorrit is a disabled girl who is hospitalized because of an infection. The girl has been nursed on this ward several times in connection with infections. At 1 pm on a Friday a nurse sees Dorrit's mother arrive on the ward.

> The nurse accompanies the mother to the wardroom. The mother is quiet but seems used to being with her disabled daughter on the ward.
>
> The nurse gives information to the mother about the girl's condition the last 24 hours, what the doctor has said, and what has been done so far. They talk about what it is like to take care of Dorrit, e.g. difficulties when they feed her, what she likes to eat.
>
> The mother informs the nurse that she can remain with Dorrit until 2.30 pm. At that time she has to pick up a son at the day-care center and she has no baby-sitter until 6 pm. tonight. Then she can be on the ward with Dorrit the whole weekend.
>
> The nurse responds that that's great. She adds "Perhaps you could feed her some porridge while you're here, before 2.30?" The mother agrees and the nurse leaves the room. (X fd 1 p. 5)

Here, the nurse confirms the mother's competence to carry out basic care for her daughter, something which also reduces the nurse's own work:

X She wants to be with her, but it's hard being here and taking care of her around the clock. 'We' (the nurses) no longer have the resources to take care of these disabled children.

I She's used to being here and has been here a lot?

X *Yes, she takes care of her daughter and tells us when she needs something or when she wants to go out to eat or something. She tells us then if we can help her.*

I *You asked her to give the child some cereal during the afternoon, before she had to leave. Why did you do that?*

X *Because she's the one who is most used to feeding her the cereal if there is something special, since no one else has fed it to her yet, and she said it goes up and down. If it doesn't work when she feeds her then there isn't much reason for us to try either, because she's the one who is best and knows her child best. That was my thinking. (X ri 1 p. 17)*

Within the confirming orientation, the nurses exhibit professional superiority with the authority to demand parental participation by delegating tasks. The nurses' reflections express perceived obligations to inform and persuade parents to acquiesce, with the focus on accommodating parents into the hospital context.

Forcing Actions

Within the demanding style the nurses' expressions in communication with parents sometimes have a forcing orientation. In these cases, the communication includes exhortations and imperative directions in an explicitly manipulative way. The nurses choose instructional actions with a clear control in directions given to parents, so that *"parents are doing the right thing" (Q ri 1 p. 15)* In these particular situations the nurses actions involve control and manipulation. They temporarily use strong power to influence parents' participating by instructing and teaching parents how to manage specific care by themselves, related to their child's illness. The actions indicate both professional and personal accountability.

The following illustration is from a situation where a nurse made rounds with a pediatrician. A little boy Danny, one year old, has breathing problems.

When the doctor finishes talking and stands next to the chart rack to write the prescription, the nurse goes over to the side of the crib, where the mother is standing on the other side.

The nurse informs once again what the doctor already has told the parents. She talks slowly and distinctly, at the same time as she gestures with her hands to emphasize what she's saying, namely that, "First Danny is going to get an inhalation before he can go home. The doctor is writing a prescription for a medication that will be given

> by mouth at home." She asks again if the mother has understood. The mother nods. /.../
>
> Later on: The nurse is going to take a capillary blood sample from little Danny's finger. She gets what she needs and goes back into Danny's wardroom. She asks the mother to hold him in her lap while sitting on the big bed.
>
> The nurse tells the mother what she's going to do and tells the mother what she should do in order to help the nurse and the boy. The nurse gives directions and encouragement to the mother during the whole situation, which takes about 5 minutes, about how she should hold him and what she is expected to do during the taking of the specimen. (Q fd 1 p. 6)

The atmosphere in this encounter situation tends to be more and more anxious and tense. The nurse's intention is to attune the parent to the situation, to comply through giving instructions. The nurse's reflection on the situation is typical for a forcing orientation:

> *"So then I tried to explain to the mother by using very simple language so that she'd understand. That I didn't talk so fast. But I took it sentence by sentence, so to speak. So that she'd understand our thinking. /.../ I think it's important for these mothers to get instructions, because she probably understood, but still not always. The mother's still the one who's responsible for her child". (Q ri 1 p. 12)*

Worthwhile noting is that the nurse first uses a typification of mothers as 'these mothers', then changes to this particular mother, 'she'. This is quite usual in the demanding style with a forcing orientation, as is the tendency to, at one hand expect parents to be involved and undertake the basic care because of their parenthood, and on the other act in a 'mothering' way in giving advice and instructions:

> *"I wanted to teach and give instructions on the right way to hold the child".*
>
> *(Q ri 1 p. 12)*

When showing a forcing orientation the nurses typically state that it is their duty to teach parents, since they do not understand the situation and need help. The nurse above talks about her authority in the actions as based on her professional knowledge and experiences:

> *"... Yes, you can interfere too much. You can do that and (laughing), sometimes I find myself giving a lecture. Yes, that's what it is. But I think I have the experience that these young mothers don't have, so telling them the right way to do things is ... what I think is the best. But I know I am too mothering (laughing)". (Q ri 1 p. 14)*

In encounters with a forcing orientation, the sociality in demonstrating nurses with the situation, it is the nurse who knows best, and who has a mandate to

control and look after children and parents. This means asymmetric and unequal relationships between nurses and parents.

Another situation with a forcing position toward a parent is illustrated below. A nurse has been told, in a report from a nursing colleague, that Douglas, a five-month-old boy, doesn't get sufficient nourishment. His mother probably does not make his formula in the right way. The situation starts by the nurse who knocks on the door and enters the room.

> The mother stands by the adult bed close to the window with Douglas, five months, in her arms. The TV set is turned on.
>
> The nurse approaches and stands beside the mother. She speaks slowly with the mother in short sentences, stressing every word talking about preparation of the food. She makes certain gestures when she asks about how the mother is doing in her preparation of the formula.
>
> The mother answers curtly and nods or shakes her head in response. She says that Douglas will be fed now at 5 p.m. and that she is waiting for this, keeping him in his arms, as he is hungry and unhappy.
>
> "You can show me how you make the formula now, so let's go out to the kitchen," the nurse says. The mother puts Douglas in the pram that is placed in the room and they go out to the kitchen. The nurse looks in the refrigerator to see if there is any pre-boiled water. As this is not the case, she takes a pot, which she gives to the mother at the same time as she takes out a bottle, which she places, on the counter.
>
> Douglas is a little grumpy. The nurse asks the mother if she may pick him up. The mother nods. The nurse lifts up Douglas in her arms, rocks him and chats with him. Meanwhile she watches the mother pour water from the tap into the pot, about half the pot, puts the pot on the stove and turns it on. When this is done the nurse walks up to the mother with Douglas, saying, "It's best to be with mother," as she lifts him over to his mother's arms. Then she leaves the kitchen without any more comments. (O fd 1 p. 3-4)

The nurse reflects upon this situation by describing her intentions as follows:

> *"Well, my thought was a little that we would look a little at how she made this formula. Then that to be able to make this formula you have to have boiled water, boiled and cooled water, and there wasn't any. So we had to settle for her just getting the water ready so it could be boiled. At the same time I didn't want to make her feel she was sort of being checked on either, and amounts and such things can be checked afterward. I picked up the baby instead, so that the mother could busy herself with that a little". (O ri 1 p. 13)*

The forcing position in the nurse's actions is illustrated by her wish to influence the mother to follow earlier instructions and check if she has learned what to do, because as professionals 'we' [nurses] have an authority to control her actions:

"Well, it was to boost her up a little". (O ri 1 p. 14)

Actions and reflections in encounters with a forcing orientation indicate a view of the professional position as being superior and a forced 'mothering' orientation in order to teach parents the right, or best way, of mastering a situation. Intentions are typically described as to make parents accept the nurses' way of thinking, to *"really gets parents involved on my side in a situation" (B ri 2 p. 5).* Another nurse describes:

> *"Well, if you don't have the parents on your side, then I think you're treading on thin ice. I work better with them if I get along well with them. I really do. I don't say: 'This is how it'll be during this period', but instead we [nurses] talk, discuss it. /../ Well, we usually do like this because it's best, then I have a little authority behind what I say, too. Then they [parents] understand that: 'Yes okey, that's how it is.' /.../ I think I can decide what I think is right, so it's, well, it usually isn't any big problem. It really isn't". (Q ri 1 p. 24)*

Demanding Style: Summary and Overview

The demanding style focuses on accommodating parents into the hospital context. The nurses identify themselves as professionals and authoritative superiors. Their intention is to assimilate parents into the basic care of their children and other tasks included in the nursing and medical care, or how to carry out and understand an entire situation. They use a two-way communication, and have a unilateral social orientation towards parents. The amount of time in encounters is limited to the time required to complete tasks and instruct parents how to carry out demanded tasks. Within the demanding style, the approach is task oriented and can include confirming or forcing actions.

Content in actions and perceived meanings of actions categorized as belonging to the assumptive style are outlined in tableau C.

Tableau C. Demanding style: Content and Meaning

Content of Actions		**Perceived Meanings of Actions**	
Verbal Communication	Questioning and answering Information, Teaching	Intention	Assimilation of parents
Non-verbal Communication	Frequent eye contact Body positions as in assistance	Attention	Instructing Teaching Directing Suggesting
Arrangements	Working tasks: instructions teaching preparation	Definition	Survey situations Preparing Controlling
Atmosphere	Sympathetic in confirming situations or reluctant in struggling for parental compliance	Intersubjectivity: Understanding of self	Superior as professional
Time	Time required to complete tasks	Understanding of parents	Want them to participate and comply
Social Orientation	Assimilative by confirming or forcing	Relationships	'Looking after them' (child and parents)
Focus	Accommodation		

Eliciting Style

In the third action style parent's cooperation is elicited by making them familiar with the hospital environment. Actions are based on the parent's personal situation, their wishes and opportunities. The nurse's actions are carefully considered. They choose actions after having thought seriously step by step and they arrive at a determination of the situational conditions. In this style the nurses' focus is on integrating parents by promoting their divergent resources. They show interest in parents as particular persons:

> *"That you should be observant and sensitive, and you should be able to give a little of yourself and talk with the parents. You have to create a form of communication together with the parents and in some way it's on their terms. You have to found out what they think and what they want and..." (R ri 1 p. 22)*

The situation below illustrates the style. The encounter occurs at 7.25 p.m. when a nurse deals with the acute admission of Eddie, 9 years old, to the ward. His parents and an older brother, 9 years old, are accompanying him.

> The nurse introduces herself and welcomes the family. The family introduces themselves in turn and in response to the nurse's inquiry the mother says that she is the one who will stay. The others will be leaving shortly. They go together to the ward. Eddie says that he hasn't slept in a hospital before. In the room there are two adult beds. The nurse asks Eddie if he thinks the bed is too big. He thinks it's fine. The father responds by saying he hopes Eddie won't fall out of it.
>
> The nurse says that usually the beds are placed close together, "so you'll be really cozy." The mother says to the father that it's time for them to leave now. The family exchange hugs and the father and the older brother leave.
>
> Eddie sits on the bed and the mother sits down on the edge beside him. The nurse sits down on a chair beside the bed, elbows resting on the bed and supporting her head in her hands while talking to them. She starts to ask them about Eddie's ailments (which she has had reported to her on the phone earlier).
>
> The mother tells about his stomach pains and about looking up the doctor of a small town some distance away. /../ By asking various questions the nurse learns about what had happened during the day and what both the mother and the boy think about it.
>
> When they have talked about what happened during the day and about Eddie's present condition, the nurse informs them about the ward; their routines, her collaboration with a children's nurse whom they'll meet soon, and the procedures when the doctors make rounds. She indicates the bell on the bedside table and encourages them to call for a nurse if the stomach pains should return during the night. She tells them that the doctor has ordered them to take a blood sugar test once tonight at 9pm, and tomorrow morning before breakfast. There are no restrictions as to his diet. He can eat what he likes. She informs them about meal hours and how the mother can go about getting her meals. The nurse points to the folder on the table and tells them that it contains a great deal of information about the ward

> and how they work there. Then she takes them out to the corridor and shows them the playroom with magazines and games. She also shows them the kitchen and asks what Eddie wants to eat now. /.../
>
> Carrying the tray with her she shows them that they can sit in the dining room next to the playroom while Eddie is eating. Then the nurse leaves them alone for a while. Five minutes later the mother comes to the office with the tray. The mother expresses her delight in the boy's hunger and that he wanted to eat and the association to the care. (O fd 1 p. 15)

Typical for actions in the eliciting style is that they involve reciprocal communication. There are dialogues with mutual questioning and answering. The nurses actively elicit parental activities by questions. They show interest and enable parents to tell their stories and describe circumstances in the current situation. They allow parents to choose from different alternatives in the present situation or for future situations. Based on parents' choice the nurses plan the integration of the family into the ward.

Non-verbal communication is frequently informal and unconventional. In the illustration above the nurse sits on a chair beside the bed with her elbows resting on the bed and her head in her hands. This actions are interpreted as the nurse creates an atmosphere and a structure in the encounter where the parents can feel secure. According to the nurses reflections on eliciting actions the intention is typically directed towards encouragement of the parents to act by themselves as well as along with the nurses.

Within the eliciting style informal talk in combination with formal tasks create an atmosphere in the encounters that shows interest in parents as particular persons. The nurses try to come close to the parents. The nurses' actions are directed at parental resources and thereby then enable parents to act on their own. By enabling parents to act according to their wishes and opinions their own resources are elicited. This is illustrated by the retrospective reflection on the situation above:

> *"I wished they would get a positive opinion of the ward right from the beginning. I think it's important to treat them well right from the beginning, because I believe that's important concerning the rest of the hospitalization, treating them well. The same thing, that you check things out a little, see how you should receive them, depending on what type of family they are". (O ri 1 p. 24)*

She defines her actions by checking things out and informing the mother by familiarizing, in a sensitive way, both her and the boy with what is going to happen further on in the hospital setting:

"You want to try to see how things are with the family, what kind of people they are, so that you sort of know how to present the information. Check out whether they are very anxious about what they were told down in the pediatric clinic".

(O ri 1 p. 26)

Eliciting parental actions by creating opportunities for them and their sick child to become integrated at the ward is important for the nurses:

I What is it that's important to know when you come to the ward?

O To know what is planned during this hospitalization, why we're here at all, how long we're going to be here, what's going to happen, and at the same time to tell them what it's like here and the way we work, so that they get sort of an overall picture of the whole thing, know which people they're going to be involved with and that we care about how they feel and. (O ri 1 p. 26)

Among the analyzed situations where nurses show the eliciting style, all types of encounters occurred. An essential characteristic is that in the nurses' choice of actions they place 'subjective time', or 'personal inner time' to the parents' disposal. They spend more time together than is required to simply complete the work tasks. Time is used both for instrumental information and for informal social talk to *"learn to know each other"* (R ri 1 p. 9) or for other communications about problems. They use the time needed to get to know the parents, the family's background and to understand their actual situation.

The importance of learning to know each other is indicated by the use of the metaphor to 'see the lay of the land'. The nurses show attention by sensitivity to parents' conditions and ways of cope. Verbal and non-verbal communication encourages dialogues to bring out parents' questions and wishes. The eliciting style is characterized by communication with the parents and the intention to "walk side by side with parents" (Z ri 1 p. 5).

The following illustration is from a treatment and caring situation on the day care ward. A nurse is responsible for a one-day treatment of Erik, a three-year-old boy who has been at the hospital many times. He is very short of stature, partly due to his illness. Moreover, his abdomen is big as a result of an enlarged liver and he has difficulties to walk. He is waiting to receive a liver transplant. The boy's mother and little brother are with him. The situation occurs at lunchtime.

The encounter starts when the nurse finds Erik and his mother and younger brother in the dining area. The mother and Erik are sitting opposite each other at one end of the middle table. The little brother, 9 months old, is sitting in a baby chair at the

corner. They are all having spaghetti and meat sauce. The nurse cheerfully greets Erik and the others. She receives happy talkative greetings in return. "You can eat before we start the Albumin infusion," she says. /.../ Meanwhile she has sat down on the chair next to the mother at the table. They talk about fruits and vegetables. The mother is from an Asian country, and sometimes the nurse shows that she does not quite hear her or understand what she is saying and then she asks the mother to repeat. Suddenly the nurse asks the mother: "How are you today then?"

The mother answers that her sleep was better last night as the little brother also slept better having recovered from his cold. While the nurse sits by the table she asks the mother more about practical things according to the hospital care /.../ Meanwhile the nurse peals a pear for Erik and cuts it into pieces. After a while the nurse and Erik's mother straighten up in the kitchen. The mother clears the table and wipes it off with a cloth. She wants to go and fetch something and asks the nurse to watch the little brother. When the mother comes back the nurse says that she cannot baby-sit any longer as she has to prepare Erik's infusion. She goes to the room where medicines are prepared and gets things ready. /.../

The nurse rolls out the infusion set-up while Erik is sitting by the table. Erik asks for his book about "The Lion King." The nurse fetches it. They talk about the Lion King while the nurse attaches the infusion.

Meanwhile the mother and the little brother have left the table to go to the playroom corner next to the dining area.

When the nurse has started the infusion in Erik's hand, he wants to get down on the floor and he walks over to the playroom.

The boy sits down in front of a garage on the floor, keeping the infusion stand next to him. The mother sits down next to his brother for a while until he wants to play too. Then the mother goes straight ahead to the nurse. She has taken off her glasses and asks the nurse to help her with a sore caused by the glasses. The nurse fetches compresses and helps her. At the same time she says, "You have to be careful with your sores so you don't get an infection, in case Erik has surgery. You must see an optician and have your glasses adjusted". The nurse helps her pad the bows[7]. /.../

After a while the nurse takes out a cart from the supply room. While the mother takes the little brother into their room to lie down with him until he falls asleep, the nurse takes Erik down to the therapy room where he can play. /.../

Back on the ward again the mother has risen from bed. She has made sure the little brother cannot fall out of bed. She asks the nurse if there is a room where she can watch "Dallas" on TV. The nurse shows her to a room where she can sit. Then the nurse leaves the mother alone. (J fd 1 p. 6-10)

It is significant for the eliciting style that the nurse carries out actions concerning the daily life at the ward, as well as actions related to specific treatments under circumstances as similar to normal everyday life as possible. In the situation above this is illustrated by the nurse's respect for the family's cultural background and her willingness to relieve the mother of certain tasks. By these actions the nurse is enhancing the mother's integration into the ward, as they signify a relationship which enables the mother's own resources and

[7] Observation Comment: The mother will not be allowed to be at her son's operation to receive a liver transplant if she has any sores, because of the risk of infection.

elicits her involvement in whatever is going on. The nurse's intention to integrate the mother into both the actual situation and the daily life at the hospital is illustrated in her actions which reinforce the mother's place on the ward and elicits her to act by herself. The nurse reflects:

> *"Parents are happy when you give their child a little extra attention and remember small things. That you sit down and talk with them. Sometimes this mother has a newspaper with her from her native country. And we usually talk about that newspaper. We talk about ... not exactly about her problems, we have the social worker for that, but about everyday things and how things go at home with the children and things like that. Erik is very lonely at home. Small confidences like that. It's through small things that you can give the child a little extra special attention". (J ri 1 p. 5)*

The intention to familiarize the parent with the situation is referred to in the nurse's reflections:

> *"Of course the mother really knows a lot, even if she doesn't understand everything, and what she doesn't understand maybe she'll come back and ask about later. And she knows a lot about her son's illness. We're very open about information and contacts and so on. I think pediatric medical care is really good. The parents are involved in everything". (J ri 1 p. 8)*

This nurse also stresses her intention to create confidence in the hospital ward by being sensitive in everyday situations and by making sure that the parent knows what the nurse, as a professional, is doing for the child:

> *"I mean Erik's mother, she doesn't feel like a nurse, and I don't want her to either. But she should be included and know what we're doing. They [parents] should be able to trust us, and I feel as she [this mother] does". (J ri 1 p. 10)*

By being professional, knowing about the child's care, the nurse believes that she creates situations where the parents feels comfortable and can learn how to care for the child:

> *"When you're doing things, then you can ... well, the mother is often involved, with her eyes, and her manner if she has time, and she watches what you do and the like,....that the mother is involved and sees what's going on. The mother has watched so many times when we've done this and been involved and always asks why we do things". (J ri 1 p. 8)*

In the eliciting style parents' conditions are emphasized. The nurses spend enough time with the parents so that they can get to know each other as per-

sons. In the reciprocal acting, side by side with inter-reflections, the nurses seem to strive for deliberating parents' own resources to better care for their children.

There are to distinguished patterns of actions, within the eliciting style; *empowering actions* and *guided participation.* These will be further described in the following sections.

Empowering Actions

Within the eliciting style, being sensitive to parents' conditions in order to enable parental involvement and joint efforts in the care of children, the nurses sometimes explicitly reflect on their actions in terms of empowering parents' own resources, and strengths. They describe their attention to parents' conditions from a holistic perspective and their intentions as to impart power to parents to do something by themselves:

> *"A goal in the encounter is to empower the resources every family has on their own". (P ri 2 p. 7)*

It seems clear that empowering actions by the nurses enable and give parents ability to participate in the care by promoting their resources. Typically, arrangements are actively carried out in order to transfer power to parents and is referred to as *"a need to persistently ask parents to live-as-at-home"* (P ri 1 p. 15). An intention to facilitate the actual situation is common:

> *"So small things can make big differences, both for a child and a family and for the ward". (P ri 2 p. 18)*

Empowering actions are illustrated in the encounter situation below. Ebbe is a 4-month-old boy who has had surgery for congenital glaucoma in a larger hospital in another town. During the operation he suffered anaphylactic shock. Due to his poor condition and exhaustion he has lost weight. In order to improve his general condition and help the parents with feeding routines, he has been taken into the ward with both his mother and father. Several encounters take place during three hours with several interruptions, during the night. The first attention by the nurse towards the parents is at 10.15 pm when she makes her evening round to all wardrooms.

The nurse knocks on the door of Ebbe's room and opens it. She says good evening and enters. She shakes hands with the parents and reminds them that they met the previous week.

In the room there are two adult beds, one on either side of the baby's crib. A pram is placed inside the door. The mother, who is of Asian origin, sits with legs crossed on her bed.

The father is standing by the nursing table with Ebbe. /.../ Both greet the nurse in a friendly and cheerful tone. The father asks at once whether the tape on Ebbe's cheek should be changed as it has become a little wet. The nurse replies that that isn't necessary. It would hurt the boy to remove the tape and only cause him pain. "It doesn't matter if the tape is a little wet."

The nurse stands at the bottom of the bed where the mother is sitting. She asks how the feeding is coming along.

The mother expresses her happiness at having managed to breast-feed Ebbe his entire 9 pm meal of 80 ml. No supplement was required. Her Swedish is difficult to understand, but she keeps talking a great deal.

The nurse starts a long communication. Sometimes she turns to the father, who either clarifies or adds his own comments. She asks questions to find out whether the mother prefers to breast-feed. The mother nods and confirms that this is what she wants most of all, but she has so little milk and has to wait for it to come when Ebbe wants to eat.

The nurse tells her that the more Ebbe nurses, the more milk her breasts will give. If Ebbe is too weak to nurse, she can pump them to start the production of milk. Turning toward both of the parents she repeats this several times and in the same way. Then the mother tells the nurse that at home they have woken Ebbe up every hour to give him formula from a spoon. He hasn't had the energy to nurse.

The nurse asks them how they would like things tonight. She gives some suggestions. She can, for instance, come in at midnight to weigh Ebbe. Then they can let him nurse, weigh him again, and finally, if needed, they can give some extra formula through the feeding tube, up to 90 gr. The mother and the father agree that they need to sleep, and that Ebbe can sleep with the nurses after he has been breast fed to allow them to sleep by themselves in the room. But in case he whines and cries the mother wants him with her in the room.

"We'll try to comfort him and if it doesn't work we'll bring him", the nurse says. Several times the nurse has turned toward the father who is holding the boy to say: "He's such a wonderful baby." The father talks to the boy, who stretches out his arms and gurgles a little. After repeating what has already been mentioned about breast-feeding and sleeping, they agree that the nurse should return around midnight when it is time for breast-feeding. "We'll do whatever suits you best," the nurse says before she leaves the room. (R fd 1 pp. 10-12)

The nurse's orientation towards both parents is engaged, intimate, and reflecting. She supports and enables both of them. Her body position, by sitting down on the chair beside the bed and talking and facing both parents with frequent, sustained eye contact creates a pleasant and cozy atmosphere. She shows interest in the parents as persons and tries to 'read' how they want to arrange the situation. In the verbal communication there is an interplay

between parental knowing and the nurse's professional knowing which elicits the parents' reflections and give them opportunities to make their own choices. The nurse spend as much time with the parents as is needed for her to reach shared understanding of the situation and to integrate the parents in the care.

Later on, during this nurse's shift, another situation with the same parents takes place. At midnight she knocks on the door and enters the wardroom again.

> The father lies between the sheets in the adult bed by the window. The mother sits at the end of the bed. Ebbe lies sleeping next to the pillow.
>
> The nurse asks how things are going. The mother says that Ebbe has been grumpy and didn't fall asleep until 11.30 pm, but that now he's sleeping soundly. The nurse responds that in that case he's probably too tired to nurse now. "I wouldn't want to wake him up when he's just gone to sleep." That's what they did at home the mother says, as he has to eat. "But he just falls asleep, he's too tired." The nurse sits down in the chair beside the bed and talks to both the mother and the father again about starting the breast milk production by having Ebbe nurse every three hours or by the mother's pumping her breasts.
>
> She turns to the mother and the father alternately. The father has turned around in his bed to face the nurse. The nurse encourages the mother to pump now instead, to allow the boy to sleep while they are giving him the formula through the feeding tube.
>
> The mother says that she thinks she has so little milk because she doesn't eat enough rice, "there's just potatoes." The nurse replies: "Of course you can eat rice, but what's most important is that you eat and drink a lot." The mother agrees. */.../*
>
> A quarter of an hour later the nurse returns to the room. The mother is holding the pump against her left breast. The nurse sits down on the edge of the bed next to the mother. She watches the mother and assists her. Several times she stresses the importance of regular breast feeding or pumping in order to get the milk production started. The nurse urges the mother to sit comfortably and try to relax, and tells her that she can alternate breasts after a while. The nurse and mother observe together that there are 30 ml in the bottle. "That's good" the nurse comments, "then I'll give the baby that through the feeding tube at 3 o'clock. There isn't as much in the other breast. The mother says that her left breast is best. "Babies often have a favorite breast," the nurse replies. "Let him nurse at the other one when he is most eager," she continues. After a few more minutes the mother stops pumping. The nurse takes the bottle and the pump with her when she leaves, bidding them a good night. "Promise to bring the baby if he whines," the mother says. (R fd 1 p. 13)

The nurse's reflections concerning her intention of what she wants to achieve is:

> *"... what I wanted to do was to see how things had gone at home over the weekend with respect to feeding. And hear a little, check out, find out what the mother had planned, what she wanted, if she wanted to breast-feed or if she wanted to use a spoon for feeding. And try to support her in what she wanted to do, what she wanted then, and help her so that it would work". (R ri 1 p. 3)*

And when reflecting on her actions she declares:

> *"Hmm, I think it's important, because what I think and how I want things doesn't matter. You have to be sensitive and listen, because it's the mother, after all, who's going to breast-feed and it's her decision, and it's her baby, and it's her situation. I don't know anything about her home situation or what they really want. I have to ask so that it suits her, because she's the one who should decide how she's going to handle things with her baby". (R ri 1 p. 6)*

Eliciting, empowering situations typically are reflected upon by the nurses as situations where parents' strengths and resources are in focus. The nurse above demonstrates this by expressing her intention to understand the parents', especially the mother's, personal ways of living. Here she regards herself as a facilitator who can use her professional knowledge in empowering the mother:

> *R I think that as a caregiver you shouldn't take over so much, but that you should still see the child as the mother's child. It was really such a trifle, but that you don't do it, because it's so easy just to do it, completely mechanically, you take the child and lift it over, but, well, that the child knows that its mother is lifting it. Maybe you don't think it matters, but I think that for both the child and the mother, I think that it's just these small things that can be important.*
>
> *I What do you think is important to be careful about in this way?*
>
> *R Well, that the mother feels like she's participating. It's her child, so that we don't just go in and do things and, well, something like that. (R ri 1 p. 24)*

To a follow up question she continued:

> *"I think it's important to try to get the parents to see that he's a really terrific baby despite the fact that feeding is a problem and that they're having a hard time and such. /.../ so you select the good points and tell them to the parents so that you sort of, that they'll be proud of those things. If you say that he's a terrific baby and that's how it is, because it's important to the mother and father, they naturally want to hear that they have a great child. I believe that. And then if there are feeding problems and it's troublesome and the like, then you have even more of a need to hear that you have a great baby". (R ri 1 p. 24)*

Reflections on similar encounters reveal the nurses intentions with their actions as *"getting the other's bearings"* (J ri 2 p. 6). It is an active endeavor to 'be there', which makes them use more time in the encounters than what is required to complete instrumental work tasks. The nurses typically take the initiative to interactions by informal talks and by showing an interest in what parents and children want to say and to offer her view.

The informal way of learning to know one another, nurse and parent, is based on the nurses' holistic view of the situation. This commonly involves the nurses' tendency to be personal to some extent:

> *"I sort of open up a little and tell them about things I've done and so on, not too much, but just a little so that I get some contact, that they have a little confidence in me". (T ri 1 p. 12)*

Various proposals, encouragment of divergent possibilities of procedures or arrangements and supporting the ability to negotiate in situations, are typical for empowering actions.

The following situation illustrates a nurse's readiness to make proposals and offer choices with respect to parental thinking and problems. Elina is two years old, and her mother and little sister are on the ward. Elina has leukemia and receives chemotherapy every third week. During the other weeks she is cared for at home by her parents. The girl has received her medicine on the ward. Elina's mother is sitting on a chair in a far corner of the playroom. The little sister is sitting in a carriage in front of her. Elina is standing next to her mother. She is wearing a thermal coverall. The mother's coat lies on another chair next to her. (This indicates that they are just making a short visit on the ward.)

> The nurse sits on some drawers beside them. She busies herself with the little sister's cap and jokes and talks with her.
>
> Then suddenly the mother turns to the nurse and says: "What do other parents do who have children like Elina, who can't meet other children, so they can let off some steam? I'm going crazy. The way she flies around at home."
>
> The nurse says that some parents make use of play therapy, and then of course they have siblings. She jokes with Elina's little sister and says we'll have to give you growth hormone. The mother says no, she's at such a cute age.
>
> Now the nurse changes her voice and starts to talk in a serious tone of voice. They share talking about the fact that there aren't any appropriate children living near them. /.../ The nurse gives the mother an alternative, that play therapy may perhaps be a good solution for them. She can decide on several hours per week with the play therapist. Then she'll have fixed times. The mother looks interested. She has nothing against prearranged times, quite the opposite, she says.
>
> The nurse and the mother together agree that they should come back tomorrow and get the medicine here on the ward again. Then the mother says that she wants to try to give the medicine herself over the weekend.
>
> When they go to play therapy a while, the nurse again encourages the mother to talk with the play therapist about whether Elina can be there on a regular basis.
>
> (J fd 2 p. 4)

The way the nurses position their body is characteristic in the empowering, eliciting style. It is common that they squat down in front of parents and children. The nurses also quite often use humor and make jokes in the encounters, as the nurse in the illustration above does. Joking is described as a good way to elicit a relationship with parents:

> *"Joking can lead to good contact between us. Especially some of the fathers are that way". (A ri I p. 7)*

The focus in the empowering actions is on promoting families' coping skills:

> *"As a nurse I have to support parents' own power and mobilize their resources. I have to coach the strength they have and reinforce them. I have to make room for the parents, both the mother and the father to act. /.../ It takes a little time to see parents' power and resources. But you can get to know the power by listening and looking at how the parents act together and with the child". (P fd 3 p. 7)*

Guided Participation

Within the eliciting style, the nurses' intentions of guiding parents in specific and advanced care of their children are also expressed. Having children with illnesses places stress on all members in families. Some encounters contain arrangements to authorize parents to cope with changed and difficult circumstances and to teach them to carry out advanced tasks in the care of their child. This is particularly common when parents leave the hospital and need support and help to prepare to care for a child at home. Here, guided participation, where the nurses help parents to become able and skilled at settling new circumstances in everyday life by obtaining the knowledge that is needed. The arrangements are directed at accomplishing a recurring goal of encouraging parents' own resources to take care of their child.

This way of acting has similarities with Rogoff's (1990) ideas about apprenticeship, as a methaphor for circumstances through which individuals can learn. In guided participation, individuals take part in skilled and socially meaningful activities in an apprentice-like process. In this process, less experienced but resourceful parents are engaged with nurses who have professional knowledge about the activities. The encouraging of parents can be either tacitly addressed through social actions or explicitly structured through conscious teaching activities. Guided participation encompasses an intensive training with instructions that correspond to the parents' resources.

The guided participation occurs in arrangements where the relationship with the parents need to be enough established in order for the nurses to have sufficient knowledge about parents' activities.

An illustration of guided participation is given below. A mother lives-in with her son, 13-year-old Edmund, who has newly discovered diabetes. The following situation takes place in a wardroom during the nurse's afternoon shift. The intent of the caring is to have the parents accept the new conditions and what it will mean to the family. A colleague has reported to the nurse that the mother and the boy want to train injections this afternoon. The nurse has met the mother and Edmund briefly earlier.

> At 4 pm the nurse goes to Edmund to take a blood sugar test. The mother and Edmund are lying on their respective beds, which are placed close together. On the counter, which is intended as a treatment table, there is equipment for the injection of insulin and blood sampling. The mother has a bedside table by her bed with a phone that has been connected. /.../
>
> When the nurse comes the mother tells her that they have tried using an insulin pen several times. It worked well she thinks, and she asks Edmund for his opinion. The boy nods his head in agreement. "Okey," Edmund has pricked mother.
>
> "Good that you keep at it," the nurse says. The nurse talks to them about practicing using the pen, stressing that it is good to do so many times. /.../ Edmund is preparing the blood sugar apparatus with the needle. The nurse asks him to tell her how to do it, and Edmund explains as she proceeds. The nurse chats with him while she takes blood samples from the cannula on his right hand. She encourages the three of them to guess the blood sugar count. Edmund guesses 8, the mother 6 and nurse L guesses 5.6. It proves to be 3.6. They laugh together. The nurse talks to them about learning to fill a syringe. She explains that even if you use an insulin pen, you must know how to fill an insulin syringe from an insulin bottle. "You can practice with salt solution." Mother looks at Edmund and laughs, "Then we'll have a water war. Wrap up the bed in plastic." The nurse agrees and laughs. When the test is done and the nurse has put away the insulin, she leaves them. (L fd 1 p. 3)

Half an hour later Edmund's mother comes out to the nurses' office with a cup of urine. The nurse is writing on the chart, but looks up when the mother comes.

> The mother asks the nurse what to do with the urine sample. The nurse accompanies her out to the utility room. At the very back of the room, behind trash bags, a washing machine and rinsing machine there is a sink and cupboards. The nurse indicates the sheet of paper that is posted there for Edmund's tests. She demonstrates the test stick. Then she hands over the urine test stick to the mother and says, "You do it, you've done it before." The mother dips the stick.
>
> The nurse tells her to wait one minute. The timer that is supposed to be on the counter is gone, so the nurse uses her watch but stresses that there should be a timer here. "Edmund will enjoy this. He likes to time things," the mother says. The mother compares the stick to the chart on the container and reads the results. The

> nurse confirms this and shows the mother where to make the entry. Then she shows the mother where to put the trash. */.../* An hour later Edmund's mother comes to the nursing office again to find the nurse because the infusion pump squeaks. The nurse accompanies her to the room to adjust it. The mother is interested and asks several questions. The nurse shows her where to press to adjust it so that she can manage it herself if it happens again. (L fd 1 p. 4)

Later on another blood sugar test is taken and a new situation visualizes the enabling guiding, teaching, and supporting of the new conditions for both the boy and the mother.

These illustrations describe a common complex form of sociality in the eliciting style as it reveals both empowering actions and guided participation. The pattern of actions contains informal social talks running parallel with repeated information and teaching of new skills. The nurse comes up with frequent proposals and choices according to the parent's concerns. The nurses' experience of themselves in these advanced care situations is as professionals with specific practical knowing and experience. Their actions appear as guided participation with nurses as 'facilitators' to enable increased and entirely new knowing with respect to the children's illness. The empowering dimension in the action is, however, also obvious.

Typical for the empowering and guided participation actions is that the care of children is viewed as a common concern and it is a matter of concern for all actors to get involved in the care. The attention in nurses' actions is directed towards sensitivity for the 'readiness' of parents, and the way families cope in troublesome life situations. If there are more family members, attention is directed to the entire family:

> *"...that the whole family is involved in this, that all of them have been here, that all of them have seen how he gets his injections and his tests, and they're old enough so that all of them can learn, because it's the concern of the whole family".*
>
> *(L ri 2 p. 21)*

Also typical for empowering and guided participation actions is that parents are viewed as particular individuals with different strengths and resources which are positively valued and elicited. Relationships with parents are perceived as a kind of developing partnership, with a reciprocal and equal orientation:

> *" As much as possible parents are to decide about their own life. I have to listen to them, what they have to say. If it not will be medically dangerous, I want them to*

> *choose. I have to listen what they want. You can do things in many different ways". (P ri 2 p. 5)*

A further illustration of guided participation is taken from an encounter with a mother and her adolescent son, Evert. The son needs gavage feedings of a nutritional solution for several weeks in the home. The mother and a nurse had tried earlier to come up with a practical and appropriate way of giving the nutrition solution more quickly, in an adequate and practical way at home and in school. They have made agreements that it is important that it works well for both him and the family.

Later on in the afternoon the nurse meets Evert's mother at the door to the wardroom.

> Referring to their communication the day before, the nurse asks how they have done today with injecting the 'food'. The mother responds that they have done quite well, and that they probably can go home tomorrow.
>
> The nurse takes a peek into the room where Evert is sitting on the bed and says, "We'll talk a little here first and then we'll come in to see you." She asks the mother more questions about how long each meal has taken and how they feel about it. They share thoughts of the treatment. A few minutes later the nurse and the mother go into the wardroom.
>
> The mother sits down on the bed, which is placed next to Evert's. The boy is sitting cross-legged in his bed reading - leafing through a paper during the entire communication. The nurse sits down on a chair next to Evert's bed so she can see both Evert and his mother while they are talking.
>
> The nurse asks about the practical situation at home. How they can manage the schedule for giving the nutritional feeding and the long time it takes to inject the nutritional solution through the probe. "It feels like having a baby in the house again," the mother says.
>
> Evert keeps looking down at the paper. He confirms by nodding that he'll probably do fine, and shakes his head to say that he does not want to drink the solution. The nurse stresses several times that it is primarily the family and most of all "you, Evert, who should decide what hours and amounts are best in order to make things work out for everyone at home." She leans towards the boy saying this. He does not look up.
>
> The mother tells the nurse that the entire family is going to talk with a physician tomorrow. The father and the younger sister are also going to come to the hospital to take part. The nurse asks the mother if she may be present at the meeting. The mother would like her to. They confirm their agreement about the talk with the physician, and the nurse leaves the room. (O fd 1 p. 4)

This nurse describes her choice of actions to find proposals for a best solution for the boy and family. She reflects in terms of guiding the family:

I You emphasized a number of times how important it is that they find a way that works for everyone in the family. Then you turned to the boy and said: "especially that it works for you". You repeated that on a number of occasions. What were you thinking?

O I wanted some response. /.../ that he said what he thought and felt. Then it's once again that idea about two, that they should also take a little responsibility for the decision, help them make a decision they think is good.

I What are your thoughts when you express yourself this way?

O Hmm ... Mostly it's that they'll feel that together we can find the best solution, not that we nurses say and decide that this is how it is. In some situations you sometimes have to do so in order to help the parents if you see that they can't make such a decision. But I think that many times you can decide together and then I think it may feel better for them to sort of get a little help in reaching a solution. /.../ You have to listen and check the lay of the land. (O ri 1 p. 20)

The two patterns of actions within the eliciting style, empowering and guided participation, frequently occur together in the encounters. As empowering actions may occur without guided participation (more rarely vice versa), the two patterns of action have been described as distinguished. In all encounters, interpreted as dominated by the eliciting style, the nurses view themselves as facilitators in eliciting parents' strengths and resources and to make conditions for care familiar. This is done by *"check the lay of the land"*, listen, guiding parents by apprenticeship in actual situations and to prepare for the future. When using the eliciting style the nurses reflect on themselves as professionals, using both general human abilities and practical knowing to empower parents and guide them to learn new skills.

Eliciting Style: Summary and Overview

The eliciting style focuses on integrating parents in the hospital context. The nurses identify themselves as professional facilitators. The intentions are directed at enabling and empowering parents to use their own resources and articulate their wishes and opinions. Reciprocal communication in learning to know parents and families is essential. The nurses use more time than needed for complementing tasks and spend time for informal talk. Within the eliciting style, the approach is both task oriented and parent oriented and can include empowering actions and guided participation.

Content in actions and perceived meanings of actions categorized as belonging to the eliciting style are outlined in tableau D.

Tableau D. Eliciting style: Content and Meaning

Content of Actions		**Perceived Meanings of Actions**	
Verbal Communication	Questioning and answering Concern for shared understanding Joking	Intention	Familiarizing and integrating Enabling and empowering Promotion of resources
Non-verbal Communication	Frequent eye contact Close and encouraging body positions	Definition	Interested in parents' thinking 'See the lay of the land'
Arrangement	Encouraging parents to act by themselves by guided participation	Attention	Sensitive to parents' coping, resources and what they mean
Atmosphere	Interest in parents as persons and being personal informal related to daily life	Intersubjectivity: Understanding of self	Professional facilitator to enable parental involvement and knowledge
Time	More time spent with parents than required simply to complete tasks	Understanding of parents	Respect differences Every parent has strengths and resources
Social Orientation	Reflecting, and enabling	Relationship	'Enabling them' (child and parents)
Focus	Integration		

Collaborating Style

The fourth action style is the collaborating style. This style contains conscious reciprocal actions for and collaborating with parents and finding agreements on equal basis. Actions in this style focus on equal partnership and united efforts. The nurses' attention is directed towards parents' opinions and knowing with reference to the care of their child:

> *"To hear their ideas and thoughts in situations and what we can help them with and work together with them". (Y ri 1 p. 16)*

When the nurses' patterns of action constitute a collaborating style they usually know the parents during earlier encounters. Actions within the eliciting style had lead to a collaborating style. Through learning to know each other the nurse searches for shared understanding and co-operation.

The following illustration describes a situation where a nurse acts in a collaborating style towards a father with a 10-month-old daughter Charlotte. The girl was born with a too short intestinal tract. She is fed by gavage. On this particular day Charlotte is to undergo an examination of her small intestine. A pediatrician is going to do a biopsy. The day starts with preparations for the procedure and continues with the examination in another area of the hospital.

> It is nine o'clock in the morning. The nurse meets Charlotte and her father in the doorway to the nurses' office. The father is carrying the girl in his arms. He is also wearing a backpack. The nurse shows them into the room that is at their disposal during the day. The girl is to be weighed and measured at once and then prepared for the examination. The father puts Charlotte on the bed and takes off all her clothes except her diaper. Meanwhile the nurse has gone to the supply room to fetch a towel. When Charlotte is undressed the father picks her up and joins the nurse in the room where measurements are taken. The nurse and father are not talking to each other. The father seems to have been through this before and knows how to place Charlotte on the scales. On the step of the scales, which are on the floor, the nurse has placed a towel.
>
> The father lifts Charlotte up when the scales have indicated a weight and walks over to the bunk where the measuring stick is. The nurse stands at one end holding Charlotte's feet against the part, which is adjustable. The father holds the girl's head against the wooden support at the other end.
>
> When all the measurements have been done, the father goes to the wardroom with Charlotte. The nurse enters the treatment room and fetches the rolling cart, which she has prepared with equipment for dressings, and starts an IV.

When she returns to the wardroom, Charlotte is lying on the bed. The father has put on a pair of pants, but her torso, where the central venous catheter (CVK)[8] is placed, is exposed.

The nurse removes the old dressing on the tube and taps. She cleans and redresses the area. Meanwhile the father is holding Charlotte's arms lightly so she cannot get at the tubes. He stands beside the bed. He speaks lovingly to his daughter. She touches his face, babbling a great deal, "da,da,da." She utters no words but is happy all along.

The father and the nurse act side by side. The nurse looks frequently at the father. She makes a few comments about the dressing. Residue must be removed by means of a special solution. She asks whether they have problems with the dressing at home. The father comments that they now have this medical solution at home too. Charlotte kicks her heels against the bed, seeming to like the sound it makes. Her movements put her in a crooked position on the bed and now and then the father adjusts her position, moving her closer to the nurse.

Now and again the nurse asks the father if he thinks she should do "this or that". She talks about the sedative that will be given during the examination - the child may be a little drowsy afterwards. The father replies that she is usually drowsy the following day as well.

With her hands Charlotte finds the protective papers that were removed from the dressings when they are put in place and places them against her chest in imitation of the nurse. The nurse attaches the infusion to the tube when she has made sure that the central venous catheter works as it should. The feeding tube in Charlotte's nose has apparently been in place for a month. The nurse asks the father if they shouldn't remove it in preparation for the examination, after which a new one will be inserted. The father removes the tape attaching it to her cheek himself, pulls out the tube from her nose and gives it to the nurse[9]. Some mucous comes with it and he asks for a tissue to wipe her nose with. Then he puts a shirt on the child and removes the diaper.

Charlotte has moved her bowels. The father fetches a cloth and a new diaper from the backpack, while the nurse keeps the girl's bottom still. She comments that it is red. The father responds that right now it is fine compared to what it used to be like[10].

The girl is unhappy and cries. The nurse does not intervene but comforts her by saying that her father will be back soon.

The father wets a cloth and cleans the girl's bottom. Then he holds Charlotte's body still while the nurse gives her the enema. Charlotte demonstrates that this is uncomfortable and is a little unhappy.

The nurse says: "Let's put on the diaper right away so you can pick her up and comfort her." When this is done the father puts on Charlotte's panties and picks her up in his arms. The tubing has now been attached and the nutritional solution is hanging on a mobile stand.

The nurse asks if the father wants to stay in the room with the girl or move around on the ward, as she wants to know if the infusion should be regulated manually or

[8] CVK = A central venous catheter for giving fluids of foodstuff.
[9] Observational Comment: The child receives TPN (Total Parenteral Nutrition), and at home the parents feed their child through the probe themselves.
[10] Observational Comment: Charlotte's illness gives her corrosive and watery feces.

> run on batteries. The father hangs up the tubing cord on the stand, showing that is the way he wants it. The nurse leaves the room saying that she'll be back when it's time to leave. (IA fd 1 pp. 4-6)

The typical expressions in this nurse's actions, and in the collaborating style in general are identified in the communication. The nurse's verbal talk contains an exchange of questions and answers concerned with shared understanding and reciprocal agreements. The nurse and the father exchange opinions and wishes with each other in a negotiating manner. The nurse initiates arrangements by questions and the father shows his opinions and wishes by making decisions. In the non-verbal communication there is frequent eye contact between nurse and the father. They do not talk very much but the nurse stays close to the father and follows his actions and recognizes signs and cues by sensitive attention in order to grasp his opinions, wishes, and parental knowing. The nurse's activities occur in joint actions with the father's activities, with respect to shared resources and knowing concerning the little girl. Their co-actions indicate an atmosphere of both closeness and distance in an air of respecting each other's knowing and integrity.

The situation above went on for forty-five minutes. The amount of time that the nurse spend with the parent and child is determined by the time that is required to reach the agreements and to complete the task together in a socially open sphere of confidence. A new encounter, with the father and the little girl, occurred half an hour later, and illustrates the nurse's intention of reaching agreements.

> The nurse, the father and the little girl arrive at the examination room. The father puts the girl on the examination table on his own initiative. The father stands next to her. The nurse gets the items that are needed. The doctor comes in to say hello and then starts his own preparations. While doing so he asks the father how they have been doing at home since the last appointment and about Charlotte's health. Since x-ray will be used, they all put on lead aprons. A lead apron is placed on the table next to the father, and he puts it on. The doctor says to the nurse that Charlotte will now be "drunk on sleep."
>
> The nurse takes out the syringe with Dormicum and attaches it to one of the stopcocks by the infusion. The father holds Charlotte. When she has stopped prattling and her body is slack, the nurse tells the father to put her down. /.../
>
> During the entire examination [11] the nurse stands at the head of Charlotte's bed, checking her breathing and giving her oxygen when she needs it. The father and the nurse co-operate in holding Charlotte in the best position for the examination. The father takes many initiatives now as well. He wants to put the girl on her back. The nurse wants her on her side, which is done. /.../

[11] When the physician inserts the biopsy tube through a mouthpiece her mouth and down through her throat, esophagus and down via the stomach to the small intestine where x-rays and samples are taken, and during the sigmoidoscopy.

> When the examination has been completed, the doctor inserts a feeding tube down through Charlotte's nose. The nurse is about to fasten it to her cheek and intends to put a soft compress between the skin and the taper. The father protests sharply: "No damn tissue." The nurse excludes it and uses only the tape. The nurse then gives Charlotte an antidote to the sedative. When she is about to wake up, the nurse asks the father to put his daughter on her side. Soon Charlotte starts crawling, and then the father lifts her up and says that he will carry her back to the ward. (IA fd 1 pp. 10-14)

There are several encounters between this nurse and the father during a period of six hours. The nurse's collaborative style is shown in different co-operative actions during the subsequent situations. Her intentions and attention in choosing actions are:

> *"... to be obliging concerning parents' differences and to fulfill this father's wishes". (IA ri 1 p. 4)*

Her choice of co-operative actions is delivered in viewing the father as an equal actor. She respects his parental knowing and his opinions of arrangements. The nurse defines this co-operation as a kind of negotiation:

> *IA He's so determined, he wants things <u>his</u> way. And things should go fast and then be finished with. That's how he wants things.*
>
> *I On several occasions during the day you asked, "What does Dad think?"*
>
> *IA I think he should think something. He has to be involved in the way he wants things. It's not important to me if I do exactly as I would like. If he wants me to do things in another way, I will. (I ri 1 p. 7)*

This nurse declares her understanding of parent's actions as parental knowing, equal to professional knowing. This does not mean, however, that she regard herself as responsible for setting limits if necessary:

> *IA The father takes a lot of initiative. That's not negative. But then you have to be able to set limits.*
>
> *I Are there limits to flexibility?*
>
> *IA Yes, there have to be, if I see that the child isn't breathing, or that she's supposed to lie on her side for the biopsy, then I have to do something.*
>
> *(I ri 1 p. 8)*

In all kinds of encounters with parents the sick children's well-being always comes in first place for the nurses. From the nurse's point of view both actors know enough to make agreements to secure optimal care.

The nurse's intention, in the situation above, is to collaborate with the father by making agreements through negotiations:

> *"... I want the parent to cooperate and be as involved as possible, but I also want to have some necessary control of the child's well being". (IA ri p. 9)*

Negotiations as a means to reach common understanding are of great significance in the collaborating style. Verbal and non-verbal communication indicate the nurses' sensitive attention to parents' opinions and wishes, and their striving to reach concordance in understanding each other's viewpoints, within an atmosphere signifying respect for the situation and all actors.

In my search for information about explicit intentions of negotiating actions among the nurses who used a collaborative style, I found that they consistently denied having negotiated but instead referred to agreements. There seem to be no consciously planned negotiations. Answers such as *"it is bad to use such actions"* (A ri 2 p. 4) are common, but to make *"agreements with parents are good and necessary"* (A ri 2 p. 4). Despite being confronted with examples of what appeared to be negotiations, the nurses consistently maintained this position. To make agreements in a collaborating perspective is experienced as essential:

> *"Because in some way the parents are always the ones who know their child best, who know a lot about what things mean, and especially when you have children who are chronically ill and seriously ill. /.../ Then I think it's really important to try to work with the mother or father or whoever it is who's there, because they have an unbelievable amount of information to give. And you notice rather clearly if they think that no, I don't really agree with this or if they believe you're on the right track". (AA ri 1 p. 11)*

Another nurse using the collaborating style, reflects on her establishing a relationship of reciprocity and joint actions with a child's parents:

> *I How have you established such contact for working in collaboration?*
>
> *A I must say that that's a hard question. Since the child got sick I've talked with them and told them what's being done and what can happen. We've gone through things bit by bit and got to know one another. (A ri 1 p. 3)*

She also refers to the necessity to develop a close contact with the parents:

> *I What is it you observe and see in them to get to know them?*

A Well (sighs), you're with the child the whole time when you're giving treatments and medicine, so the child is the center of things the whole time, so in some way you're close to them the whole time.

I Because you're busy with the child the whole time, then you have the parents there the whole time?

A Yes, explaining what you're doing and talking about it. (A ri 1 p. 5)

In the collaborating style, parents are viewed as equals, delivering parental knowing to the situation. Accordingly, both actors negotiate with concern for understanding one another in making agreements and obtaining agreement concerning the best care of the child. The power is balanced between the nurse and the parent by join efforts in the care. Both parties express opinions and wishes with respect to their knowing in different situations. Sharing of feelings, experiences, and knowing is negotiated in order to reach agreements for restructuring of both partners' actions. Typically, the nurses refer to their meanings of actions as joint and collaborative and emphasize the importance of achieving concordance.

The negotiating verbal communication transfers opinions and wishes to reach agreements where both sides compromise and promise to do something for one another. These actions are combined with non-verbal communication of frequent eye contact and other kinds of signs of common understanding. Nurses who use collaborating actions try to respect parent's positions and give attention to signs and cues for making agreements. Verbal communication in the collaborative style includes informal social talks.

The amount of time, typically correspond to time needed to reach necessary agreements and complete tasks together. The reciprocity in the relationship is expressed as 'working together', and the joint actions signify close associated relationships regarding commitments towards each other. The nurses' knowing in the situations is delivered closely associated with parental knowing, which makes an atmosphere of two interrelated action processes of closeness and distance. The nurses maintain a professional distance towards parents and deliver knowing in nursing care in accordance with children's needs and parents' wishes and opinions. The professional distance includes respect for parents and their knowing and thoughts.

The following encounter illustrates the complex conditions in several situations where nurses act according to the collaborating style. It is a situation where a nurse prepares a cart for medical treatments. The cart contains medicines and

supplies for changing Clara's infusion bag and infusion setup. The girl is two and a half years old. She has leukemia, and receives cytostatic treatment in the hospital. She is staying at the hospital and her mother takes care of her. Her little brother is with them too. The nurse has been the contact nurse[12] for Clara and her family for the past year and their communication, containing a streak of humor, is indicative of the perception of a confident relationship where both partners respect the other's position. The nurse expresses it this way:

> *"Knowing each other allows us to joke together in situations". (A ri 2 p. 5)*

The following situation illustrates respect and reciprocity in nurses' co-operative orientation towards both the parent and her children. It starts at 9 am when the nurse walks into Clara's room.

> Clara is sitting on the edge of an open daily paper on the bed. The infusion is standing next to the bed. The junior bed has been pulled out into the corridor outside the room. "Hello honey," the nurse says to Clara. "Let's look at your chest (where the Porta Cath. is placed) and your tummy" (where the stopcock is). She lifts up her shirt. "Should I tickle your tummy too?"
>
> Clara looks at her and laughs. The nurse laughs and looks at how the tubing is placed inside Clara's panties. The mother approaches and laughs when she sees how the tubing comes out at the bottom of the panties. "She has put on the panties herself as you can see," she says to the nurse.
>
> "But where are you?" the nurse says to the younger brother, who crawls out from under the bed, almost. "Aha, *there* you are," the nurse says, "I didn't see you at first." The younger brother, around ten months old, can crawl a little and pulls himself forward to examine the floor.
>
> The infusion stand on wheels looks like great fun to touch. The mother moves him out a little on the floor and shows him some toys.
>
> The mother tells the nurse, who is removing tape to get at the stopcock in order to take samples and give medication, that they may be able to go home today if a certain blood count has sunk below 0[13]. "I know I shouldn't count on it beforehand," the mother says. The nurse agrees by nodding approval. She grabs the paper on the bed, and asks Clara to lift her bottom so that she can take the paper, and sits down in the chair by the window to read. /.../ The mother is reading the paper. Sometimes she looks at the nurse and smiles. The nurse looks over frequently at the mother.
>
> When the nurse is finished with the infusion, she helps Clara stand up in bed so she can remove the old tube that is all mixed up in Clara's panties. "What have you done?" the nurse laughs. The mother also chuckles. /.../ Clara crosses the floor pulling the infusion, which she calls "the squeak," with her. She drops the pacifier on the floor. /.../

[12] To keep continuity in nursing for a child who stays at the ward for a long time or stays frequently, there is a particular contact nurse for that child and the family.

[13] Observer's comment: Concerns the concentration of Methrotrexate in the blood.

> Meanwhile the nurse has assembled her gear on the cart and as she leaves the room she says, "We'll see what the test results show in a while." The mother nods. When the nurse is leaving the room the mother takes out some knitting from a bag. The little brother is on the floor and Clara is on her way to the playroom. (A fd 2 pp. 2-9)

By the attention to parents' signs and cues negotiations can be carried out to achieve agreements. The relationship signifies reciprocity and mutual respect:

> *I When you were going to attach the IV and give the medicine, you sat Clara on the bed and you two handled things. What are your thoughts in such a situation?*
>
> *A The mother is calm and secure. She could relax. She knows that Clara and I can take care of this, she knows that.*
>
> *I You believe that this means that it's nice to relax and that you can do this with Clara yourself?*
>
> *A Yes. It's only those times when Clara is unhappy or, well, if she's not in a good mood or doesn't want to do it, then she can resist, but usually it goes all right. If Clara wants to sit in her mother's lap, she can do that. (A ri 2 pp. 8-9)*

Such a vulnerable situation occurs later on. The nurse still chooses collaborative actions with respect to the arrangement to remove the infusion, including the needle in the Porta Cath, from Clara.

> When Clara learns that the needle in the Porta Cath is to be removed she is worried and starts squirming. Both the mother and the nurse comment that they know she does not like this, that it is troublesome and that she thinks it hurts, especially removing the tape that has been sitting around the needle for several days.
>
> The mother places Clara in her lap and sits down in the chair by the window. First the nurse has to take a blood sample from the stopcock. Clara calms down a little.
>
> Meanwhile they talk about the family's car problems. One is being repaired and the family needs two cars, as the mother brings both children when they go to take tests at the hospital. "You could take mine," the nurse jokes, "but there wouldn't be room in it for all of you."
>
> The nurse comments that her nose runs when she stoops, although she does not have a cold. The mother replies that here at the hospital she is not worried about infections. "I know you think about that yourselves" she says. Then they talk about the nice weather outside and say that it would be nice for the family to be outside when they come home. "But the doctor is going to call about test results so we'd better be inside," the mother says. The nurse encourages them to be outdoors. "Either he will call again, or you'll let us know you're out and then you can call us," she tells the mother.
>
> When it's time to remove the dressing and the needle again, the mother tries to bribe Clara with a visit to McDonald's afterwards. The nurse asks the girl about their dog. She would like them to bring a picture of it so she can see what it looks like. Then nurse and the mother look at each other. The mother says, "Now we'll have to hold you and do it so it goes fast." The mother hugs Clara and holds her arms in a

fixed position. The nurse removes tape and the needle from the porta cath. "She's so strong," the mother says. Clara is sad afterwards. She sits leaning her face towards her mother's bosom. The nurse sits facing Clara and her mother for a while.

After a while she says to the mother that she has wondered whether they should give Clara a sedative spray in her nose next time the needle is to be placed in the skin by the porta cath. The nurse does not like seeing Clara suffers so.

She explains to the mother that Clara will be tired for a while after the sedative spray but it may be better anyway. It will be more difficult to remove it before they go home, because then they must wait a while for her to come round before they can leave the hospital.

The mother listens and nods. Maybe it would be good for Clara to do it that way, as she finds it so hard, she says. At the same time the nurse and the mother ask themselves for whom it is worst; Clara, the mother, or the nurse? They will both think it over until next time so they can make a joint decision. The nurse remains seated next to them for a moment. The mother is going to straighten things up in the room before they leave, and Clara says that she wants spaghetti and meat sauce first. The nurse leaves them. The little brother sleeps in the pram outside and the nurse leaves the door open. (A fd 2 pp. 10-11)

The arrangement is expressed by their joint actions. Informal social talks and some joking make the difficult situation and activity easier:

I *You brought up Dormicum[14] with the mother. Is this an idea that's developed since you put in that IV needles in the beginning of the week?*

A *Yes, I've thought about it. About if things could be a little calmer then.*

I *Tell me about why you've taken it up now with the mother?*

A *So that she can think a little about it...if she wants it that way. /.../ what she thinks about it is important.*

I *Why?*

A *It sedates her and she gets tired and drowsy and the like, and it's important that the mother agrees about giving the sedatives. Not everyone does.*

I *Are you going to bring it up next time the situation arises?*

A *If everything goes well, it'll be 4 weeks from now when we put in the needle again. I'll bring it up again then. (A ri 2 p. 12)*

This transcript illustrates how agreements, as a kind of negotiations, is used by the nurse to reach shared understanding and find the best solution for pain reduction and to reach agreement with the mother, an intention typically referred to by the nurses in the collaborative style.

[14] Dormicum is a anesthetic used for pain reduction.

Collaborating Style: Summary and Overview

The collaborating style focuses on co-operation to achieve a confident partnership. The nurses' identify themselves as professional partners and equals in joint actions with parents. Their intentions are to make agreements, recognized as negotiations, to restructure their actions. Reciprocal communication and sensitive attention based on both actors' knowing. The time is used for considering and negotiating conditions in a situation. Informal social talks confirm a partnership. Within the collaborating style the approach is both task oriented and parent oriented.

Content in actions and perceived meanings of actions categorized as belonging to the collaborating style are outlined in tableau E.

Tableau E. Collaborating style: Content and Meaning

Content of Actions		**Perceived Meanings of Actions**	
Verbal Communication	Questioning and Answering Concern for shared understanding and agreements Negotiations	Intention	Collaborating through agreements
Non-verbal Communication	Frequent sustained eye contact and other cues	Definition	Co-operating and re-structuring of actions
Arrangement	Joining structure Co-acting	Attention	Sensitive to parents' knowing, opinions
Atmosphere	Both closeness and distance Respecting Mutuality	Intersubjectivity: Understanding of self	Professional knowing as equal but different to parental knowing
Time	Time required to reach agreement and complete tasks in reciprocity	Understanding of parents	As equal party bringing parental knowing
Social Orientation	Reciprocity	Relationship	'Collaborate with them' (child and parent)
Focus	Collaboration		

Approaches in Encounters

Concerns of parental interests, involvement, participation or mutuality are co-created by nurses and parents. Both actors have possibilities for alternative actions or non-actions. As professionals, familiar with the hospital context, the nurses have a given authority in recognizing conditions and selecting actions, but of course they cannot deliver actions isolated from parents.

An overview of focus, social orientation and relationships in the proposed action styles exhibits distinguishable approaches in the encounter situations.

In the assumptive and demanding styles the dominating focus is on parents' adaptation and accommodation to situations where task oriented arrangements are requested as a professional duty. The nurses' focus towards parents involve complying parental actions. In the assumptive style, focus is on parental maintenance and expectations on parents' own initiatives. This implies coping with parents and their participation through effecting work tasks as dimensions of professional interventions. The nurses' perceived meanings are transformed by intentions to 'organize them' - the child and parent - in a distanced relationship. In the nurses' arrangement inaugurations, serving, effecting, and pleasing parents are task oriented. In the demanding style, focus is on active accommodation of parents. Professional interventions here means assimilating parents into hospital care. Also in this style, the nurses' approach to parents is task oriented. However, a more explicit use of the nurses' professional superiority is shown. The perceived meanings are transformed by intentions to 'look after them' - the child and parent - in a controlling relationship linked to their duty. The task oriented approach in assumptive and demanding styles is linked with a unilateral social orientation.

In the eliciting and collaborating styles, focus is on enabling the parental resources and knowing, and on sensitivity to co-operate as equals in sharing the care of a child. This indicates an integration of the parents' view into the situation. In the eliciting style focus is on promotion of parental wishes and opinions. The actions assert to empower parents to be involved in the hospital care. Professional interventions in this style include parent orientation, and arrangement typically concern information helping, comforting, giving assistance to parents, and empowering through guided participation. The focus in the collaborating style appears as actions on an equal basis. This indicates a respectful, mutual commitment from the actors. Through negotiations, the nurses' arrangements respond to parents' wishes and opinions. The inter-

ventions are structured by joint actions with equal respect, sharing resources and competence. Both nurses and parents take initiatives towards each other to co-operate. The nurses' intention of parental involvement occurs via informal on-going nurse-parent exchange of talk and cues. The informal talk-sessions, during the activities, facilitate to achieve agreements in complicated decision-makings.

The constitution of a parent oriented approach, in the eliciting and collaborating styles, appears typically as a response to parents' needs and wishes during talk-sessions in ongoing nurse-parent exchanges and is linked with a reciprocal social orientation. The nurses create a structure in the encounters of joint efforts for reciprocity, through questioning answering, social talk and a kind of joking with each other. Typically, formal interventions are combined with informal talks and comments, referring to what is going on, what is happening to the child or parent, or what might happen in the future. These actions can be visualized metaphorically as "dripping water".

When analyzing and interpreting focus and social orientation in the action styles, two distinguished dimensions are found. One concerns *task orientation*, the other concerns *parent orientation*. When the encounter is characterized by a task oriented approach, activiries are carried out as a professional duty to adapt and accommodate parents into the hospital context. When the encounter is characterized by both a task oriented and parent oriented approach, effecting nursing tasks is combined with actions to assign parents and to establish commited relationships with them by turning families' conditions and requests into the hospital context.

Mastering encounters by focusing on tasks includes social actions as 'undertakings' and superior authoritative professional actions. The nurses' perceived meanings are concerned with professional habits, routines, and trained skills. Mastering encounters by focusing on parents includes informal social actions as integrated in professional actions. The nurses' perceived meanings are concerned with mutuality and equality in a 'partnership'.

A complete description of the content and structure of the action styles is outlined in two tableaus, The differentiated content of actions is outlined in tableau E, and the differentiated perceived meanings of actions in tableau F.

Tableau F. Action Styles: Content of Actions

Action Styles: / *Content of Actions:*	*Assumptive Style*	*Demanding Style*	*Eliciting Style*	*Collaborating Style*
Verbal Communication	Answering and directing. Short information and task-oriented talk	Questioning and answering Information Teaching	Questioning and answering Showing concern for shared understanding Joking	Questioning and answering Concern for shared understanding and agreements Negotiations
Non-verbal Communication	Distanced outlook Occasional and brief eye contact. Distanced body position	Frequent eye contact Body positions as assistance	Frequent sustained eye contact Close and encouraging body positions	Frequent sustained eye gaze and other shared known cues
Arrangement	Effectuating work tasks	Work tasks: instructions teaching preparation	Creating structure Encouraging parents to act by themselves and act together - side by side	Joining structure Co-acting
Atmosphere	Kind but cold	Sympathetic: making parents conform on 'the same wavelength' Reluctant: struggling for parental compliance	Interested in persons. Getting to know parents through invitations and talk closely related to daily life	Both closeness and distance Respect Mutuality
Time	Time together determined by time required to effect a task	Time determined by time required to complete tasks and arrangements	More time spent with parents than that is required simply to complete tasks	Time spent with parents determined by time required to reach agreement and complete tasks in reciprocity
Social Orientation	Distanced: acquiescent evasive resolute	Assimilative: confirming forcing	Reflective and enabling	Mutuality
Focus	Parenting maintenance	Accommodation	Integration	Collaboration

Tableau G. Action Styles: Perceived Meaning of Actions

Action Styles: / *Perceived Meaningsof Actions:*	*Assumptive Style*	*Demanding Style*	*Eliciting Style*	*Collaborating Style*
Intentions	Inviting parents as residents 'Getting the job done and do what is to do'	Assimilating parents	Familiarizing and associating with parents Enabling and empowering	Collaborate with parents through agreements
Attentions	Inaugurating and effectuating 'Being available'	Informing and instructing. Directing and suggesting. Complying	Sensitive to parents' coping, energy and meanings	Sensitive of parents knowledge, opinions and wishes
Definitions	To serve and help Inviting	To survey situations by controlling	Interested in parents' means 'See the lay of the land'	Co-operate and restructure
Intersubjectivity: Understanding of self	Being needed as a professional	Superior as professionals	Facilitator Professional knowledge to enable parental knowledge	Professional knowledge as equal part to parental knowledge
Understanding of parent/s	Take own initiative Want own territory	Want to participate by complying	Every parent has strengths and resources	As equal part bringing parental knowledge
Relationship	'Organizing them' (child and parent)	'Looking after them' (child and parent)	'Enabling them' (child and parent)	'Collaborate with them' pπ(child and parent)
Approaches	Task-oriented		Both Task-oriented and Parental oriented	

Common Themes in Nurses' Communication

Besides the individual practical knowing in encounters with parents it is revealed that the nurses, as a professional group in the pediatric context, have constructed shared knowledge of encountering parents. Identified as social representations of encountering parents, they appear as thoughts ordered around predicted and common themes, that enable them to classify and describe expressions or explain actions of parents and of their professional identity towards parents. These thoughts serve as socially embedded knowing concerning implicit and explicit forms of everyday social thinking and support and normalize their interaction with parents and their interaction as colleagues. Such 'socially shared practical knowing', therefore is likely to support the nurses' mastering and evaluating of encounters with parents in general as well as of particular situations.

It is not a coincidence that the nurses display shared knowing in encountering parents. They move and work as a social, professional group at the pediatric wards, sharing everyday practical activities. Ideas and beliefs of encountering parents proceed over time in all kinds of communication, as reports, talks, discussions and debates, and in actions related to more or less similar encounters with parents.

The identified social representations, revealed as socially shared knowledge, among the nurses in this pediatric context contain common themes in their communication of:

- Ideas of parents, parental activities and parental types.
- Ideas of the nursing profession, particularly expressed in terms of being a 'children's nurse', and ideas of uniformity and interchangeability in the nursing care.

These themes will be further described below.

Common Ideas of Parents

Parental Activities

A dominant and common theme, circulating in the nurses' communication, is that 'parents are the experts on their own children'. To 'help themelves' (in Swedish 'ta för sig') is a frequent metaphoric phrase in the nurses common talks. When the nurses talk about parents, they mention honesty, trust, creativity, and acceptance of differences among parents as they are, and of 'parental knowing' as 'expertise knowing' concerning their own children. Therefore, parents are expected to act and to 'help themselves' to take own initiatives in different situations in the hospital context. The nurses talk about parents as the ordinary care givers, expected to act 'as if they are at home', by using parental skills in the basic care of their children:

> *"...parents will take their own initiative when they get the chance, and they help themselves like at home". (F ri 1 p. 5)*

A common idea of parental activities is based on a wish to encourage parents' involvement:

> *AA "... many parents who are used to being here at the hospital, on a ward, they learn how to be and act if we [nurses] show them [parents]how to participate in the care. It is the parents' child. You want them to be there and they learn that they can use their opinions and wishes in accordance with the situations. They learn that they can act in that way, the parents who have been enabled in that style of care.*
>
> *I So it is something that you [nurses] have taught the parents?*
>
> *AA Yes, I think so. I think so. I think you can see that with parents who have been here as residents for a long time. (AA ri 1 pp. 19- 21)*

However, it seems as if there is a limit to the extent to which parents should help themselves. Dissimilarities arise between the ideas of expecting parents to 'help themselves', and 'act on their own'. On one hand, the nurses expect parents to act on their own, to insist that something will be done, and take own initiative of what they need. On the other hand there are thoughts that *"parents can make unreasonable demands"* (C fd 2 p. 3). The idea that parents should feel and activate themselves like at home, can be contrasted through the opposite idea of parental activities as being 'too much at home'. If parents act as too familiar with the hospital, the nurses think that they are 'used' as

professionals, and that parents are *"exploiting their methods" (C ri 2 p. 3).* The nurse describes later on:

> *"Such institutionalized parents formalize specific ways of being demanding in their activities towards us". (C ri 2 p. 4)*

The nurses also have common views about parents "who do not take the opportunity to help themselves". If so, the idea that parents are satisfied consumers of care is commonly expressed:

> *"Parents are satisfied if we provide everything they need for their own good.They are parents, no more, and if they look after what is best for the child and the professionals also do so, then things will work out. Then the wishes of both the parents and us are in accord, and that's why we're there". (N ri 2 p. 12)*

A shared belief among the nurses seems to be that in every situation there is a correct middle way for parents 'to help oneself'. The Swedish word used by the nurses to describe this 'right', moderate condition is "lagom". This little word means 'just the right way' of parental activities in different situations. Not too little, not too much, but just the right amount in the specific context. Why the idea of a "right way" of parental activities seems to be important for the nurses, is illustrated in the conversation below:

I *You perceived that some parents helped themselves more than others do?*

B *Oh, yes, yes.*

I *What's best? Working with parents who are demanding or with parents who don't act?*

B *It's a tough job if they act too much. The right way (lagom) is always the best, typical Swedish, but if the parents tear and pull at you the whole time, then that's a source of irritation. You can understand that they're worried, and you try to talk to them, but they have that worry, and that's trying. The mornings are stressful, and we have so many patients who are withdrawing from other people and want food and the like.*

I *Then what's the right way of actions?*

B *Well, only calling when there really is something, not asking the same question ten times even though you've explained it. Then you get irritated and don't create good relationships. But they know we're available and ask when they think it's necessary. Unfortunately we have no time for the worried mother who is running after us and pulling at us. She's the parent who'll get the worst care because there's no time to sit down as she wants to talk and listen.*

I *Then the right way for parents to act is to do the basic care on their own?*

> *B Yes, it's sort of necessary with the available workforce of nurses and the kind of children we have here. (B ri 2 p. 13)*

The shared ideas of parental activities, seem to be based on beliefs that either are parents eccentric when their children are sick and will 'help themselves', or parents 'help them-selves' because they have abilities concerning their sick child. These ideas in turn, seem to indicate different action styles in encounters and to influence what the nurses pay attention to in their delivering of actions.

Parental Types

The nurses commonly declare that they cannot deliver nursing care to the children without parents' presence and help. Their presumption is that:

> *"Parents are interested and motivated in the hospital care of their children".*
>
> *(B fd 2 p. 9).*

However, another common theme concerns parental types. It is apparent that the nurses always had a readiness for unexpected encounters with parents. They express that they always have to keep in mind that: *"You never know what parent it is"* (B fd 2 p. 9). Different parental types are referred to in their communication as argument for different actions. Some parents are *"easy to read in face-to-face"* and understand as *"interested and ready"*, other parents are *"trying and cumbersome"* (U fd p. 4). The different possibilities to 'read' and interpret parents' needs, stress, and wishes, determine priority and bring possibilities or obstacles into encounters. To moderate and normalize what happens in encounters with parents it seems as the nurses have developed common ideas of parents as being *excellent parents, disinterested parents* and *extraordinary parents*'.

The idea of excellent parents refers to parents who take of their own time to be with the hospitalized child and who relieve the pressure on the nurses by performing the basic care by their own. An excellent and capable parent can understand that it is a child's grade of illness, which determines the level of nursing care. Excellent parents are involved in the care during a hospitalization, and continue with the basic care of their child from their preconditions, and they help themselves in a 'good and right manner'. A usual comment in the nurses talks, referring to an excellent parent, is *"that is really a good and capable parent"* (K fd 1 p. 5). However, in the account of parental

involvement in the care the nurses may also question their own actions in encounters. In their talks of excellent parents they sometimes put thoughts into words as:

> *"It is true that the capable parents don't get the same attention on the ward".*
>
> *(L ri 2 p. 7)*

The other type of parents is the parent who lacks interest of being involved in the care. As the nurses deal with the face-to-face situation with parents, choice of actions becomes more difficult if the parent is disinterested. It is parents' feedback that the nurses act upon to create a relationship. Parents who do not want to be involved, or are not capable of being involved, are thought of as 'strangers'. When parents lack interest in being involved, the nurses seem to evaluate their actions in relation to the common idea of disinterest parents. The importance of parental participation in the care of disabled children is deeply incorporated in the hospital policy. Normally this is done by accommodating or integrating them into the hospital ward.

An illustration from the field describes nurses' evaluation of their actions towards disinterested parents. The illustration is from a communication between two nurses, which took place in the nursing office, concerning a newly arrived family with a child who was an accident victim, and who has been cared for earlier in the intensive care unit at another large hospital. The family consists of the father, the mother, the 2-year-old, and an 8-month-old little brother. In the earlier encounter, in a wardroom, the nurses felt uncertain about the boy's nursing needs. The nurses describe what happens during the encounter.

> Imagine that when I said to the parents, "The boy looks like he's comfortable. Don't you think he looks content?" Then the parents answered, "You know better than that!"
>
> The other nurse says that she had asked if the parents wanted to change the diaper and take care of the child. The father had then responded: "That's your job."
>
> In the nursing office the nurses looked confused at one another, made grimaces using their mouths, eyes and faces, shook their heads, but made no further comment. (M fd 3 p. 1)

In this case the nurses' intentions of parental accommodation to the hospital care was met by lack of interest. The account from this encounter was that the nurses hesitate in further encounters with these parents during this work shift (M fn 3 p. 3). The idea of disinterested parents normalized the nurses' non-actions. However, besides non-actions toward disinterested parents, the nurses

also communicated another approach towards disinterested parents to be persistent in the efforts to involve:

> *"You have to work hard for getting parents involved sometimes". (P fd 2 p. 18)*

Typically, parents who show lack of interest to be involved in the care is commonly viewed as; either a frustrating situation, from which one should keep away, or a challenging one, where the resistance should be met by efforts to work harder in the encounter. Both ways of mastering encounters with disinterested parents are respected and understandable in the nurses' communication.

A third type of parent is the extraordinary one. These parents are talked about as difficult to encounter as they have extraordinary expectations. This is the case when sometimes, things just 'happen' and the nurses become frustrated because of lack of control:

> *"What shall I do, the parent just went on with his critical questions /.../ I had to follow the doctors' advice". (C ri 2 p. 25)*

A parent with extraordinary expectations can influence a nurse to feel very uncertain and frustrated:

> *"I just can't meet that parent. She made me feel so crazy". (U fd 1 p. 13)*

To normalize their own actions in encounters with these parents the nurses talk about families who require extraordinary expectations concerning nursing care as troublesome. Sometimes these parents are referred to as knowing 'too much' and being 'too familiar' with the hospital context. *"They are a little too institutionalized" (K ri 1 p. 9).* One nurse describes an extraordinary parent in this way:

> *H They aren't your ordinary family, they aren't, they aren't one of the most usual families we have.*
>
> *I In what way are they not ordinary?*
>
> *H First of all, I think the family becomes special when they have a very ill child. There are certain demands and they, or the demands, they have a right to certain things, too, but, well, maybe they're a little too institutionalized. They know just a little too much about how things work here.*
>
> *I The parents?*
>
> *H Yes, the parents become too institutionalized, which can be both good and bad. It's great that they're here and for them to be involved in the care is a necessity, but it's, well, sometimes there can be a little too much of the family. (H ri 1p. 9)*

The nurses describe this type of parents as the ones who give orders and acts as superior, in the place of the nurses, and professional authority:

> C *They direct things quite a lot, these parents. Of course they're used to hospital staff and hospital care. /.../ They are extremely, how should I put it, involved in the care, almost a little too much. They have a lot of opinions and they contemplate a lot and they think for themselves and they want to change things.*
>
> I *Can they be too involved in the care?*
>
> C *I think I could be that kind of parent myself. I can understand them in a way, and it happens a lot with children who have problems like earlier with certain congenital conditions, that the parents know their child very well and we don't know them in the same way. We are knowledgeable about the medical aspects, but we don't know them, how they react to certain things. I don't think, I don't think we should say that we always know best when it's not a matter of medical facts. But sometimes it can be hard. (C ri 1 p. 6)*

The extraordinary parents, who are often familiar with the hospital and the wards and claim extreme expectations, are frustrating for the nurses to encounter. In dealing with such parents their shared knowledge seems to support actions to put a brake in the parents' actions and turn them towards a 'right' involvement in the wards, or to normalize non-actions.

Common Ideas of the Nursing Profession

The overall common idea of the nursing profession among the nurses seem to be that they are 'working with children'. The nurses also communicate shared ideas of uniformity and interchangeability.

Children's Nurse

The most common and all-embracing statement in the nurses' communication with each other is that they above all are 'working with children and a child's interest during a hospitalization'. This implies a professional obligation to take the children's perspectives. A common expression among the nurses is that *"the children always come first in our work" (J fd 1 p. 5).* They emphasize that the main position in their everyday work is to be on the children's side.

The nurses refer to their education in pediatric nursing care during which they dealt with issues such as psychological development, well-being, symptoms, treatment and the course of diseases in children. In their communications they also state, at the same time, that to care for babies and small children is also to take care for parents and involve them during hospitalizations and in changed life circumstances. As professionals they cannot overlook parents and families, because *"parents are important for the sake of children" (AA ri p. 8).*

The nurses also communicate common ideas about limits for parents' involvement and that conflicts may occur when these limits are overstepped:

> *"Caring for the children mostly works quite well. When there are sometimes conflicts in the care on the ward, then they are between parents and nurses. I don't say it's wrong, because they are naturally protecting their territory". (U ri 1 p. 16)*

Uniformity

The nurses have important collaboration and 'we-relations' towards each other as a professional group. As co-existing colleagues the nurses seem to share the idea of an ideal type of each other – a typification, who acts in the same way in encounters with parents. *"To do the same in situations"* (S ri 1 p. 12) is highly valued. This idea appears a strongly emphasized in the pediatric unit. Relationships between *a* nurse and *a* parent appear as subordinated to a *we*-relationship among the nurses working at the same ward. The following illustration is an example of the tendency to refer to the professional group's way of acting the normal:

> *'We [nurses] always do the preparation of surgery in this way. I [this specific nurse] want to change it a bit, but they [parents]have to get it in the same way because they all have to know the same things". (C ri 2 p. 6)*

Common arguments for doing the same as colleagues, is that parents will get confused otherwise:

> *"It is important that we try to do the same thing. Otherwise parents and children get very confused if things are not the same in situations". (A ri 2 p. 16)*

By not following shared ideas and views when giving information or arranging things the nurses' professional trustworthiness is perceived as threatened.

However, the nurses are aware that to do the same is impossible. A nurse comments:

> *"If you do things differently it is disturbing for the other nurses. But at the same time it is impossible to do everything in the same way". (G ri 1 p. 9)*

Common ideas concerning the value of imitate colleagues who have more experience, and 'back up each other' are also expressed:

> *"We work along the same line. ... We try to back each other up in every way. No one is better than anyone else, so we can all do things in the right way. Even if someone has more experience than the others we still try, because then families feel safer and more secure. And it's better for those of us working with the families if they can trust us. It is a requirement for us to be able to do a good job. To create a good relationship both actors have to trust each other". (K ri 1 p. 16)*

The outmost responsibility, however, is regarded as the individual nurse's:

> *"I can willingly tell them [the colleagues] how I would act, but they have to do it on their own, and I don't take something over which another nurse has started".*
>
> *(S ri 1 p. 17)*

The nurses describe total agreement about the importance of one another, both as individuals and as a professional collective, with respect to support and progress in the practical knowing of encountering parents. A nurse comments it like: *"Sharing experiences is the way we support and learn from each other" (G ri 1 p. 12).* The communication with colleagues in everyday occasions, during verbal reports or in work groups, confirms and corrects the nurses' thinking and knowing of routine or problematic situations. There is explicit consensus that they need this communication to transfer shared experiences and knowing of how to master parental concerns, and to develop uniformity in actions. A nurse, in a leadership position, summarize the importance of shared collective talks:

> *"Reports about the interplay with parents and families make nurses to learn from the confirming and correcting dialogues". (Af 1 ri 1 p. 8)*

To conclude, it seems vital for the nurses to transfer ideas, experiences and knowing to each other. They commonly refer to both tacit and outspoken support and assistance from the nursing collective:

> *"I manage and like this complex and tough work with parents because of support and assistance from the other nurses". (K ri 1 p. 27)*

Interchangeability

Through the shared idea of 'doing the same in situations' it is understandable that the nurses commonly refer to each other as having *"interchangeable positions"* (L fd 2 p. 5). Because of different work shifts, working at night, during the day and all over the pediatric unit, the nurses have to count on replacement by the nurses they collaborate with. This organization of work means that the nurses actually are viewed by the nurse manager and themselves to be interchangeable. Even during work shifts when one nurse is responsible for caring for a family, the other nurses have to be prepared to replace her so that she, for example, can be relieved for lunch. When a nurse goes off duty, another nurse will be able to care for the child and encounter the parents or a family. The nurses seem to agree about the importance to transfer 'as much knowing as possible to the nurse colleagues':

> *"You never know what will happen. That's why we all have to deliver actions of a similar kind in situations". (A ri 1 p. 16)*

The shared idea of interchangeability seem to be linked with a view of the identity of the nurse as insignificant. It does not matter which nurse who encounter which parents. However, the principle of interchangeability requires organized means to transfer information about children and parents between the nurses. In the studied unit this was not always done, something which cause problems:

> *"She [the mother] wants some special routines to be followed with her child. This wasn't in our documentation. It could actually have been written, and then she'd get irritated. When you'd come to her in the morning, she'd be annoyed and angry and would complain about it. This had happened at night, and yesterday they didn't do things the right way. /../ I think it's tough. You don't want to say anything about your colleague either. It's not that easy when you have an encounter when you haven't cared for them before so as to know exactly what they want. The mother understood this and also thought it was hard to make demands. Then we wrote down the routines that she wants for her child so it could be transferred to all nurses". (T ri 2 p. 6)*

The idea of interchangeability implies, by definition that it is not possible for parents to request a particular nurse to care for their child. In the studied unit, the idea of interchangeability was formulated in a document to support nurses in their encounters with parents.

> All of them [the nurses] have the same knowledge and want to do their best in all situations. (Report document from the pediatric unit.)

This common shared idea was also made explicit to parents so *"parents can feel safe and get the best of them all" (Af 2 ri 1 p. 6).* A nurse manager formulates the idea of interchangeability:

> *"... although families are their [nurses] patients, they are residents and we all have to treat them in the best and similar kind of way, the way the family wants, and be sensitive to the way they want things to be here with us". (Af 2 ri 1 p. 7)*

PART 6

Discussion, Implications, Conclusion

Discussion

The revealed practical knowing in encounters with parents, as described and conceptualized in this study, implies some particularly important aspects of joint care and mutuality, which will be discussed in the sections that follow. First, issues of joint care and mutuality as socially embedded knowing are discussed, emphasizing the fact that in order to fulfill the task of involving parents in the care of a child, the nurse inevitably need to establish a relationship by means of a combined professional and personal stance. This section is followed by a discussion of the presence of asymmetric relationships originating in the nurses' professional authority. Finally, socially shared knowledge as a basis for confirmation and predictability in a professional group is discussed.

Joint Care, Mutuality, and Professional Stances

Nurses in pediatric practice are required to establish professional social relationships in encounters with parents. Maintaining the sense of parenting while joining the care of a hospitalized child, prescribes symmetric relationships and mutuality in encounters between nurses and parents. The prospect of joining each other on a mutual basis has been identified as a central but problematic issue in this study. Even if mutuality is recognized as an important condition in order to facilitate parents' perceptions of being able to take initiatives and act themselves, the nurses' actions do not always convey this message. Although the nurses expressed a wish to support mutuality and participation, their actions sometimes announced something else.

One crucial core of professionality is the 'one-sidedness' caused by a professional dominance in relationships (Qvarsell & Linden, 1994). By means of using authoritative and/or committed actions in particular situations, the nurses in this study mastered the one-sidedness differently. An encounter offers a number of alternative actions, which, taken together, result in better or worse

possibilities to attain mutuality. Having defined mutual practice as an interpersonal structure, where both actors take initiative in order to complement each other in attaining joint care, mutuality between nurses and parents in a pediatric context is not easy to attain. To reach balance, between professional knowing and parental knowing, it seems necessary to overcome the inbuilt asymmetric relationship in the fundamental condition for the encounter between a nurse and a parent.

According to this study, the nurses' interpretations of joint care and mutuality implying the articulation of a nurse-parent relationship, seemed to constitute an important element in the nurses' professional stances. Here, the structure of action styles reveals distinctions in how nurses understand joint care and mutuality, with respect to relationships with parents. In this sense, the action styles can be regarded as an outline of differentiated practical knowing in a variety of situations. An essential question concerns how individual nurses' professional stances influence skills and perceptions in relation to parental involvement, realization of joint care, and mutuality. As was shown in the empirical data, individual nurses' intentions seemed to differ in terms of commitment to search for intersubjective understanding vs offering professional service, i.e. 'getting the job done' by giving information, taking specimens, etc.

Generally speaking a nurse's task of achieving mutuality and joint care with parents is doubtless recognized as being both difficult and challenging. However, a professional position implying dominance and asymmetric relation-ships with parents, provides certain opportunities and power to influence the situation. It is significant from this study that asymmetric relationships arose under particular conditions, where the nurses' approaches to involvement differed in terms of reciprocity.

In the assumptive and demanding action styles, characterized by a task oriented approach, the nurses seemed to ground the conditions for mutuality and parental involvement unilaterally by means of offering professional duties. Predetermined routines and skills were expected to involve mutuality in the sense of mutual goals, e.g. a healthy child, rather than involvement in means to reach the goal. In these situations moral obligations were referred to and seemed to evoke feelings that one 'ought' to carry out certain actions and that one needed permission from colleagues and management to act otherwise. Further, lack of adequate time, to fulfill all expected duties, was a commonly used explanation given by the nurses when reflecting upon restricted social actions.

Here, the notion of professional duties comprised in carrying out certain activities as a professional expert, by means of norms, directives and standards within the hospital context, seemed crucial.

On the other hand, in situations where the nurses acted in a reciprocal way through sensitively trying to find out 'how the land lies', their actions were oriented to learn to know a parent as a person. The eliciting and collaborating action styles comprise an approach, which are both task oriented in carrying out actions, and parent oriented involving personal informal social talks. In these situations, the nurses explicitly expressed that they wanted and had to carry out certain actions in accordance with a parent's wishes, opinions, and knowing. Here, the nurses' professional stance seemed to include a personal commitment with a conscious use of individual time and choice of actions with the parent/s in focus.

In this study the nurses' professional stance seemed to permit divergent practices for conducting joint care and mutuality, covering 'authoritarian professionalism' as well as 'committed professionalism'. When acting according to a committed professionalism, the nurses seemed to regard themselves as problem-solvers from the perspective of the parents, rather than from general professional duties. Further, committed actions seemed to involve a sense of meanings in the actions that directed nurses to transform and develop skills from thoughtfully weighed and reflected experiences of parental involvement. Actions interpreted as based on committed professionalism seem to constitute a base for empowering processes and guided participation.

Asymmetric Relationships

Policy documents, directing professional activities in the studied pediatric context, emphasize concordance in caring practice. These documents state that the professional orientation towards parents shall be grounded on an egalitarian basis. Parents are expected to participate by taking initiative, by performing basic care of their children, by participating in preparation of treatments, and by sometimes also performing rather advanced technical tasks in their children's care. The official policy for involving parents thus makes explicit that although the nurses are to establish an egalitarian relationship with parents, it is the nurses themselves who have the ultimate responsibility for the care.

This policy leaves the nurses to deal with inevitable asymmetric relationships with parents. Most of the nurses in this study expected themselves to be aware of and to keep a balance of power in the encounters. They regarded this as an obvious consequence of the fact that they were familiar with the hospital context and that they had professional knowledge of pediatric nursing. In line with what has been said, asymmetric relationships between nurses and parents thus was recognized and legitimated by the nurses, and by the hospital policy for nursing care and by patients.

The nurses in this study, when referring to all nurses 'doing the same thing' with respect to parents, emphasized the importance of maintaining 'uniformity' and interchangeability between themselves and their colleagues. This view, interpreted as shared thinking in the group, and verbalized in the nurses' use of the term "we" as a collective concept for their professional group, was frequently found in phrases such as, for example, "we always do it this way". The support within the group of nurses thus seemed to be an important contextual factor which, in addition to the ones mentioned earlier, may be regarded as influencing the professional power in particular situations

When the nurses perceived a need to defend their professional context, or when they wanted to act as advocates for children, parents or even colleagues, they found themselves in more or less open troublesome and challenging situations with respect to how they should deal with the asymmetric relationship between themselves and the parents. In the structure of action styles, three kinds of actions are suggested: organizing actions, complying actions and enabling actions. These will be discussed below from the perspective of keeping a power balance in encounter situations.

Keeping a Balance of Power by Means of Actions

Organizing Actions

In the first kind of actions the nurses in this study seemed to facilitate a balance of power by 'organizing the care' in a way that assumed parental involvement. Behind these actions, there is an expectation that parents will take the initiative to further social engagements and interaction if the nurses invite them to do so and confirm that they are available as professionals.

The consequences of this kind of professional dominance, in this study characterized by actions in the assumptive style, can be proposed as creating a space of 'freedom for parental engagement' in order to prevent parents from remaining uninvolved during the hospitalization of their child. This organized 'freedom' in the encounters can be used as an arena for parents' own actions to join in the care. However, such spaces of freedom may also cause parents to feel deserted in a hospital context. Ultimately, the consequences of organized arenas of freedom for the parents to act are likely to depend on nurses' and parents' determination of conditions in subsequent encounters and interactions.

Complying Actions

A second kind of actions, in keeping the balance of power within the professional dominance, is recognized in the demanding action style where the nurses take initiative by means of an authoritarian professional dominance, with active accommodation of parents into situational contexts and hospital life. Here, the nurses acted as professional superiors through in-order-to motives to control and assimilate parents by 'looking after them'. Such actions may confirm parents' wishes to participate in the care and the nurses in the study referred to them as means to balance their power in the relationships by facilitating assimilation of parents into the hospital context.

However, this participation and involvement in the care is based on the nurses' conditions. It is possible that some parents are content when supervised by nurses' controlling directions. But, there are situations in this study where the nurses had to act in an explicit authoritarian way to obtain parental compliance. In their reflections the nurses referred to these actions as used in situations where "*the professional authority gives me the power to tell what is best*" (Q ri 1 p. 7).

In these situations, accommodation of parents seemed to be identical with 'compliance'. Compliance[15], in this study concerns a view of parental adaptation in relation to control and authorized power conducted by the nurses in order to reinforce a professional view of what is the right and the best way of mastering a situation. In this study, accommodation and compliance seemed to be attained by allowing parents to undertake a vital role of comforting and

[15] The concept of compliance is defined in medical research as to what extension a patient's behavior is in accordance with medical ordinations, referring to medication as well as way of life. Research of compliance from this perspective is extensive but is not particularly referred to here (for example Richt, 1992).

supporting their children provided they were willing to be taught by the nurses about their child's care.

From the nurses' horizons the relationships within complying actions can be discussed as aiming at information and instruction without coming too close to parents in terms of sharing their meanings and wishes. From the nurses' perspective, it was obvious that professional knowledge and expertize was superior to parental expertise in institutionalized joint care. One may question whether such forcing and restricted actions contribute to parents' feelings of security in their parental role, or if they bring about discouragement and uneasiness.

The organization of parental presence by positioning them in a situation that demands compliance is similar to models of self-care in health and health promotion as presented in literature (Orem, 1985). Such models have extensively influenced health and nursing care as they, as collaborative models, are expected to reduce hospitalization costs and shorten length of stay. By means of routinized instructions and preparation of specific care, the philosophy of self-care acknowledges technical skills under the assumption that clients want control over things. However, criticism has been directed at this kind of self-care and models of involvement by complying actions (Leininger, 1991, 1992; Katim, 1995), because these actions do not account for either contextual or cultural differences. Further, as these models are largely directed towards patients as individuals, they do not, encourage a family orientated practice. Nor do these models acknowledge an interactionistic approach where learning to know one another's wishes, opinions and experiences need to be articulated.

In this study, the nurses confirmed an authoritarian position by referring to their professional superiority. According to Parmee (1995), compliance based on a professional superiority occurs through a medical mode of 'paternalism'. Wikander (1995) describes nurses' paternalistic actions towards parents in hospital care as being partly a response to parents' expectations in a situation where nurses take over the responsibility by doing things and giving advice to worried parents. Also Neill (1996) has noticed communication of a 'paternalistic nature' on the part of the professionals in pediatric contexts. In addition, Taylor, Pickens and Geden (1989) have described authoritarian instructions, involving consequences and control by means of looking after, as being "weak paternalism" (p. 50). These authors propose the concept of weak paternalism to be replaced by 'maternalism', as being more appropriate in a nursing context. In this study, situations where actions can be looked upon as

being maternalistic appeared when the nurses encountered parents in order 'to look after them' and to instruct them as performers of tasks as useful and competent parents. Although it may be regarded as necessary for the nurses to expect parents to help themselves in order to decrease their workload, there may also be risks with this approach. For example, Halldorsdottir (1996) has argued that it is important not to ignore nurses' maternalistic tendencies to control situations by putting themselves in a position of being responsible. Instead she suggests showing superiority, in terms of practical knowing, as more likely to improve nursing care (Halldorsdottir, 1996).

Enabling Actions

A third kind of actions in keeping the balance of power within the professional dominance was used within the eliciting action style. Here, the nurse acted as a facilitator to involve parents. By actively trying to associate a parent with the situation, by "checking the lay of the land", using informal social talks, as continuous 'waterdrops', the nurses encouraged parents to take part in the care of the child and to take their own initiatives. This kind of eliciting and enabling actions was also recognized to prepare for the collaborating action style.

In the context of children's hospitalization, the key element in a nurse-parent-relationship is likely to be the idea that parents are capable of assessing their own needs and the needs of their young children. Acknowledging parents as being experts on their own way of living, i.e. circumstances, aspirations, and requirements, may sound as an obvious policy in strategies for involving parents in the care of their children. Mutuality and intersubjective understanding from the nurses' perspective were revealed in this study as being strengthened by the use of inter-active reflections. Such inter-reflections for enabling and collaborating can be regarded as a kind of 'social negotiations' (Morse, 1991; Scannell, 1993; Kramer & Messick, 1995).

Morse (1991) argues that a process of negotiations in nurses' relationships with patients is connected with a degree of commitment towards each other. Furthermore, negotiations are suggested as important in empowering processes (Cochran, 1992; Connely et al., 1993; Söderbäck, 1996). By social negotiations a nurse can approximate the equality and cooperate in joint care of a child to give the parent/s an important position. In such encounter situations the nurse acts more as a resource mobilizer. According to Messick and Kramer (1995) everyday realities and emotions in institutionalized contexts are recognized as

mediators in negotiations and have impact on actions. The ways different participators in an encounter are affectively committed towards each other trace negotiations. To keep a power balance through negotiations, in asymmetric relationships, is likely to fluctuate over time depending on parents varying amount of information and skills.

The nurses' use of enabling actions in this study was mostly linked with a holistic family oriented perspective of pediatric care. Such a perspective is in accordance with the ecological theory for human development, proposed by Bronfenbrenner (1979, 1989) and used in family cenetered care approaches and models. Also assumptions derived from humanistic nursing knowledge set forth by Watson (1988) and Kim (1983, 1987, 1994, 1998), and dynamic views of a context as proposed by Hartrick (1995, 1998) is in line with this approach in encounters.

A holistic perspective on the part of the nurses involves actions to guide parents' self-awareness and self-helping as well as promoting their resources. The professional role on this explicitly intersubjective level, is that of 'moderator'.

Enabling actions as a way to establish power balance, correspond with Larner, Halpern and Harkavy's (1992) description of how social workers use transmitting actions which are responsive to a family's wants and preferences. According to Larner et al., such actions can be described along five dimensions. The first dimension concerns the balance between nurturing and guiding. The second dimension concerns the amount of time and attention devoted to families' and children's basic needs and personal adjustment. The third dimension is related to the dynamic balance between 'doing for' and enabling. The fourth dimension concerns support and practical help so as to create conditions that will permit parents to risk new ways of thinking, coping, and relating to others. Finally, the fifth dimension concerns parents' willingness to be empowered and to take responsibility for their involvement.

It is essential to have in mind that in this study the parental perspective is not investigated. The focus is limited to nurses' dealing with and mastering parental involvement. The parents can of course only evaluate their experiences of the nurses' actions themselves. However, it is likely to believe that if parents are forced into mutuality and collaboration, and if they are unable to handle the situation, disempowering barriers will probably emerge. There may be parents for whom certain circumstances mean that both time and consi-

derable repair work are required before eliciting their own resources becomes an option.

> Sometimes strengths must be built in before they can be built on. (Larner et al. 1992 p. 253)

In a relationship, inevitably based on professional dominance, actions oriented towards organization, compliance and enabling were used in the purpose of attuning parents to joint care in the hospital context. Considering the location of these strategies in the conceptualized structure of action styles, they can be used one by one or in combination in order to meet difficulties caused by the a-symmetric relationship between nurses and parents. When successfully used, parental involvement on professional as well as parental conditions probably will occur. However, this study has shown that the step from a general policy how to perform parental involvement into encounter situations is a difficult one. In order to initiate parental involvement, practical knowing about how to empower parents, how to recognize and encourage cultural and contextual issues and how to negotiate, is probably essential. According to Smeltzer (1991) nurses cannot attend encounters in hospital care or make any decisions without using negotiation. Smeltzer suggests minimized time of hospitalization, active participation in the care and nurses' availability as imperative to skills of negotiation. How nurses negotiate for clarification and agreement in different situations, when there is a stress on involvement and joint care certainly requires further research. Here, a contextual perspective is essential since the level of sociality vary (Messick & Kramer, 1995).

Socially Shared Knowledge in a Professional Group

When investigating the nurses' actions, in their mastering of encounters in different situations, it was obvious that certain ideas and beliefs of parents and of their professional position towards parents were shared and could be regarded as a particular dimension in the nurses' 'language of practice'. Considering these common themes in the nurses' reflections, it was assumed that this shared knowledge had developed in this particular professional group and their common professional context. The shared views, arguments, and knowledge can be regarded as a social 'cement', which maintained a sense of professional belonging among the nurses. In both routinized and problematic

encounters, collective ideas and beliefs seemed to bridge normative directives in policy documents, regulations and other information into the nurses' practical knowing. This way of looking at the complexity of practical knowing in a certain context is somewhat intricate. If shared knowledge means that the nurses carried out actions that were taken-for-granted in the particular context, they participated in a dynamic, collective process of interpreting and communicating conditions and meanings. Accordingly the nurses' ideas of acting in a moderate 'right way', delivering duties, or becoming committed and engaged in the relationships with parents, might be recognized as a collective dimension in the nurses' practical knowing. As such, it might have the function of sustaining collective agreements inside the professional group, i.e. by dissociating contradictive information from outside the group.

This study has indicated that practical knowing, as delivered by individual nurses, and collectively shared ideas of how to approach parents and how to perform nursing care may mirror one another. The complementing perspectives have pointed at a dynamic perspective of practical knowing in a pediatric field. This perspective implies that directives and regulations for a nursing practice are received and interpreted not only by individual nurses, but also at a group level. The fact that everyday practical knowing is socially constructed, through processes of transforming and conventionalizing knowledge, is not always taken into consideration. Although this study did not primarily look for collective dimensions in the nurses' encounters with parents, the importance of shared professional knowledge in the nurses' actions and reflections seemed clear.

Encounters as Pedagogical Situations

Encounter situations can be looked upon as constituting more or less obvious pedagogical arenas. Combinations of clear and distinct information, instructions and hidden agendas, emanating from directives and artifacts guide nurses' actions in everyday practice. Pedagogical processes in practical situations outside explicit educational settings, has been suggested to be implicit and 'immanent' (Ödman, 1995). According to Ödman, institutionalized contexts are likely to mediate such immanent pedagogy. When nurses enter into various encounters with parents and families,the situation can be looked upon as such an implicit pedagogical context.

The encounter situations are never the same, as child-patients, their families, social conditions, time and space change. In other words, nurses' professional conditions include variation and unanticipated situations, which requires an ability to pay attention to hidden alternatives and possibilities. It is likely that explicit and implicit pedagogical ideas transform intentions regarding how to approach parents and families in a relevant manner. Included in these considerations, a nurse also has to clarify what should be achieved in the encounter. In this study I have suggested a distinction between authoritarian and committed professional stances. These two approaches seemed to imply different pedagogical strategies. Using my conceptualization in the structure of action styles, two qualitatively different pedagogical principles are suggested. One principle emphasizes adaptation and accommodation of parents and families to task oriented circumstances at the wards. The other principle stresses parents and their resources and wishes. This implies eliciting and enabling actions in order to establish collaboration with parents. Here, a more explicit parent orientation in the nurses' actions was found.

These approaches may be regarded as two ways of socializing parents in hospital contexts. Hellesnes (1975) has suggested two models for socialization in pedagogical settings, which seem to be relevant here. According to Hellesnes one can distinguish between socialization characterized by adaptation and socialization characterized by framing. 'Adaptive socialization' is described as taking place within a passive structure without any consciousness as to what is going on. A 'framing socialization' on the other hand is suggested as taking place within a structure, which pays attention to the process of socialization and actively tries to influence it by encouraging the individual's own position in the situation. In this study the task-oriented approach can be looked upon as an element in the adaptive model for socialization, while the parent-oriented approach rather belongs to the framing model. When socializing parents into a hospital context the adaptation – framing approaches can be thought of as pedagogical strategies for involving parents, where intentions, goals to achieve and how to set limits are at hand. If one looks at the encounter situation as a context for socialization of parents, the nurse has a professional responsibility to 'educate' the parent. However, apart from giving instructions and information, she also has to create an atmosphere, which facilitates the process of increasing the parent's sense of involvement. It goes without saying that a varied repertoire of actions in combination with a reflected awareness of the totality in her task, are necessary requirements in this mission.

Implications

Nursing Practice

Although it is beyond the aim of this study to outline how to improve nurses' practical knowing in encountering parents, some comments will be made. It was interesting to note that the nurses who participated in the study reported that prior to the reflective interviews they had never reflected in a detailed way about their actions in encounters with parents. But through these reflections they seemed to attain new discoveries concerning limitations and opportunities in their professional practical knowing.

However, the conceptualization of nurses' practical knowing in encounters with parents, by means of the structure of different action styles, is derived from observations and reflective interviews. Even if the nurses' actions were unconscious and unreflected, they have contributed to the description of a rich and complex practice. The study thus verifies that unconscious actions do not mean lack of individual capabilities. Rather, it illustrates and articulate tacit knowledge as individual, unconscious capabilities, applied in familiar contexts (Polany, 1958; Lincoln & Guba, 1985; Molander, 1993)

The unconscious character, from the nurses' perspective, of the practical knowing in encounters requires more attention. This study has shed light on some of this taken for granted knowledge, for example that the nurses embrace an idea of the existence of a right kind and level of involving parents. Practical knowing, as it is carried out by individual nurses, is rarely articulated in the public professional contexts. Undoubtedly, in order to become verbalized and developed, experiences need to be reflected upon.

There are several examples in the results of this study that uncover elements in the nurses' practical knowing, which have not been described earlier, for example, the importance of non-verbal communication. Another example is that although the nurses said that theoretically they knew that parents cope best with uncertainty by receiving encouraging support, they continued to leave

them on their own. Or they automatically drew their attention away from a situation that could be emotionally trying. In still other situations, the nurses tendencies to use their embodied knowing by marking a bodily subordination to parents by squatting down beside them was interpreted as a way of decreasing their professional dominance. It was also shown that by using the informal parental orientation, such as social talk, use of humor, and placement of their body, the nurses expressed their perceptions of the parents and of what they found relevant in situations.

According to van Manen (1991a, b) flexibility and spontaneity within a tactful structure can complement formal knowledge in practice. For example when showing encouragement this has to be done with a certain sensitivity for the other's need, and can be regarded as a matter of acting thoughtfully. A conscious use of reflected thoughtfulness is likely to increase knowledge about what is needed in terms of skills in encounters.

It seems important to develop nurses' ability to reflect upon what a particular parent needs in terms of encouragement, support advice or comfort, and to explicitly regard this as an essential professional skill. Reflection on actions, and entire situations, can enable practitioners to become more aware of what they pay attention to in a situation (Schön, 1983; Boud, Koegh, & Walker, 1985; van Manen, 1991a). By means of a conscious pedagogical perspective of nurses' mastering of encounters with parents, a reflective practice can be developed within the context of a nursing practice.

Nursing Education

The implications for practice, derived from experiences in this study which emphasize social skills and abilities to meet various situations, are also valid with respect to nursing education. In this sense the understanding of a professional practice, advanced by this study, challenges assumptions of static, universal knowledge as a basis for successful nursing practice. According to what has been repeatedly observed in this study, the ability to establish relationship with families is of great importance in order to attain parental involvement and participation.

Here, the conceptualized structure of action styles can be utilized in nursing education to make explicit a variety of actions in relation to a broad collection of concrete situations.

By increasing the nursing student's awareness of slightly different nuances into social actions, their insights in possible versions of professional stances can be trained, as can their understanding of problems linked with professional dominance. Obviously, the articulation of social phenomena in encounters requires a language of practice in order to achieve awareness in situations. However, abstract concepts can never adequately describe the complexity in patterns of actions and qualitative distinctions between them. Learning and developing skills to involve parents require an educational context which recognizes the importance of experiential learning where various forms of sociality, e.g. distancing, intrusive, disruptive or enabling can be trained and reflected upon (Boud et al., 1985). Apart from sociality in this sense, the study has pointed at social skills, in terms of being able to interact and negotiate with parents, as important. Using a combination of training, these skills in practical contexts and conscious reflections on what was done in relation to what could have been done is likely to stimulate development of nursing students' professional skills.

To sum up, this study has made the complexity and variation in nurses' practical knowing in encounters with parents visible and within reach for students and educators to use in the process of developing nursing skills. Conscious reflections, based on a 'socio-nursing' approach, highlighting the two dimensions as inter-dependent, and focusing on students concrete experiences from the field of practice, seems to be a strategy to prefer. When considering the fact that nurses' practical knowing in the organization of today's health care face decreasing resources, particularly in terms of time, it seems more important than ever to consider, question, and develop educational practice for learning to develop social dimensions in nursing knowledge.

Quality and Transferability

In previous chapters (p. 55 and 107), issues of trustworthiness in relation to data production and analysis and interpretation procedures have been commented upon. Here, some questions concerning quality and transferability in relation to the study are brought up and discussed. According to Larsson (1993), criteria of quality in qualitative studies emphasize consciousness of perspective, richness of meaning in the result, and contribution to theory.

The study was based on a conscious epistemological perspective, which directed the development of a theoretical perspective and methodological approach. Accordingly, the fundamental view on nurses' practical knowing in encounters with parents, has been that it is a dynamic, complex, and social phenomenon. The theoretical perspective was based on this view and offered specific con-cepts, which were used as tools in the interpretation procedures. The methods, following a naturalistic approach, have been chosen in order to get as much information as possible by being as close to the concrete encounters as possible in the production of data.

Richness of meaning concerns whether a study provides results which can originate new meaning of the studied phenomenon (Larsson, 1993). In this study, identification, verification, refinement and differentiation of the data provided a richness of meaning in the sense that it revealed a substantial description of elaborated content in nurses' actions and reflections on actions. Such development of identified, differentiating concepts as was carried out in this study, has been suggested as pivotal for theory development of everyday nursing practice (Kim, 1992, 1994, 1998).

A critical issue in empirical studies is whether the findings are transferable to other situations and persons than the ones that have been studied. Here, it concerns whether the findings of action styles would have similar, even if not identical, meanings, relevance, and significance in other contexts (Lincoln & Guba, 1985). The restriction to a specific group of nurses and the limited context in this study has made it possible to intensify the focus and search for understanding and conceptualizing encounters in a specific, limited everyday pediatric practice. The question whether the results are transferable to other

similar situations and contexts or not, is still relevant but was not of primary interest in the study. However, encounters with parents in hospital settings are usually organized in similar ways and according to similar intentions. Although specific ideological and normative goals might vary between pediatric wards, as do the specifics of pediatric patients and their parents, the overall goal in pediatric units is essentially the same – to care for hospitalized children.

The overall goal of involvement and participation in hospital care might mean that what has been presented here, may have bearing on other groups of nurses, in other contexts pertinent to the subject of encountering relatives of hospitalized children or adults, emphasizing involvement and participation. (see e.g. Andershed, 1998). Nevertheless, further research is necessary to develop and confirm the results in this study.

Conclusion

In the overall aim of this thesis I promised to provide insights into nurses' mastering of encounters with parents in pediatric hospital care. The study has explored nurses' socially and professionally embedded stocks of knowledge by analyzing and interpreting their practical knowing as revealed in encounters through actions and reflections. As has been shown in this study the nurses' practical knowing was delivered through actions, which could not be understood simply as applied thoughts and wishes but were based on experiences, habits, claims, expectations, motivations and intentions in situations limited by time and space and influenced by the involved actors.

A description of a structure of four action styles has been conceptualized, which provides the results of the study in a summarized form. These action styles were identified in all types of the defined situations, i.e. those associated with entrance to or leaving the wards, taking specimens, treatments and general and specific nursing care. Furthermore, they were identified in all situations regardless of the children's kinds of illness or time and space limits.

It has not been easy to find a language that communicates complex, inter-connected and multifaceted actions. The conceptualized action styles constitute

the result of a systematic, stepwise procedure of interpretations of data, based on individual nurses' actions and reflections. However, the data also formed a 'pool' of information about the potentiality of actions and their perceived meanings at a group level. The conceptualized action styles can be looked upon as a "language of professional practice" for the studied group, which goes beyond individual nurses' performance of activities.

The identification of some themes in the nurses' socially shared knowledge about parents and of their profession gave the conceptualization of action styles a social quality, specific for the particular context in which they were derived. As the nurses expected parents to be involved in the hospital care and daily life at the ward, their actions were intended to affect them in some way. This mutual dependency between nurses and parents, seemed mostly to be taken for granted in the everyday practice, but was carried out differently in the encounters. A certain aspect of quality in the nurse-parent-relationship, concerned the nurses' 'in-order-to motives and intentions', and 'because-of' responses to parents.

Further, 'joint care', with nurse - parent as caregivers, seemed to be a challenge in the sense that it was built upon an unavoidable asymmetric relationship. The nurses' position was by definition stronger than the parents position, due to the former's professional status and familiarity with the context. The nurses in this study exhibited different action strategies to overcome this and to achieve balance between their own and the parents. An important dimension in the nurses' actions was their striving to perform just right actions (in Swedish 'lagom') to get parents involved. This idea seemed to be based on a common view of the existence of a 'correct' norm for what to do in a certain situation. However, since they also realized that they could never recognize what was 'just right', reflections on what was the right moderate actions were frequent among the nurses as was the search for right moderate actions.

The major theme for this study has been a concern with what kind of practical knowing the nurses delivered in their encounters with parents, and how this can be understood and described. The results of this study indicate clearly that nurses' practical knowing in encounter situations is closely related to social dimensions. The assumptive, demanding, eliciting and collaborating styles represent four professional approaches, all with the explicit intention of involving parents, but with different outlines for how to integrate social and professional dimensions.

Further Research

The expressions of actions in different styles, and their intertwining within an institutional context, leave a number of themes that constitute topics for interesting further research. It would be of interest to study more systematically the conceptualization within the structure of action styles for substantiation, differentiation, and validation, both in similar pediatric contexts and in other institutional contexts. Other practices, differing from the pediatric unit studied here, could probably develop detailed and complete descriptions of encounters with family-members, both in institutionalized contexts and in professionals' visits in home-based care. It would, in addition, be of interest to study more systematically the ways in which an action style in particular situations is contextualized as belonging to typifications of diseases, chronic or acute conditions, or personalized as connected with individual stocks of knowledge in social skills. The significance of negotiation skills by professionals also requires research in order to attain conscious, open-minded attention to these actions when encountering clients.

For contextual purposes, transcultural comparisons would be of great interest with respect to further research. A significant finding in this study is that enabling actions are probably cultural bound, both country-wide, and as regards towns versus rural areas and different social classes. Actions, which enable involvement of parents and families, need to be further investigated in a cultural and contextual perspective, both as in various Swedish institutional contexts, and with respect to cultures of institutional care of children and their families, and of adults and their relatives, in different countries. It is well known that a western view of encounters as an event between individuals is not valid in other cultures. Communal living is wide-spread in a large part of our world (Leininger, 1991, 1992).

In Southern African cultures for example, where the community as an extended family plays a major role, the rights of the individual must be weighed against the benefits they bring to the community at large. Here,'communitarian role' of extended families influences the interaction with all kinds of insti-

tutions in a society (Chachine, 1999). The nature of relationships between individuals thus depend on values and aspirations of the people in a particular culture and society. Obtaining knowledge about transcultural professional action styles in everyday nursing practices would be an important goal for a future research project.

Shared practical knowing, as associated with social representations in the nurses' practice appeared in this study. What such common everyday practical knowing in a group contains, and what ideas and beliefs about family members means for nurses' everyday work and practice, requires more systematic inquires in order to develop advanced knowledge about context-bound social actions. Such studies would be valuable contributors to understanding of social construction and distribution of action styles in different professional practices.

My inquiry aimed at examining professional nurses their encounters with parents. Nevertheless, the perspective of joint care and mutuality is of interest also for other actors in institutionalized practices. Research on being parents or relatives of hospitalized persons, or persons receiving home-based care, is still lacking. Further, the ways in which children and adolescents experience joint care with professionals and parents would be interesting perspectives for future studies. Working in teams where professionals and family-members are mixed also raises important research questions, particularly as advanced care to an increasing extent is provided at home.

A Final Remark

The conceptualization of nurses' action styles in their everyday pediatric practice has shed light on hidden and taken for granted relationships in a specific institutionalized context. It is my sincere hope that the present work will contribute to an enhanced interest and a better understanding of the 'small things that matter' in everyday nursing practice.

References

Ahmann, E. (1994a). Family-Centered care: the time has come. *Pediatric Nursing, 20* (1), 52-53.

Ahmann, E. (1994b). Family-Centered care: shifting orientation. *Pediatric Nursing, 20* (2), 113-117.

Alderson, P. (1993). European Charter of Children's Rights. *Bulletin of Medical Ethics, October*, p.13-15.

Alvesson, M., & Sköldberg, K. (1994). *Tolkning och reflektion. Vetenskaps-filosofi och kvalitativ metod.* Lund: Studentlitteratur.

Andershed, B. (1998). *Att vara nära anhörig i livets slut. Delaktighet i ljuset – delaktighet i mörkret.* (Doktorsavhandling). Uppsala: Uppsala universitet.

Andersson, M. (1998). Den goda sjuksköterskan - om etik och handledning. I K. Dahlberg (Red.), *HYV Handledning i yrkesmässig växt inom vården* (s. 20-32). Lund: Studentlitteratur.

Beach, D. (1995). *Making Sence of the Problems of Change: An ethnographic Study of a Teacher Education Reform.* (Dissertation). (Göteborgs Studies in Educational Sciences 100). Acta Universitatis Gothoburgensis.

Benner, P. (1984). *From Novice to Expert.* Menlo Park: Addison-Wesley.

Benner, P., & Wrubel, J. (1989). *The Primacy of Caring. Stress and Coping in Health and Illness.* Menlo Park, Calif.: Addison-Wesley.

Benner, P., Tanner, C. A., & Chesla, C. A. (1996). *Expertise in Nursing Practice.* New York: Springer Pub. Co.

Bischofberger, E., Dahlqvist, G., & Elander, G. (1991). *Barnets integritet. Etik i vårdens vardag.* Arlöv: Almqvist & Wiksell.

Blumer, H. (1969). *Symbolic Interactionism: Perspective and Method.* Englewood Cliffs (NJ): Prentice-Hall.

Boud, D., Koegh, R., & Walker, D. (1985). *Reflection: turning experience into learning*. London: Kogan Page.

Bowlby, J. (1953). *Child Care and the Growth of Love*. Harmondsworth: Penguin.

Bradley, S. F. (1996). Process in the creation and diffusion of nursing know ledge: an examination of the developing concept of family-centered care. *Journal of Advanced Nursing, 23* (4), 722-727.

Brembeck, H. (1995). *Efter Spock. Uppfostran idag* (3.e upplagan). (Doktorsavhandling). Göteborg: Etnologiska Föreningen i VästSverige.

Bronfenbrenner, U. (1979). *The Ecology of Human Development*. Cambridge, Mass: Harward University Press.

Bronfenbrenner, U. (1989). Ecological Systems Theory. In R. Vasta (Ed.), *Six Theories of Child Development*. (pp. 187-249). London: J. Kingsley.

Brown, J., & Ritchie, J. (1990). Nurses' perceptions of parent and nurses' roles in caring for hospitalized children. *Children's Health Care, 19* (1), 28-36.

Bruner, J. (1990). *Acts of meaning*. Cambridge Mass.: Harvard University Press.

Bäckman, G., Malmsten, K., & Olsson, U. (1998) Vård-etik – en relationell ansvarsetik. *Tidskriften VÅRD 3, 7-12.*

Callery, P., & Smith, L. (1991). A study of role negotiation between nurses and the parents of hospitalized children. *Journal of Advanced Nursing, 16* (7), 772-781.

Callery, P. (1997). Maternal knowledge and professional knowledge: co-operation and conflict in the care of sick children. *International Journal of Nursing Studies, 34* (1), 27-34.

Carlberg, G. (1989). *Dynamisk utvecklingspsykologi*. Stockholm: Natur & Kultur.

Carper, B. (1978). Fundamental Patterns of Knowing in Nursing. *Advances in Nursing Science, 1 (1), 13-23.*

Casey, A. (1988). A partnership with child and family. *Senior Nurse, 8* (4), 8-9.

Casey, A. (1995). Partnership in nursing: influences on involvement. *Journal of Advanced Nursing, 22* (6), 1058-1062.

Chachine, I. (1999). *African reflection on Christian marriage and Western reflection on Christian marriage. Do they conflict?* (Thesis). (Studies in view of life D20). Uppsala: Uppsala University.

Chinn, P., & Kramer, M. K. (1995). *Theory and nursing: a systematic approach* (4. ed). St. Louis: Mosby.

Cleary, J. (1992). *Caring for Children in Hospital. Parents and Nurses in Part nership*. London: Scutari.

Cochran, M. (1992). Parent Empowerment: Developing a Conceptual Framework. *Family Science Review, 5* (1&2), 81-92.

Connely, L. M., Keele, B. S., Kleinbeck, S. V. M., Kraenzle Schneider, J. & Kuckelman Cobb, A. (1993). A place to be yourself: Empowerment from the client's perspective. *Journal of Nursing Scholarship,25, (4), 297-303.*

Coyne, I. T. (1995a). Partnership in care: parent's views of participation in their hospitalized child's care. *Journal of Clinical Nursing, 4*, 71-79.

Coyne, I. T. (1995b). Parental participation in care: a critical review. *Journal of Advanced Nursing, 21* (4), 716-722.

Coyne, I. T. (1996). Parent participation: a concept analysis. *Journal of Advanced Nursing, 23* (4), 733-740.

Crossley, N. (1996). *Intersubjectivity. The fabric of becoming.* London: SAGE.

Dahlberg, K. (1994). *Vårdandets helhetssyn.* Lund: Studentlitteratur.

Darbyshire, P. (1993). Parents, Nurses and Pediatric Nursing: a Critical Review. *Journal of Advanced Nursing, 18* (11), 1670-1680.

Darbyshire, P. (1994a). *Living with a Sick Child in Hospital. The experiences of parents and nurses.* London: Chapman & Hall.

Darbyshire, P. (1994b). Parenting in Public. Parental Participation and Involvement in the Care of their Hospitalized Child. In P. Benner (Ed.), *Interpretive Phenomenology. Embodiment, Caring and Ethics in Health and Illness* (pp. 185-210). London: SAGE.

Darbyshire, P. (1995). Family-centered care within contemporary British pediatric nursing. *British Journal of Nursing, 4* (1), 31-33.

Dearman, A. (1992). Perceptions of parental participation. *Pediatric Nursing, 4* (7), 772-781.

Deitz, V. L. (1991). *Pediatric nurses' and parents' perceptions of parental participation in the care of hospitalized children.* (Dissertation). The University of Tennesse, USA.

Dixon, D. M. (1996). Unifying Concepts in Parents' Experiences With Health Care Providers. *Journal of Family Nursing, 2* (2), 111-132.

Donaldson, S. K., & Crowley, D. M. (1992) The Discipline of Nursing. In L. H. Nicoll (Ed.), *Perspectives on Nursing Theory.* (2 nd ed.). (pp. 204-215). London: Lippincott.

Dunst, C. J., Trivette, C. M., & Deal, A. G. (1988). *Enabling and Empowering Families.* Cambridge Mass: Brookline Books.

Dunst, C. J., Trivette, C. M., & Deal, A. G. (1994). *Supporting & Strengthening Families. Volume 1: Methods, Strategies and Practices.* Cambridge Mass.: Brookline Books.

EACH. (1993). European Charter of Children's Rights. *Bulletin of Medical Ethics, October, 1993.*

Edvinson, M. (1984). *Beredd på behandling.* (Redovisning 1984:4). Stockholm: Socialstyrelsen.

Eenfeldt, M. (1989). *Barn och föräldrar i samspel.* Lund: Liber.

Elander, G. & Hermerén, G. (1989). Autonomy and Paternalistic Behavior in Care. *Scandinavian Journal of Caring Science, 3* (4), 153-159.

Ely, M. (1993). *Kvalitativ forskningsmetodik i praktiken:cirklar inom cirklar* (C.G Liungman, övers.). Lund: Studentlitteratur (Original publicerat 1991).

Enskär, K. (1997). *Assessing the Life Situation of Children and Adolescents with Cancer and their Families.* (Dissertation). Linköping: Linköping University.

Erlöv, I., & Petersson, K. (1992). *Från kall till personlighet. Sjuksköterskans utbildning och arbete under ett sekel.* (Doktorsavhandling). Lund: Lunds universitet.

Evans, M. (1994). An investigation into the feasibility of parental participation in nursing care of children. *Journal of Advanced Nursing, 20* (3), 477-482.

Farrell, M. (1992). Partnership in care: pediatric nursing model. *British Journal of Nursing, 1* (4), 175-176.

Flick, U. (1998). Everyday knowledge in social psychology. In U. Flick (Ed.), *The Psychology of the Social.* (pp. 41-59). Cambridge: Cambridge University Press.

Flising, L., Fredriksson, G., & Lund, K. (1996). *Föräldrakontakt: en bok om att skapa, behålla och utveckla ett gott samarbete: en handbok.* Stockholm: Informationsförlaget.

Freire, P. (1968). *Pedagogy of the Oppressed.* New York: Seanury Press.

Gadamer, H. G. (1975). *Truth and Method* (translated by Garrett Barden). New York: Seabury P.

Guba, E. G., & Lincoln, Y. S. (1989). *Fourth Generation Evaluation.* Newbury Park, Calif.: Sage

Guba, E. G., & Lincoln, Y. S. (1994). Competing Paradigms in Qualitative Research. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research* (pp. 105-117). London: SAGE.

Gustavsson, A. (1996). *Att förstå människor – tillämpning av den formella datastrukturanalysen.* (Texter om forskningsmetod nr 1 1996). Stockholm: Stockholms universitet, Pedagogiska institutionen.

Gustavsson, A. (1998, aug.). *En hermeneutisk tolkningsmodell.* Konferens om Validering i Kvalitativ Forskning, Högskolan i Örebro, Sverige.

Halldorsdottir, S. (1996). *Caring and Uncaring Encounters in Nursing and Health Care - Developing a Theory.* (Dissertation). Linköping: Linköping University.

Haugen Bunch, E. (1983). *Everyday reality of the psychiatric nurse. A study of communication patterns between the schizophrenic and the psychiatric nurse.*(Dissertation). Oslo: Gyldendal.

Hammersley, M., & Atkinson, P. (1983). *Ethnography: Principles in Practice.* London: Tavistock.

Hammersley, M., & Atkinson, P. (1994). Ethnography and Participant Obser vation. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research.* (pp. 248-261). London: SAGE.

Hartrick, G. A. (1995a). Part 1: Transforming Family Nursing Theory: From Mechanism to Contextualism. *Journal of Family Nursing, 1* (2), 134-147.

Hartrick, G. A., & Lindsey, A. E. (1995b). Part 2: The Lived Experience of Family: A Contextual Approach to Family Nursing Practice. *Journal of Family Nursing, 1* (2), 148-170.

Hartrick, G. A. (1998). A critical pedagogy for Family Nursing. *Journal of Nursing Education, 37* (2), 80-84.

Hellesnes, J (1975). *Sosialisering og teknokrati.* Oslo: Gyldendal

Hägglund, S. (1999). Peer-relationships and children's understanding of peace: A socio-cultural perspective. In L. Bar-Tall, & D. Oppenheimer (Eds.), *Children's and adolescents' understanding of war, conflict and peace: International perspectives.* Jossey Bass.

Jodelet, D. (1991). Indigenous Psychologies and Social Representations of the Body and Self. In J. Jodelet (Ed.), *Madness and Social Representations.* Harvesten: Wheatsheaf.

Jodelet, D. (1995). Sociala representationer; ett forskningsområde under utveckling. I M. Chaib, & B. Orfali (Ed.), *Sociala representationer* (s. 27-56). Göteborg: Daidalos.

Johansson, A. (1986). Föräldrarnas intåg största förändringen. (1986, 13 april). *Dagens Nyheter.*

Johansson, B. (1983). *Konsten att kunna vårda. Om vårdpedagogik och omvårdnad.* (FoU-rapport nr 47). Stockholm: SÖ/Utbildningsförlaget.

Johansson, B., & Pilhammar, E. (1985). *Omvårdnadsarbete. Innehåll och kunskapsbehov.* (Rapport nr 1985:20). Göteborg: Göteborgs universitet, Institutionen för vårdlärarutbildning.

Johansson, B. (1989). *Omvårdnaden och dess villkor. En studie av kunskapsanvändning i förhållande till determinerande faktorer.* (Rapport nr 1989:1). Göteborg: Göteborgs universitet: Institutionen för vårdlärarutbildning.

Johansson, B. (1995a). *Forskningsprogram i Vårdpedagogik.* (Rapport nr 1995:2). Göteborg: Göteborgs universitet: Institutionen för vårdlärarutbildning.

Johansson, B. (1995b). *Quantitative or qualitative research - or a combination?* (Report 1995:3). Göteborg: Göteborg University, Department of Advanced Nursing.

Johansson, B. (1995c). *Omvårdnaden inom akutsjukvården i Skaraborgs och Älvsborgs läns landsting.* Rapport från projektet Aktiv Uppföljning. Stockholm: Socialstyrelsen.

Johansson, B. (1996a). *Från allmänmänsklig kompetens till omvårdnads-kompetens.* (Rapport nr 1996:1). Göteborg: Göteborgs universitet: Institutionen för vårdlärarutbildning.

Johansson, B. (Red.) (1996b). *Vårdpedagogisk antologi.* Lund: Studentlitteratur.

Jonsson, G. (1969). *Det sociala arvet.* Stockholm: Tiden/Folksam.

Josefson, I. (1988). *Från lärling till mästare.* (Fou-rapport). Lund: Student-litteratur.

Josefson, I. (1991). *Kunskapens former: det reflekterade yrkeskunnandet.* Stockholm: Carlssons.

Katim, I. (1995). The Contrary Ideals of Individualism and Nursing Value of Care. *Scholarly Inquiry for Nursing Practice: An International Journal, 9* (3), 231-239.

Kawik, L. (1996). Nurses' and parents' perceptions of participations and partnership in caring for hospitalized child. *British Journal of Nursing, 5* (7), 430-434.

Keatenge, D., & Gilmore, V. (1996). Shared care: a partnership between parents and nurses. *Australian Journal of Advanced Nursing, 14* (1), 28-36.

Kim, H. S. (1987). Structuring the Nursing Knowledge System: A Typology of Four Domains. In L. H. Nicoll (Ed.), *Perspectives on Nursing Theory.* (2 nd ed.) (pp. 134-142). Philadelphia: Lippincott.

Kim, H. S. (1992). An Approach to Concept Differentiation and Theory Generation in Nursing. *Korea Journal of Nursing Quary*, 7 (1), 44-55.

Kim, H. S. (1994). Practice theories in Nursing and a Science of Nursing Practice. *Scholarly Inquiry for Nursing Practice: An International Journal. 8* (No 2), 145-166.

Kim, H. S. (1998, april). *Nursing Epistemeology: Directions for the Future.* Paper presented at the Gortner Knowledge Development Retreat, University of California, School of Nursing, USA.

Kjellman, B., & Bourdin, M. (1982). Föräldrar på barnklinik. "Oväntat" positiv bild av klinik och personal. *Läkartidningen, Sep. 8;79* (36), 3075-3078.

Kramer, M. K., & Chinn, P. L. (1988). Perspectives on Knowing: A model of Nursing Knowledge. *Scholarly Inquiry for Nursing Practice. 2 (2), 129-139.*

Kramer, R. M., & Messick, R. D. (Eds.). (1995). *Negotiation as a Social Process.* Thousand Oaks: Sage.

Kristensson Hallström, I., & Elander, G. (1994). Parental Participation in the Care of Hospitalized Children. *Scandinavian Journal of Caring Sciences, 8* (3), 149-154.

Kristensson Hallström, I., & Elander, G. (1997). Parents' Experiences of Hospitalization: Different Strategies for Feeling Secure. *Pediatric Nursing, 23* (4), 361-367.

Kristensson Hallström, I. (1998). *Parental participation in paediatric surgical care. Clinical, ethical and economic considerations.* (Dissertation). Lund: Lund University.

Kristjánsdóttir, G. (1992). A study of the needs of parents of hospitalized 2- to 6-year-old children. *Issues in Comprehensive Pediatric Nursing, 14,* 49-65.

Kristjánsdóttir, G. (1995). Perceived Importance of Needs Expressed by Parents of Hospitalized Two- to Six-Years-Olds. *Scandinavian Journal of Caring Sciences, 9* (2), 95-103.

Kvale, S. (1996). *Inter Wievs.* London: Sage.

Köhler, E-M. (1973). *Samfostran. Pedagogik för föräldrar.* Stockholm: Aldus/ Bonniers.

Köhler, L., & Merrick, J. (Red). (1984). *Barns hälsa och välfärd.* Lund: Studentlitteratur.

La Montagne, L. L., & Pawlak, R. (1990). Stress and coping of parents of children in a pediatric intensive care unit. *Heart & Lung, 19* (4), 416-421.

Larner, M., Halpern, R., & Harkavy, O. (1992). *Fair Start for Children.* New York: Vail-Ballou, Binghampton.

Larsson, S. (1986). *Kvalitativ analys - exemplet fenomenografi.* Lund: Studentlitteratur.

Larsson, S. (1993). On Quality of qualitative studies. *Nordisk Pedagogik, 13*, 194-211.

Lauvås, P. & Handal, G. (1993) *Handledning och praktisk yrkesteori.* Lund: Studentlitteratur.

Lee, P. (1998). An analysis of Casey's conceptual framework. *International Journal of Nursing Studies* (35), 204-209.

Leininger, M. (1991). *Culture care diversity and universality: a theory of nursing*: New York: National League for Nursing Press.

Leininger, M. (1992). Self-care ideology and cultural incongruites: some critical issues. *Journal of Transcultural Nursing, Vol 4:1* (No 2), pp 2-4.

Liljeström, R. (1973). *Uppväxtvillkor. Samspelet mellan barn och vuxna i ett föränderligt samhälle.* Stockholm: Allmänna förl.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry.* Beverley Hills, Calif.: Sage.

Lindquist, Y. (1973). *Terapi genom lek.* Stockholm: Esselte Studium.

Ljungdahl, I. (1985). Föräldramedverkan - myt och verklighet. *Pedagogiskt magazin* (5)

Ljungström, C. (1985). *Lekterapi på sjukhus.* Stockholm: Liber.

Lundgren, M. (1988). *Sagans läkande kraft: sagoläsning som krisbe-arbetning för barn.* Stockholm: Wahlström & Wahlström.

Löfberg, A. (1994). Attaining quality. Some scientific and methodological implications. In B. L. T. van der Linden, & B. Qvarsell (Eds.), *The Quest for Quality* (pp. 29-45). Amsterdam: Stiching Kohnstamm Fonds voor Onderwijsresearch / SCO.

MacPhee, M. (1995). The Family Systems Approach and Pediatric Nursing Care. *Pediatric Nursing, 21* (5), 417-423.

McKenna, H. (1997). *Nursing Theories and Models.* London: Routledge.

Medicinska forskningsrådet. [Swedish Medical Research Council]. (1993). *PM angående ansökan till forskningsetik kommitté.*

Melnyk, B. (1994). Coping with unplanned childhood hospitalization: Effects of informational interventions on mothers and children. *Nursing Research, 43*, 50-55.

Merleau-Ponty, M. (1995). *Phenomenology of Perception (5e ed.)*. London: Routledge.

Merriam, S. B. (1994). *Fallstudien som forskningsmetod.* Lund: Studentlitteratur.

Ministry of Foreign Affairs. (1991). *United Nations Convention on the Rights of the Child.* Stockholm: Sweden.

Mogensen, E. (1994). *Lära i Praktiken. En studie av sjuksköterske-utbildningens kliniska avsnitt.* (Doktorsavhandling). Stockholm: Stockholms universitet.

Molander, B. (1993). *Kunskap i handling*. Göteborg: Daidalos.

Morse, J.M. (1989). Strategies for Sampling. In J.M. Morse, *Qualitative Nursing Research.* Sage Publications.

Morse, J. M. & Field, P. A. (1996). Nursing Research. The application of qualitative approaches. (Second edition) London: Chapman & Hall

Moscovici, S. (1984). The phenomenon of social representations. In R. M. Farr, & S. Moscovici, (Eds.), *Social Representations.* Cambridge: University Press.

Moscovici, S. (1998). The history and actuality of social representations. In U. Flick (Ed.), *The Psychology of the Social.* (pp. 209-247). Cambridge: University Press.

Neill, A. S. (1961). *The integration of a child into a social world.* London: Cambridge University Press.

Neill, S. J. (1996). Parent participation 1: literature review and methodology. *British Journal of Nursing, 5* (1), 34-40.

Nethercott, S. (1993). A Concept for all the Family. Family centered care: A Concept analysis. *Professional Nurse, Sep. 8* (12), 794-797.

NOBAB. (1992). *Nordisk standard för barns behov på sjukhus.* (The Nordic Standard for Children's Need of Care in Hospital). Stockholm.

Olin Lauritzen, S. (1990). *Hälsovård som rutin eller relation. Svensk mödra- och barnhälsovård möter invandrarfamiljer.* (Doktorsavhandling). Stockholm: Stockholms universitet.

Orem, D. E. (1985). *Nursing; concepts of practice* (3e ed.). New York: McGraw-Hill.

Orlando, I. (1961). *The dynamic Nurse-Patient Relationship. Function, Process and Principles.* New York: G. P. Putnam´s Sons.

Palmer, S. J. (1993). Care of sick children by parents: a meaningful role. *Journal of Advanced Nursing, 18* (2), 185-191.

Parmee, R. (1995). Patient education: Compliance or Emancipation. *Nursing Praxis in New Zeeland, 10* (2), 13-23.

Paterson, J. G., & Zerad, L. T. (1976). *Humanistic Nursing.* New York: Wiley.

Peavy, R. V. (1992). A Constructivist Model of Training for Career Counselors. *Journal of Career Development, 18* (3), 215-227.

Peplau, H. E. (1952). *Interpersonal relations in nursing: a conceptual frame for psychodynamic nursing.* New York: G.P. Putnams's Sons.

Perkins, M. T. (1993). Parent-Nurse collaboration: Using the Caregiver Identity Emergence Phases to Assist Parents of Hospitalized Children with Disabilities. *Journal of Pediatric Nursing, 8* (1), 2-9.

Pilhammar Andersson, E. (1991). Det är vi som är dom. Sjuksköterskestuderandes föreställningar och perspektiv under utbildningstiden. (Doktorsavhandling). (Göteborgs Studies in Educational Sciences 83). Acta Universitatis Gothoburgensis.

Pilhammar Andersson, E. (1996). *Etnografi i det vårdpedagogiska fältet - en jakt efter ledtrådar.* Lund: Studentlitteratur.

Pilhammar Andersson, E. (1997). *Handledning av sjuksköterskestuderande i klinisk praktik.* Göteborg: Acta Universitatis Gothoburgensis.

Platt, H. (1959). *The Welfare of Children in Hospital.* (Report of the Committee on Child Health Services.). London: HMSO.

Ploug Hansen, H. (1995). *I grænsefladen mellem liv og död. En kulturanalyse af sygeplejen på en onkologisk afdelning.* Copenhagen: Gyllendal Undervisning.

Polanyi, M. (1958). *Personal knowledge.* Chicago: Routledge & Kegan Paul.

Prus, R. (1996). *Symbolic Interaction and Ethnographic Research. Intersubjectivity and the study of Human Lived Experience.* Albany: State University of New York Press.

Qvarsell, B. & v. d. Linden, B. L. T. (1994). *The Quest for Quality, the evaluation of helping interventions*: Amsterdam: Stichting Centrum voor Onderwijsresearch.

Qvarsell, B. (1996). *Pedagogisk etnografi för praktiken – En diskussion om förändringsfokuserad pedagogisk forskning.* (Texter om forskningsmetod. Nr 2). Stockholm: Stockholms universitet. Pedagogiska institutionen.

Richt, B. (1992). *Mellan två världar. Om konflikten mellan livets krav och doktorns önskningar. Lärdomar från familjer med diabetessjuka barn.* (Linköping Studies in Arts and Science, 75). Linköping: Linköpings universitet.

Robertson, J. (1970). *Young Children in Hospital* (2 ed.). London: Cambridge University Press.

Robertson, M. H., & Boyle, J. S. (1984). Ethnography: contributions to nursing research. *Journal of Advanced Nursing, 9* (1), 43-49.

Rogoff, B. (1990). Apprenticeship in Thinking: Cognitive Development in Social Context. New York: Oxford University Press.

Rooke, L. (1994). *Omvårdnad. Erfarenhet-reflektion-teori.* Lund: Studentlitteratur.

Rowe, J. (1996). Making oneself at home? Examining the nurse-parent relationship. *Contemporary Nurse, 5* (3), 101-106.

Rushton, C. H. (1990). Strategies for Family-Centered Care in the Critical Care Setting. *Pediatric Nursing, 16* (2), 195-199.

Sanday, P. (1983). The ethnographic paradigm. In J. Van Maanen (Ed.), *Qualitative Methodology.* (pp. 19-36). Thousands Oaks: Sage.

Scannell, S. (1993). Negotiating Nurse-Parent Authority in Paediatric Home Health Care. *Journal of Paediatric Nursing, 8* (2) 70-78.

Schutz, A. (1962). *Collected Papers I, The Problem of Social Reality.* Haag: Martinus Nilhoff.

Schutz, A. (1967). *The phenomenology of the Social world.* Evanston: North-western Univ. Press.

Schutz, A., & Luckmann, T. (1973). *The Structures of the Life-world, Vol. I.* Evanston, Illinois: Northwestern University Press.

Schutz, A., & Luckmann, T. (1989). *The Structures of the Life-world, Vol. II.* Evanston, Illinois: Northwestern University Press.

Schwandt, T. A. (1994). Constructivist, Interpretist Approaches to Human Inquiry. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research* (pp. 118-137). London: Sage.

Schwartz-Barcott, D. K., & Kim, H. S. (1986). A Hybrid Model for Concept Development. In P. Chinn (Ed.), *Nursing Research Methodology: Issues and Implementation* (pp. 91-101). Rockville: Aspen.

Schön, D. A. (1983). *The reflective practitioner: how professionals think in action.* New York: Basic Books.

Silva, M. C., Sorrell, J. M., & Sorrell, C. D. (1995). From Carper's patterns of knowing to ways of being: An ontological philosophical shift in nursing. *Advanced Nursing Science. 18, (1), 1-13.*

SFS 1976:280. *Lag om rätt till föräldraledighet.* [in The Swedish Social Act]

SFS 1976:381. *Lag om barnomsorg.* [The Swedish Childcare Act].

SFS 1980:620. *Socialtjänstlagen* [The Swedish Social Act].

SFS 1982:763. *Hälso- och sjukvårdslag.* [The Swedish Health and Medical Service Act].

Shelton, T. L., Jeppson, E. S., & Johnson B. H. (1987). *Family-centered care for children with special health care needs.* Bethesda: Association for the care of Children's Health.

Shelton, T. L. (1995). Excerpts from Family-centered Care for Children Needing Specialized Health and Developmental Services. *Pediatric Nursing, 21* (4), 362-364.

Silverman, D. (1987). *Communication and Medical Practice. Social Relations in the Clinic.* London: Sage.

Sjöström, B. (1995). *Assessing acute postoperative pain. Assessment strategies and quality in relation to clinical experience and professional role.* (Dissertation). (Göteborgs Studies in Educational Sciences 98). Acta Universitatis Gothoburgensis.

Sjöström, U. (1994). Hermeneutik - att tolka utsagor och handlingar. In B. S. Starrin, & P-G. Svensson (Red.), *Kvalitativ metod och vetenskapsteori* (s. 73-90). Lund: Studentlitteratur.

Skau, G. M. (1993) *Mellan makt och hjälp. Förhållandet mellan klient och hjälpare i ett samhällsvetenskapligt perspektiv.* Stockholm: Liber

Smeltzer, C. H (1991). The art of Negotiation. An everyday Experience. *JONA, 21 (7/8). 26-30.*

Socialstyrelsen. (1991). *Den slutna barnsjukvården i Skåne – struktur och kvalitet. Aktiv uppföljning.* (Projektrapport). Stockholm: Socialstyrelsen.

Socialstyrelsen. (1992). *Barnsjukvårdens struktur och kvalitet i Norrbotten och Västerbotten. Aktiv uppföljning.* (Projektrapport). Stockholm: Socialstyrelsen.

Socialstyrelsen. (1993). *Barnhälsovård, barnsjukvård och barnomsorg. (Enköping, Östhammar och Gotland). Aktiv uppföljning.* (Projektrapport). Stockholm: Socialstyrelsen.

SOFFS 1993:17. Omvårdnad inom hälso- och sjukvården. (Socialstyrelsens allmänna råd). Stockholm: Socialstyrelsen.

SOFFS 1995:15. Kompetenskrav för tjänstgöring som sjuksköterska och barnmorska. (Socialstyrelsens allmänna råd). Stockholm: Socialstyrelsen.

SOU 1975:87. Barn på sjukhus. Stockholm: Socialstyrelsen.

SOU 1990:44. Demokrati och makt i Sverige: Maktutredningens huvudrapport. Stockholm: Allmänna förlaget.

Spence, J. (1951). The doctor, the nurse and the sick child. *Canadian Nurse, 47,* 13-16.

Spitz, R. (1945). Hospitalism. *Psychoanalytic Study of the Child, 1,* 53-74.

Spradley, J. P. (1980). *Participant observation.* New York: Holt, Rinehart & Winston.

SPRI. (1997). *Verksamhetsuppföljning av barnmedicinsk vård 1996* (SPRI rapport 1996). Stockholm: Spri och Barnläkarföreningen.

Stenbak, E. (1986). *Care of Children in Hospital.* Copenhagen: World Health Organization.

Stockfelt, G. (1975). *Föräldramedverkan: en studie av samarbete mellan föräldrar och personal på en sommargård.* (IAN-rapport; 146). Stockholm: Stockholms universitet, Pedagogiska institutionen.

Stower, S. (1992). Partnership caring. *Journal of Clinical Nursing, 1 (2),* 67-72.

Streubert, H. J. & Carpenter, D. R. (1995). *Qualitative Research in Nursing: advancing the humanistic imperative.* Philadelphia: Lippincott.

Sundström, P. (1996). *Sjukvårdens etiska grunder.* Göteborg: Daidalos.

Söderbäck, M. (1992). *Föräldramedverkan i vården av sjuka barn - en feno-menografisk studie om sjuksköterskors uppfattningar.* (Uppsats inom Pedagogik 60 p.). Högskolan i Örebro, Institutionen för samhälls-vetenskap.

Söderbäck, M. (1994). *Sjuksköterskors möten med föräldrar på en vårdavdelning. En pilotstudie.* (Opublicerat manuskript).

Söderbäck, M. (1996). *Nurses' Empowering of Parents in Pediatric Settings: a conceptual analysis.* (Health Care Pedagogy – Nursing, Report 1996:5). Göteborg University: Department of Advanced Nursing.

Taylor, S. G., Pickens, J. M., & Geden, E. A. (1989). Interactional Styles of Nurse Practitioners and Physicans Regarding Patient Decision Making. *Nursing Research, 38* (1), 50-55.

Thompson, I. E., Melia, K. M., & Boyd, K. M. (1994). *Nursing Ethics.* Edinburgh: Churchill Livingstone.

Townsend, E. A. (1992). Institutional Ethnography: Explicating the Social Organization of Professional Health Practices Intending Client Empowerment. *Canadian Journal of Public Health, 83* (Suppl. 1), 558-561.

Travelbee, J. (1971). *Interpersonal Aspects of Nursing.* (2 ed.). Philadelphia: F.A. Davis Company.

Trivette, C. M., Dunst, C. J., & Hamby, D. W. (1996). Factors Associated With Perceived Control Appraisals in a Family-Centered Early Intervention Program. *Journal of Early Intervention, 20* (2), 165-170.

Tunstall, Y., & Prudham., W. (1997, sept.). *Who dares wins! The lived experience of implementation of Casey's framework.* Paper presented at the Children's Nursing: Creating the future, Belfast, Northern Ireland, UK.

van Manen, M. (1977). Linking Ways of Knowing with Ways of Being Practical. *Curriculum Inquiry, 6* (3), 205-228.

van Manen, M. (1991a). *The Tact of Teaching. The Meaning of Pedagogical Thoughtfulness.* Albany: State University of New York.

van Manen, M. (1991b). Can Teaching Be Taught? or Are Real Teachers Found or Made? *Phenomenology Pedagogy, 9,* 182-199.

Vi i förskolan, (1979). *Föräldrasamverkan.* Stockholm: Förskolans förlag.

Watson, J. (1988). *Nursing: Human science and human care. A theory of Nursing.* New York: National League for Nursing.

Wikander, B. (1995). Nurses' advice to parents with a crying infant. *Scandinavian Journal of Caring Sciences, 9* (2), 87-93.

Young, J. (1992). Changing attitudes towards families of hospitalized children from 1935 to 1975: a case study. *Journal of Advanced Nursing, 17,* (12), 1422-1429.

Ödman, P-J. (1979). *Tolkning, förståelse, vetande. Hermeneutik i teori och praktik.* Stockholm: AWE/Gebers.

Ödman, P-J. (1992). Interpreting the past. *Qualitative Studies in Education, 5* (2), 167- 184.

Ödman, P-J. (1995). *Kontrasternas spel - en svensk mentalitets- och pedagogik-historia.* Stockholm: Norstedts

Appendix

The nurses' forms of action styles in encounters with parents are generated from186 situations over a year (1995).

These situations have divergent duration from 2 minutes unto 2 hours 10 min. Some situations are overlapping and went on in continuing series.

The delivering of action styles was by;

- the assumptive style in 42 situations, dividing up as;

  with an acquiescent orientation in 12 situations

  with an evasive orientation in 6 situations

  with both acquiescent and evasive in 6 situations,

  with a resolute orientation in 13 situations

  with both evasive and resolute in 5 situations.

- the demanding style in 61 situations, dividing up as;

  with a confirming orientation 41 situations

  with a forcing orientation 20 situations

- the eliciting style in 54 situations and

- the collaborating style in 29 situations.

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