STRATEGIES SUPPORTING THE HEALTH PROCESS AS EXPERIENCED BY WOMEN WITH A LIFE THREATENING DISEASE AND EXCELLENT NURSES

KIRSTEN PRYDS JENSEN

Göteborg University
1999
ABSTRACT
Development of basic knowledge about patients’ own health strategies and the impact of professional caring/nursing on the health process are considered essential in order to improve nursing care to people in need of that service. The aim of this licentiate thesis is to explore and describe patients’ health strategies when stricken by a possible terminal disease and the impact of professional caring/nursing on the process illuminated from both patients’ and nurses’ perspectives.

Three studies were conducted within the qualitative paradigm, due to the kind of scientific knowledge wanted. Two methods were used, a descriptive phenomenological method, and a descriptive exploratory method. Ten Danish women, suffering from breast cancer, and sixteen Swedish excellent nurses were interviewed.

The patients' health strategies appeared to be dependent on their determination to go on living. In the health process, it was found imperative that the patient worked actively, created something to live for, and achieved a harmonious relationship with supportive significant others and nature. In the process the patient experienced awareness and avoidance and gained insights about life itself (paper I). The patients perceived the supportive health strategies performed by the excellent nurse as, being able to "catch their wavelength” and in a positive, genuine, supportive connectedness, transfer knowledge and courage to them (paper II).

The nurses perceived the supportive health strategies performed by the excellent nurse, as being able to construct a caring connectedness and maintain that connectedness all the way through. In the health process the nurse should be able to support the patients own health strategies and/or initiate health strategies the patients were not aware of (paper III).

There were great similarities in patients and nurses perception of supportive health strategies. The strategies may be used spontaneously by the patients or if necessary initiated and supported by the nurses.

Key Words: Breast Cancer, Caring Moment, Excellence in Nursing, Excellent Nurses Perspective, Nurse-Patient Relationship, Patients’ Perception, Phenomenology, Supportive Health Strategies.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>2</td>
</tr>
<tr>
<td>PREFIX</td>
<td>4</td>
</tr>
<tr>
<td>INTRODUCTION</td>
<td>5</td>
</tr>
<tr>
<td>LITERATURE REVIEW</td>
<td>5</td>
</tr>
<tr>
<td>RESEARCHERS PERSPECTIVE</td>
<td>8</td>
</tr>
<tr>
<td>PURPOSE</td>
<td>12</td>
</tr>
<tr>
<td>METHOD</td>
<td>12</td>
</tr>
<tr>
<td>Participants and Ethical Considerations</td>
<td>12</td>
</tr>
<tr>
<td>Interviews and Analyses</td>
<td>13</td>
</tr>
<tr>
<td>Validity and Reliability</td>
<td>15</td>
</tr>
<tr>
<td>PAPERS</td>
<td></td>
</tr>
<tr>
<td>Paper I, The meaning of “Not giving in” - lived experiences among women with breast cancer</td>
<td>16</td>
</tr>
<tr>
<td>Paper II, &quot;Catching my wavelength&quot;- Perceptions of the excellent nurse</td>
<td>17</td>
</tr>
<tr>
<td>Paper III, The Caring Moment and the Green-Thumb Phenomenon among Swedish Nurses</td>
<td>18</td>
</tr>
<tr>
<td>RESULTS</td>
<td>19</td>
</tr>
<tr>
<td>DISCUSSION</td>
<td>23</td>
</tr>
<tr>
<td>IMPLICATIONS FOR NURSING PRACTICE AND EDUCATION</td>
<td>28</td>
</tr>
<tr>
<td>FUTURE RESEARCH AREAS</td>
<td>28</td>
</tr>
<tr>
<td>ACKNOWLEDGMENTS</td>
<td>29</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>30</td>
</tr>
<tr>
<td>ORIGINAL PAPERS</td>
<td>34</td>
</tr>
</tbody>
</table>
This licentiate thesis is based on the following three papers:


INTRODUCTION
Development of basic knowledge about patients’ own health strategies and the impact of professional caring/nursing on the health process are considered essential in order to improve nursing care to people in need of that service. The primary focus for the nurse is considered to be on helping and supporting the patient/person to attain, maintain or regain the optimal level of living, wellbeing or health they choose, given their personal and environmental resources (Jones et al., 1993). In other words, nurses focus on how people are living, with their actual life conditions including chronic disease, change in body image due to accidents or surgery, or an impending death. Never the less there has been little research of strategies supporting the patients health process in professional caring/nursing. Earlier studies have focused on the meaning of professional caring/nursing perceived by patients or nurses. Few studies have compared patients and nurses experiences in this sense.

The research focus in this licentiate thesis is on exploring and describing strategies supporting the health process in order to achieve wellbeing/health, perceived by patients suffering from a life-threatening disease, here represented by women suffering from breast cancer. Supportive health strategies (strategies supporting the health process) are understood as strategies patients with a life-threatening disease and excellent nurses have experienced as crucial to increase wellbeing/health. A specific interest is taken in the experienced supportive health strategies used in the nurse – patient interaction. They are illuminated from both patients' and nurses' perspectives. Knowledge about lived experiences of supportive health strategies from patients' and nurses' perspective will contribute to the improvement of nursing care for such patients.

LITERATURE REVIEW
Patients' Views

Brown (1986) asked hospitalized patients to describe an experience in which they had felt cared for by a nurse. She found that these patients' views of professional caring/nursing supported both the theoretical descriptions of professional caring/nursing and the findings of the empirical studies. Brown concludes: "Patients speak clearly about the importance of the nurse meeting their needs (instrumental activities) and doing this in a way that protects and enhances the unique identity of the individual (expressive activities)"(p 61). Riemen (1986) found in her phenomenological study that professional caring/nursing is not only what the nurse does in physical acts of assistance but also what the nurse is. To the patients the nurse must be existentially present or available, show genuine interest in the patient and treat the patient as a valued individual. Tishelman (1993) found from her study interviewing forty-six cancer patients about the information and help they might have desired and/or received from the nursing staff, that the nurses were defined not only by what nurses are and do, but also by what they are not, and do not do. In positive encounters, the nurse was knowledgeable, interested in the patient and able to calm him or her and infuse hope. In negative encounters, the nurses were negligent and/or uncaring. Halldórsdóttir (1996) conducted a phenomenological study of caring and uncaring encounters within nursing and health care, from the cancer patient's perspective. From this she found that the caring encounter was perceived as: "The caring nurse, an indispensable companion on the cancer trajectory, the resulting mutual trust, and the perceived effect of the caring connection; a perception of solidarity, empowerment, wellbeing and healing (p. 106)". Carter (1989) describes from her phenomenological study of survivors (meaning "those who do not give up" p.237) of adult women suffering from breast cancer that the women had discovered some helpful strategies in surviving cancer. Strategies that helped the women "not to give up" appeared to be due to their ability to be optimistic, to put things behind, to have mutual solutions to problems, and to focus on the future.

Nurses' Views

Benner (1984) describes in her phenomenological study from clinical practice, based on written statements and interviews of approximately 1200 nurses that expert nurses are able to empower their patients through professional caring/nursing, and to facilitate supportive health strategies. She characterizes the power that resides in professional caring/nursing as transformative power, integrative caring, advocacy, healing power, participative/affirmative power and problem solving. Ford (1990) uses a phenomenological approach when
interviewing nurses in a cardiac context. She describes nurses lived experiences of professional caring/nursing. For a nurse to facilitate supportive health strategies he or she should be able to sense the patient’s vulnerability, to act beyond the call of duty, and to be in tune with the patient’s world. Furthermore the nurse should be attentively present, center on the patient and be able to comfort the patient.

Patients’ and Nurses’ Views

Gardner and Wheeler (1979) conducted a study, using a questionnaire and a structured interview to determine which supportive nursing behavior patients and nurses perceived as being most important. The patients ranked the following three items as most important: 1) the nurse helped me to feel confident that adequate care was provided; 2) the nurse was friendly, and 3) the nurse showed interest in me. The nurses ranked the following three items as most important: 1) to show interest in the patient; 2) to create an environment where patients feel free to express feelings; and 3) to take time to listen to the patients. The authors conclude: “There was no statistical significance between patients and nurses in their perceptions of supportive nursing behaviors for 65% of the behaviors listed in the questionnaire. Both the patients and nurses agreed that showing interest in the patient, assisting the patient, and providing moral support were among those behaviors most important to providing supportive care” (1979 p. 112). Larson conducted a study among hospitalized cancer patients in 1984. The Caring Assessment Instrument (CARE-Q) developed by Larson (1981), was used. The results showed that patients identified as most important those nurse behaviors that indicated competent clinical expertise as "knows how to give shots", "I.V. etc." and "how to manage the equipment like suction machines, etc." (instrumental behaviors). Larson (1986) found when using the CARE-Q instrument on cancer nurses that they identified as most important those nurse behaviors that indicated "listening", "touching", "allowing expression of feelings" and "talking to the patients" (expressive behaviors). Larson's studies have been replicated using the CARE-Q instrument in UK on other patients and nurses, with the same outcome. (Mayer, 1987; Keane et al., 1987). In Sweden Essen and Sjödén (1991) have replicated the study with both patients and nurses using the CARE-Q instrument. In this study the patients and the nurses agreed upon the following five items as being among the ten most important nursing behaviors. "Knows when to call the doctor", "puts the patient first no matter what else happens" "tells the patient in an understandable language what is important to know about the illness and the treatment", "listens to the patient" and "is perceptive to the patient's needs". The researchers state that: "These results indicate that both patients and nurses consider task
oriented, cognitive and affect oriented components to be important aspects of caring” (1991, p. 274). They conclude, "patients, even when they have the choice to give equal priority to the instrumental and emotional activities, still value the instrumental items higher. The nurses on the other hand, give approximately equal priority to both aspects. This indicates that they consider both to be central components of care" (p. 279). They come up with the same conclusion as found by the other researchers who have used the CARE-Q instrument, that there is a discrepancy between the patients and the nurses perception of care, where the patients value the instrumental behaviors highest, and the nurses values the expressive behavior highest. Finally Swanson (1991) has empirically defined professional caring/nursing through phenomenological investigations in three separate perinatal contexts. By interviewing women who had just become mothers, women who had recently miscarried, and caregivers, she defined professional caring/nursing as "a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility" (p. 165). The way of relating includes knowing, being with, doing for, enabling, and maintaining belief.

In summery: No research has been found with the focus on supportive health strategies, using a phenomenological approach when investigating patients and nurses experiences. The most pertinent study is Carter’s (1989), where survivors describe own experiences of helpful health strategies and concerning the nurses', Benner’s study (1984) shows that expert nurses have an ability to empower their patients through professional caring/nursing.

RESEARCHER’S PERSPECTIVE
This licentiate thesis is grounded in phenomenology. The philosopher Edmund Husserl developed phenomenology as a school of thought in the early 20th century. He introduced the idea of phenomenology, as he believed that the study of philosophy needed a new grounding that should be based on phenomena as directly experienced. Husserl argued against psychologism because of its attempt to reduce logic to psychology, by understanding the logical laws as nothing but laws for psychological activity. Such a position implied the denigration of philosophical knowledge, and an excessive demand for objectivism even in relation to the human sciences (Giorgi, 1994). Husserl’s critique of psychologism is the central idea in his phenomenological philosophy (Bengtsson 1993). He developed his philosophy of knowledge from the basis of people’s “life world”, and showed how phenomenology attempted to explicate meaning in a rigorously
scientific manner by “going back to the things themselves”. Husserl suggested that phenomena cannot be separated from the experience of them; therefore the way to get access to the phenomenon is through descriptions of it, in the person’s own words (Cohen 1987). The “life world”, as the place for concrete experiences of everyday life, taken for granted in all human activities, is seen by Husserl not only as partially pre-reflective but especially pre-scientific. It becomes the prerequisite for all empirical theories and for all scientific work. It is from this “life world”, science gathers its data, and it is to this “life world” science has to refer its results (Bengtsson, 1993). Natural experiences are, according to Husserl a kind of consciousness, and consciousness is intentional, which means that consciousness is always directed towards something but itself. The things consciousness are directed towards, are not perceived just as facts, but due to the experienced consciousness, as something meaningful. Consciousness constitutes the “life world” of humans (Giorgi, 1994). Husserl’s philosophy of phenomenology later on became the basis for the empirical sciences studying human phenomena. This foundation begins by accepting as relevant data; the descriptions of the participants’ own experiences of the phenomenon.

Nursing is defined as concerned with helping people through professional caring in being or becoming healthy. Health is the goal of nursing and one of its central concepts. Health is viewed as a way of being, living, and becoming, in whatever wellness-illness condition the person is living in. Health is an inner balance and harmony even present within illness. Being healthy refers to a process of becoming, with a sense of coherence and integrated development of the whole person (Parse, 1981; Watson 1988; Benner & Wrubel, 1989; Meleis, 1990). Health is empowerment, and nursing interventions should empower individuals and groups to develop their health potential by supporting the person's health process and by guiding the person/patient to establish the congruency and harmony in self and with significant others (Jones et al., 1993). The nurse should, so to speak, be able to support the patient to develop health strategies and increase the level of wellbeing/health.

Smith (1981) calls this view of health, the pursuit of eudaimonistic wellbeing. She delineates four views of health that include health as absence of illness; ability to perform one's role; capacity to adapt, and as the pursuit of eudaimonistic wellbeing. She states that eudaimonistic wellbeing embraces the three other views and expresses “an ideal of the civilized, cultured person who has the capacity for continuous growth, the refinement of sensibilities, and creativity” (p.48).
Professional caring is viewed as the essence of nursing (Leininger, 1977; Watson, 1985; Meleis, 1990). Caring is perceived in line with the description of Mayeroff (1971). Mayeroff characterizes caring as being able to respond to the needs of the other and understand what one's own powers and limitations are. Caring includes knowing when to act and when not to in relation to the patient, to tolerate the other and give the other room to live. Caring is to see the other, as he is, not how one would like him to be. To trust a person to grow in his own time and in his own way, and to have a genuine humble attitude towards the other. Hope and courage is always incarnated in caring. The nurse should have hope for the realization of the other through caring and courage in caring to trust the other to grow. The nurse should also trust his or her own ability to care for the other.

There is a difference between caring and professional caring/nursing. Caring is only one important aspect of professional caring/nursing (Halldórsdóttir, 1996). Professional caring/nursing is defined as the cognitive and culturally learned action, techniques, processes, or patterns that enable an individual, family, or community to improve or maintain a favorably healthy condition or lifeway (Leininger, 1981). Professional caring/nursing is always practiced in a human to human encounter, the primary focus of nursing is therefore on the interpersonal interaction occurring between the patient and the nurse. Technical and medical interventions are considered to be an adjunct to this interaction (Chinn & Jacobs, 1987).

The notion of a caring connectedness is, for the author, rooted in Buber’s (1958) thinking of the relation. He states in his book “I and Thou”, that in the beginning there is relation. The “self,” or the “I,” of each person comes into being in one or another of two primary relations, the I-it, or the I-Thou relation. He contends that what really determines the being of a man is the way he relates to the being and events of the world. It is the nature of the relationship that constitutes the person. Buber acknowledges that the I-it relationship is necessary for human life and progress to understand and order the world. Yet he claims that the I-it relation is not the primary human relationship. This is found only in the relation of I-Thou. According to Buber, the I-it relation is experiencing, and experiencing takes place within the person and not between persons. It is a purely subjective process, lacking any mutuality, and marked by the subject – object dichotomy. Buber states that no man can know another person as simply as he knows objects. Knowing another person requires openness, participation, and empathy. Buber states, “The primary words of I-Thou can be spoken only with the whole being …I become
through my relation to the Thou; as I become I, I can say Thou. All living is meeting”(p. 40). An I-Thou relation involves a real encounter and genuine mutuality.

The way of understanding the characteristics of a helping relationship in this thesis is described by Rogers (1979) under influence of Buber. Rogers outlines a helping relationship as; “a relationship, in which at least one of the parties has the intent of promoting the growth, development, maturity, improved functioning, improved coping with life, of the other” (p.413). He found that relationships, which are helpful, have different characteristics from relationships, which are unhelpful, and that these differential characteristics have to do primarily with the attitudes of the helping person on the one hand, and with the perception of the relationship by the receiver, on the other.

Buber’s and Rogers’ thinking have influenced several nurse scientists, in their way of perceiving the professional caring/nursing relationship. According to Watson (1988) caring is always actualized in a human-to-human relationship, an actual caring occasion and a caring person is “somehow responsive to another person as a unique individual, perceives the other’s feelings and sets apart one person from another, from the ordinary” (p. 34). Watson (1988) has theoretically described ten carative factors essential to a professional caring/nursing relationship and applied these in clinical care. These factors express the expectations of a nurse concerning thinking, feelings and actions in relation to the patient. Halldórsdóttir (1996) states that professional caring/nursing is actualized in the nurse-patient connectedness, where the aim is to help another to grow and actualize her/or himself or to achieve human potential.

In summery: Nursing is concerned with helping people in the process of being or becoming healthy, where health is understood as a way of being, living, and becoming, in whatever wellness-illness condition the person is living in. Health is seen as an inner balance and harmony even present within illness. The nurse shall be able to support the patient to develop health strategies and increase the level of wellbeing/health. This is practiced through professional caring/nursing in a caring encounter where the nurse and the patient are living an I-Thou relationship. To get more knowledge about supportive health strategies a phenomenological approach is regarded appropriate, because it mirrors the experiences of the participants.
PURPOSE
The aim of this licentiate thesis is to describe how nurses can support strivings for wellbeing/health in women with a life-threatening disease. This will be achieved, more specifically, by describing:
a) lived experiences of own supportive health strategies in women living with a life-threatening, disease (paper I).
b) lived experiences of supportive nursing strategies in women living with a life-threatening, disease (paper II).
c) excellent nurses experiences of own supportive health strategies in helping patients living with a life-threatening disease (paper III).

METHOD
The study design is descriptive with a qualitative approach. Two different qualitative methods are used. The data is gathered in Denmark with women suffering from breast cancer (paper I, paper II) and in Sweden with excellent nurses (paper III).

Participants and Ethical Considerations
Participants in the first and the second study were found amongst women suffering from breast cancer, who lived the phenomenon “Not giving in”. Criteria for inclusion of participants were stated as follows: long experience from hospitalization as well as from outpatient clinics, and having experience of the challenge of suffering from a possible terminal disease. They should have gone through breast cancer surgery more than one year previously, still be in secondary treatment, such as chemotherapy and/or radiotherapy, and at the time for the interview, not hospitalized. Furthermore the subjects should be willing and able to communicate their experiences. The participants were selected because they fulfilled the criteria above. The Danish Cancer Society helped to find the women participating in this study through their Patient-Telephone-Network (P.T.N.). The women chosen were asked by the P.T.N. representative for permission to give their names and addresses to the researcher. The women selected as potential participants received a letter in which they were asked to participate in the study. The aims were explained and so were measures to protect confidentiality of the participants and of the persons mentioned during the interview. Furthermore, it was stressed that participation was voluntarily and that they at any time could
withdraw. Finally the women were offered the possibility to contact the researcher at any time, if needed.

Participants for the third study were found among nurses regarded as excellent. Benner (1984) claims that expert practice may demonstrate new knowledge and new understanding. Therefore it was considered important to study the practice of excellent nurses to determine new health strategies and to advance levels of practice. The expectations were that these nurses were capable and willing to communicate their experiences. The nurses participating were proposed by their superiors. The chief physicians and nurse supervisors were sent a letter asking for names of nurses whom they considered to have a green-thumb in caring for people. The green-thumb metaphor is well known in Sweden. Its' interpretation in the nursing context was left to the superiors. The nurses selected as potential subjects received a letter in which they were asked to participate in the study. The aim was explained and so was measures to protect confidentiality of the subjects and of persons mentioned during the interview. Once again, it was stressed that participation was voluntary and that they at any time could withdraw.

**Interviews and Analyses**
In order to discover the lived experiences of supportive health strategies facilitating wellbeing/health, the phenomenological approach was regarded as the most appropriate. The data gathering was performed through semi structured and open interviews in order to explore the “life world” of both patients and nurses.

Within phenomenology there are several methods for data gathering and data analysis. One of these, used in this thesis (paper I), is the descriptive phenomenological method, developed by Giorgi (1975). The aim of this method is to study human experiences by going back to the things themselves in the world where people are living their everyday life. The research starts with a naive description of the experience under study, and data is gathered during unstructured in-depth interviews that may be continued in several sessions. Due to the amount of data the number of subjects participating in the studies are usually small. The method requires the researcher to let the experience unfold exactly as it exists for the person, and during the interview with all techniques possible, make the resulting description of the experience truly capture the experience as it presents itself to the person.
The four steps in the analysis include bracketing, intuiting, analyzing and describing the phenomenon (Giorgi, 1994). To be able to understand the phenomenon, the researcher must first arrive at the subject’s world, by a suspension, or bracketing, of all presumptive constructs about it. It deals with adopting an attitude of “open-ended presence to the phenomenon that is unfolding and be able to “see not only what one expects to see” (Giorgi, 1994, p. 91). This is done by reading the transcript as a whole with attention not only to the linguistic content, but also to the intentional, or lived experience, to get a sense of the whole. The next step is, to discriminate into meaning units by intuition. Intuiting means to clarify what the researcher is present to, based upon the subjects descriptions of the phenomenon and the researcher remains open to what is implicit as well as explicit. In summary the data analysis includes the following steps: (a) Reading the descriptions to get a sense of the whole. (b) Reading the descriptions and discriminate into meaning units, with sensitivity to the phenomenon investigated. (c) The meaning units are then transformed within the researcher’s perspective, into the language of science in a way that captures the intuited essence of the phenomenon in an individual or situated structure for each of the participants. (d) Finally, the researcher integrates and synthesizes the insights of the phenomenon under study into a general structure, and communicates the results to other researchers for confirmation and/or criticism (Giorgi, 1994).

A second method within the qualitative paradigm, used in this thesis (paper II, III), is the descriptive exploratory method described by Taylor & Bogdan (1984) and in a nursing context by Parse et al. (1985). The descriptive exploratory method is a human science method, which focuses on discovering the meaning of an event in time. The aim of the descriptive exploratory method is to intensively investigate the background and environmental interactions of a given social unit. A social unit is understood as an organized entity having common characteristics: A person, a family, or a set of persons or families. The study encompasses a macroscopic moment or a microscopic moment in time. The nature of the moment depends on the phenomenon guiding the study and the question posed in the study. Parse et al. (1985) suggests, that “when the researcher seeks to study man-environment interactions as a unit, this method is one of choice” (p.90). The method generates understanding and enhances theory.

The phenomenon under study is guiding the organization of the entire study, evolving from a particular frame of reference or researcher’s perspective and setting the context for complete
implementation of the study. In the descriptive exploratory method, the participants are found by going to the people experiencing the phenomenon, who are able and willing to give the most detailed information about the phenomenon under study. It is according to Parse et al. (1985) a method, which yields findings based upon conversations and observations. Data can be gathered through semi-structured interviews, observations, or questionnaires. The interview is a face-to-face encounter between the researcher and the person. In this encounter, the person shares specific information related to the objectives of the study. Interview questions are open ended and directed toward uncovering the meaning of the lived experience. The interview is tape recorded and transcribed verbatim. The data analysis includes the following six steps: (a) Transcripts are read to achieve a sense of the whole. (b) Transcripts are analyzed and the essential points are summarized in paraphrases. (c) Major themes are extracted. (d) The import of these themes are formulated and organized into theme clusters. (e) Theme clusters are formed as concepts and, (f) the essence of the phenomenon studied is described and communicated. The descriptive exploratory method includes an elaboration of the context of the situation, as well as the retrospective happenings and prospective plans surrounding the life event.

**Validity and Reliability**

The terms, validity and reliability are strongly associated to science conducted within the quantitative paradigm. In this tradition validity means a correspondence between a proposition and the ability of referent to match the proposition. Reliability refers to how consistent the match is. Using the same concepts within a qualitative paradigm might give the impression that the meaning of the terms is similar. Nevertheless the meaning of the terms is different, and redefined by Giorgi (1988). If the essential description truly captures the intuited essence, one has validity in a phenomenological sense. This means that one adequately describes the general essence that is given to the consciousness of the researcher. If one can use this essential description consistently, one has reliability (Giorgi, 1988).

Validity in this licentiate thesis deals with getting the data as exact as the participants describe their experiences in their own words. Validity is obtained by recording the participants' oral narratives and detailed expression of past experiences, present aspirations, and future plans and afterwards transcribes the bands verbatim. Validity is further assured by gathering the data in a favorable situation (a place decided by the participants) where the free and spontaneous dialogue is possible and where the tendencies to deception or prejudice are absent or at a minimum. Validity further deals with having developed an in-depth
understanding of the settings or people under study, in a way that the researcher is able to stay as close as possible to the original data. This part of validity is addressed by being with the participants in an attentive interview situation one to three hours with the possibility to confirm the researcher's understanding of the meaning expressed through in depth questions. And finally when presenting the result it should be possible for the knowledgeable reader to follow the different steps in the data analyses (Taylor & Bogdan, 1984). The referee panel accepting the papers for publication assures validity in this sense. Reliability is tentatively dealt with as well by the referee panel, who has been able to recognize the description. Generalization is not possible at the concrete level, but the knowledge developed can, on a meta-level, help to see or sharpen the attentiveness to other persons' experiences - persons who are in the same situation. In this school of thought, validity, reliability and generalization seems to be reasonable in the papers.

PAPERS

Paper I

The meaning of “Not giving in” - lived experiences among women with breast cancer

The aim of this study was to explore and describe the phenomenon of "Not giving in" existing among some women with breast cancer, in an attempt to enhance the understanding of the conditions for living when confronted with a fatal disease. Due to the potential to grasp the meaning of a lived experience, and gain new insights about a phenomenon, the descriptive phenomenological method developed by Giorgi (1975) was chosen.

To be able to get the richest and most genuine narratives that could illuminate the phenomenon, the study included 10 women suffering from breast cancer. These women, living in a suburb of Copenhagen, were chosen because of their experience of "Not giving in" while living with cancer and their willingness and assumed ability to describe these experiences. The time and the place for the unstructured interviews were the choice of the women. In all cases the interview took place in their homes, alone or together with whom they wanted. The women were asked to describe their experience of living with breast cancer, and encouraged to make the description as detailed as possible including feelings, reactions, and reflections, without leaving anything out. From the narratives a general structure of the phenomenon emerged. “Not giving in” presented itself in the woman as a firm determination to go on living and thereby directly face and accept, not avoid, the challenge of suffering from a possible terminal disease. The challenge inspires the woman to actively work, using
specially designed and natural strategies in the healing process, with the goal to continue living a valuable life. In the struggle to live, the woman continuously finds something important to live for and gains insights about life itself. The woman is living through the treatment process with a preconscious awareness of the constant possibility of death, and a constant avoidance of that possibility. This tension helps induce hope and radical change in the woman’s life. When actively working with the healing process, the natural strategies the women actually used were things like outdoor life, classical music, poems, flowers etc., to direct her energy towards living a healthy life. One woman started to pray to God as a temporary designed strategy, and some women turned to alternative treatment, as a designed strategy, to obtain harmony, because the principles were in line with their beliefs of self-healing. The nurse, who supported the woman in the healing process, was significant to her.

**Paper II**

"Catching my wavelength"- Perceptions of the excellent nurse.

The aim of this study was to explore the essential characteristics of an excellent nurse from the perspective of women with breast cancer, in an attempt to broaden the knowledge and the understanding of excellence in nursing practice. The descriptive exploratory method (Parse et al., 1985) was chosen. The 10 women included in this study were the same as in the above-mentioned study. The semi-structured interviews were conducted in their home setting, alone or together with whom they wanted. The women were asked to describe the characteristics of an excellent nurse and to describe a caring situation in which the nurse was involved. The women were encouraged to give answers as detailed as possible including feelings, reactions, and reflections, without leaving anything out. From the narratives told, a picture of the excellent nurse and the caring encounter emerged. The excellent nurse was knowledgeable and skilled. The nurse knew how to be with the women in crises. The nurse used herself and her entire capacity, including knowledge from nursing and medicine, knowledge about human beings and communication skills, in the interaction. The nurse met the women with a genuine positive attitude, respected and acknowledged personhood, and showed a constant and genuine concern for the person. The nurse dared to come close to the women in chaos and stay there, steady like a rock. The nurse was able to encourage hope and meaning that made the women discover other values in life. By her way of being, the nurse immediately became that trustful person the woman would like to keep in contact with, she rapidly caught her wavelength, understood her situation and treated her the way she wanted. The women claimed that the nurse was like a good friend they had known for a long time and with whom they felt
secure and comfortable. These characteristics of the excellent nurse formed the concepts: competent, compassionate, courageous and concordant. Concordance appeared to be more important to the women than expected, and was described as directly related to their perception of the excellent nurse and excellence in nursing.

**Paper III**

**The Caring Moment and the Green-Thumb Phenomenon among Swedish Nurses**

The aim of this study was twofold, namely to identify and describe the characteristics of Swedish nurses considered having a green-thumb for nursing and, to identify and describe the characteristics of a caring moment, as perceived by these nurses. The metaphor, having a green-thumb for nursing was used as synonym for excellence in nursing. The descriptive exploratory method (Parse et. al., 1985) was chosen. To obtain the richest and most genuine narratives describing the phenomenon, 16 nurses, considered by their superior as having a green-thumb when caring for people, were participants in the study. The nurses were in head nurse or staff nurse positions at in-patient units of comparatively small hospitals along the west coast of Sweden. The time and place for the semi-structured interviews were the choice of the nurses. In all cases they were conducted in an area of the hospital where privacy was guarantied. The nurses were asked to identify and describe the characteristics of a green-thumb nurse, and a situation where their actions were of great positive importance to a patient. The nurses were encouraged to give as detailed answers as possible including feelings, reactions, and reflections, without leaving anything out.

From the narratives told, a picture of the excellent nurse and the caring moment emerged. The excellent nurse demonstrates knowledge and practical skills, from nursing and medicine, self-knowledge, the capacity of using herself as a "tool" in interactions with patients, and knowledge of human beings. The excellent nurse uses the nursing process, acts adequately in acute situations, is technically skilled, and is knowledgeable about drugs and diseases. The excellent nurse knows who she is and what she stands for, and has confidence in herself. The excellent nurse uses self as a "tool" when interacting with patients, by being totally present and communicating in a consistent way. In these situations, the excellent nurse uses empathy and timing based on intuition, creativity, humor and imagination to make the patient see possibilities and new perspectives, thereby inspiring faith in and hope for the future.

Knowledge of human beings dealt with preservation of autonomy and self-control. This was expressed as the capacity to make the patient feel important and valuable in decision making, to understand the impact of illness and to acknowledge the importance of finding meaning in
living. Moreover the ability to encourage the patients to make the best of their situation was emphasized.

The excellent nurse demonstrates love for human beings, is deeply concerned and acts on the basis of ethical values and attitudes in nursing. The excellent nurse approaches the patient with a genuine positive attitude and is committed and interested as well as honest and generous when helping and supporting the patient. The excellent nurse wants the patient to feel respected, recognized, and favored. Being together with, listening to, offering the patient sufficient time to express him- or her self and really being there were also mentioned as important in the nurse-patient interaction. The excellent nurse demonstrates courage when connecting with people in a crisis, when practicing advocacy, and when coping with stressful situations in the working environment.

The excellent nurse dares to maintain a close human-to-human relationship when caring for a dying patient and his or her family. The excellent nurse is willing to go beyond the conventional limits when necessary and dare to approach patients even when the risk of rejection is obvious. The excellent nurse practices patient advocacy in spite of the possible conflicts within the team, and by intervening before a team member makes a mistake. From the narratives a picture of a caring moment emerged. Mutual attentions, harmony, trust, and the experience that "the time stopped" characterizes the caring moment. The nurse creates the situation through her consciousness and her way of being. The caring moment is the encounter where affirmation, meaning, hope, and courage, are transcended to the patient. In conclusion, the excellent nurse is one who creates a caring moment and acts consciously on the spur of the moment with competence, compassion, and courage.

**RESULTS**

The result of this licentiate thesis is fourfold. It has enlightened women’s own supportive health strategies. Furthermore it has enlightened supportive health strategies in nursing from both patients and nurses perspective. It has shown that people living with a life-threatening illness and excellent nurses agree upon essential supportive health strategies in nursing. Finally it has revealed prerequisites necessary to develop excellence in nursing.
Supportive health strategies used by women with breast cancer
"The meaning of not giving in"

Table I. Supportive health strategies and their varied embodiments as perceived by women with breast cancer.

<table>
<thead>
<tr>
<th>Supportive health strategies - perceived by women with breast cancer</th>
<th>Varied embodiments - synthesized transformed meaning units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accepting the challenge to go on living</td>
<td>by a desire to fulfill a life commitment and achieve self-actualization</td>
</tr>
<tr>
<td>Finding something important to live for</td>
<td>by a desire to experience continuity in life</td>
</tr>
<tr>
<td>Working actively on the healing process</td>
<td>by showing proper physical concerns, creating harmony and esthetic environments, and by seeking help from significant others including caring nurses</td>
</tr>
<tr>
<td>Experiencing awareness and avoidance</td>
<td>by deciding to have a positive outlook despite constant threat, and believe that the cancer is cured in spite of any doubts</td>
</tr>
<tr>
<td>Gaining insights about life itself</td>
<td>and not take life for granted, but enjoy life and take self-responsibility</td>
</tr>
<tr>
<td>Introducing radical changes in life</td>
<td>by starting to live a healthy life, by starting to respect own priorities, by solving important matters with significant others, and by discovering and appreciating other dimensions of life</td>
</tr>
</tbody>
</table>

**General structure:** The woman, who does not give in, lives her life with a firm determination to go on living and thereby directly faces and accepts not avoids the challenge of suffering from a possible terminal disease. The challenge inspires the woman to actively work, using special designed and natural strategies, in the healing process, with the goal to continue living a valuable life. In the struggle to live, the woman continuously finds something important to live for and gain insights about life itself. The woman is living through the treatment process with a preconscious awareness of the constant possibility of death, and a constant avoidance of that possibility. This tension helps induce hope and radical change in the woman’s life. This is perceived by the women as supportive health strategies.
In paper II and III reviles a picture of the excellent nurse and the caring moment from the women and the excellent nurses perspectives. When looking at the two images it is possible to compare them at the statement level. A great similarity was found. From this level the common supportive health strategies were reviled. In the following table II and III the supportive health strategies used by excellent nurses are described to the left. To the right the prerequisites for being able to use each of the strategies are listed. The excellent nurses describe the prerequisites.

### Supportive health strategies used by nurses

**Construct a caring connectedness through "Being on the same wavelength".**

Table II. Supportive health strategies used by excellent nurses when constructing a caring connectedness as perceived by women with breast cancer and excellent nurses are described to the left. To the right the excellent nurses express the prerequisites.

<table>
<thead>
<tr>
<th>Supportive health strategies used by the nurse- perceived by women with breast cancer and excellent nurses</th>
<th>Prerequisites as described by excellent nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>The nurse inspires confidence</td>
<td>by meeting the patient with a genuine positive approach, by being friendly, nice, warm kind, open and honest, and by showing respect and genuine concern and acknowledge personhood</td>
</tr>
<tr>
<td>The nurse obtains sense of congruity</td>
<td>by practicing timing</td>
</tr>
<tr>
<td>The nurse obtains reliability</td>
<td>by consistent communication</td>
</tr>
</tbody>
</table>

**General structure:** When constructing a caring connectedness the excellent nurse inspires confidence, reliability and sense of congruity, which is perceived by the women and the excellent nurses as supportive health strategies.
Table III. Supportive health strategies used by excellent nurses when maintaining a caring connectedness as perceived by women with breast cancer and excellent nurses are described to the left. To the right the excellent nurses express the prerequisites.

<table>
<thead>
<tr>
<th>Supportive health strategies used by the nurse - perceived by women with breast cancer and excellent nurses</th>
<th>Prerequisites as described by excellent nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>The nurse creates continuity in care</td>
<td>by being totally present with the patient when needed</td>
</tr>
<tr>
<td>The nurse infuses hope</td>
<td>by being knowledgeable in nursing, medicine and about human beings</td>
</tr>
<tr>
<td>The nurse makes the patient take responsibility in the healing process</td>
<td>by helping the patient experience a life commitment, and thereby find meaning in life. By preserving the patient's autonomy, through advocacy and education about the illness, the treatment and the human rights in the hospital</td>
</tr>
<tr>
<td>The nurse makes the patient work actively on the healing process</td>
<td>by explaining the meaning of finding harmony in life, and helping the patient to cope with everyday life, e.g., by using humor and small talk</td>
</tr>
</tbody>
</table>

**General structure:** The excellent nurse maintains a caring connectedness by creating continuity in care. This is done, by being totally present with the woman when needed. In the caring moments the excellent nurse infuses hope, makes the woman take responsibility for and work actively in the healing process. This is perceived as supportive health strategies both of the women and the excellent nurses.
In the following figure I, some of the results are simplified and summarized. The figure reveals the complexity of the situation in which the person with a life threatening decease are striving “not to give in”. The processes described are actualized in a caring environment. But this aspect has not been studied here.

![Diagram](image)

**Fig. I**

The arrows in figure I symbolize:

- The nurse's direct interventions with supportive health strategies.
- The nurse's interventions supporting the patient's own health strategies.
- Patient's own health strategies

**DISCUSSION**

**Methodological issues**

In qualitative methods the whole study; the theoretical approach, data collection coming from the participants’ experiences, the description of the data collected and the analysis procedure, is involved in the trustworthiness and reasonableness. The data collection with the women was carried out in a trustful encounter. The women had volunteered to participate. They knew that the researcher was a nurse who had no connection to the hospitals, where they were treated. They had a huge experience of living with cancer without ever giving in. The
interviews were conducted in their homes, on a time suitable for them. The researcher was often welcomed with a cup of coffee. The interview used to last approximately three hours and the researcher had the opportunity to explore meanings and experiences extensively. The data collection with the excellent nurses was carried out in a room at the hospital, away from their ordinary working settings. The excellent nurses had volunteered to participate. They knew that the researcher was a nurse who had no connection to the hospitals, where they were working. They had huge experiences of working as nurses and wanted to express their knowledge. The interviews were conducted on a time suitable for them. The interviews used to last approximately three hours, where the researcher had many possibilities to explore the meaning of several essential issues.

The differences between the two qualitative methods used are demonstrated in the analyses. In paper I significant statements are transformed into the language of nursing without changing the content. From this transformed meaning units the phenomenon is described. This procedure makes it possible for the researcher to maintain close to the statements from the participants. In paper II and III, the researcher is looking for themes, illuminating characteristics of the phenomenon under study. The themes are refined and gathered in theme clusters, the theme clusters are formed into concepts and finally the essence of the phenomenon is described. This procedure takes data out of the context and the results become more atomistic than the method above. Trustworthiness and reasonableness is also related to the method of proceeding and to the described substance of the categories (paper II table I and paper III table I). Trustworthiness is partly indicated by the chosen quotations that represents the atmosphere during the interview, and the concepts supported by qualities that are close to the participants description. The qualitative analyses were carried out from a nursing perspective. It was discussed and examined by the co-authors (SBP and KS), both experienced nurses.

Weaknesses may be found in selection of the participants. For the women with breast cancer there might have been a selection of women governed by preferences and opinions inside The Danish Cancer Society. When searching for excellent nurses the metaphor green-thumb was used. The superiors of the nurses were asked to make the selection. The reason for selecting a particular nurse is not very well known. Never the less, even if some valuable informants were not selected, the interviews indicated that the data obtained, were rich and informative.
Generalization in a qualitative research study deals with obtaining the essence of the phenomenon under study. By using imaginative variations in the analyses of the interviews with the women with breast cancer, an eidetic understanding and a general structure were obtained. Because this structure is based on empirical data and imaginative variations, its generality is true to the effect that there is an extrapolation beyond just these ten women. The results present one image of the phenomenon studied. Future research would possibly give more images that together would cover the experiences of most of the women suffering from breast cancer. The method is not supposed to mirror but to describe and explore the subjective reality. Therefore it is not possible to assert if these experiences are right or wrong. The subject of interest is to know the existence of these experiences and to understand the inherent meaning.

The descriptive exploratory method used in paper II and III has the same qualitative origin. It comes up with the meaning of a life event for a group of subjects who share a particular event. When working this way with data, one looks for and extracts themes through the analyses. The themes are then put together and integrated into theme clusters, concepts and finally the essence of the phenomenon studied is described and may be generalized beyond the group studied. The result identifies a number of concepts where future studies probably would find more themes that could be integrated in the concepts. As with the previous method, this is not supposed to mirror the objective reality, so it is not possible to assert if these experiences are right or wrong.

**Results**

Figure I, is illustrating the complexity of the situation in which the interaction between the nurse and the patient takes place. The caring connectedness created by the nurse makes it possible to transfer supportive health strategies to the patient in the caring moment. The patient has own health strategies that she uses consciously or strategies that can be activated by the supportive health strategies implemented by the nurse. If the patient is unable for some reason to use her health strategies, the nurse has the possibility of intervening directly with supportive health strategies, to obtain the phenomenon of not giving in.

The women described the importance of taking self-responsibility and to work actively on the healing process. It was imperative to accept the challenge to go on living and find something important to live for. In the process one had to experience awareness and avoidance to be able
to handle the constant fear, and as a consequence one gained insights about life itself. Focus on the future is inherent in the strategies of accepting the challenge to go on living and that of finding something important to live for. The strategy: experience, awareness and avoidance, embody a conscious positive outlook and the strategy: gaining insights about life itself, embraces the feeling of not taking life for granted any longer and to enjoy every minute of life. When comparing these findings to the Carter study (1989) of helpful health strategies, some similarities and some differences emerged. Carter found that being optimistic, putting things behind, and focuses on the future are helpful health strategies. Additionally Carter found that having mutual solutions to problems was a useful strategy. That strategy was not encountered in this study.

All women had experienced the feeling of being confronted with death; they had all found their answers to the question, why me? And they claimed that they were living a richer life after they had started to live their immediate priorities. Lifton (1979) claims that when a person is confronted with the end of life, this person experiences a basic human press for self-transcendence directed toward gaining a sense of continuity and vital participation in the larger human process. This experience was found in this study as well. The women got a new commitment to life where they began to get inspiration from being in close contact with nature, listening to relaxation tapes and some had a new contact to their God. They started to write poems, invent beautiful flower decorations and one changed her entire life and became an artist - sculptor working with iron and glass. Another dedicated her life to pass on the old traditions of craftsmanship to children, in order to preserve continuity. Reed (1991) describes a person’s awareness of the end of life as a context for development during which an expanded self-boundary occurs, the situation is positively related to indicators of wellbeing in the person. She identifies five modes of transcendence: creative work, children, religious belief, and identification with nature and mystical experiences. The women in this study mentioned these modes as helpful strategies used, and all expressed gratitude of having had the possibility to grow and develop.

The supportive health strategies used by the nurses were: inspiring confidence, obtaining sense of congruity and obtaining reliability to be able to construct a caring connectedness - catching the patients' wavelength. That the nurse was able to catch the patient's wavelength appeared to be of great importance when supporting the development of wellbeing/health in the patient. Little is written about this phenomenon but Benner & Wrubel (1989) and
Halldórsdóttir (1996) have described something similar. Benner & Wrubel (1989) refer to Hastings phenomenon “Making contact” with the patient. Which is “that peculiar ground where the nurse’s understanding of the illness builds a bridge to the patient’s lived experience of the illness. So that the nurse is comfortable talking about the daily consequences, and able to convey acceptance and understanding to the patient” (p. 12). Halldórsdóttir (1996) describes the development of the nurse – patient connection aspect where trust is developed as one of the most important aspects of professional caring/nursing. In this connection the nurse has to guard “a comfortable distance of respect and compassion” (p. 48). This position consists of “professional intimacy with professional distance” (p. 48). The importance of catching the patient's wavelength has not been stressed in this way in nursing literature, as significant in professional caring/nursing. It would therefore make sense to further explore the concept, to get a deeper understanding of the meaning of concordance in professional nursing practice.

In these studies there was a congruity in perception of supportive health strategies. Both the women and the nurses expressed the importance of being on the same wavelength (concordance) in the entire caring encounter, an encounter based on mutual attention and trust, where the patient was valued as a person, and treated with constant and genuine concern.

To maintain the caring connectedness - to be concordant - the nurse creates continuity in care, infuses hope, makes the patient take responsibility in the healing process and makes the patient work actively in that process. In the caring connectedness the nurse makes the patient take responsibility by preserving autonomy, through education and advocacy. When inspiring the patient to work actively on the healing process, the nurse infuses hope, and is caring in the every day situations. Benner (1984) describes this professional attitude and behavior. Watson (1985) calls an encounter like this "an actual caring occasion" and states that on such an occasion both patient and nurse experience an I-Thou relationship. This I-Thou relationship can release inner power and strength and helps the person to experience security and comfort and gain a sense of inner harmony. According to the women this connection and process generate and increase the self-healing process.

To the women, concordance emerged as crucial to establish a caring connectedness. This was not so clearly outlined in the nurses’ expressions. The connectedness itself seemed to nurture
a trustful and harmonious interpersonal relationship, necessary to perceive professional caring.

This study has illuminated helpful health strategies perceived by patients suffering from a life-threatening disease and by excellent nurses. Furthermore the prerequisites for the nurse to be able to provide supportive health strategies is clarified. In this study there are similarities in perception of helpful health strategies from both the patient and nurse perspectives. This is in contrast to earlier findings where there seems to be a difference between the patients' and the nurses' perceptions of nursing care (Mayer, 1987; Keane et al., 1987; Gardner and Wheeler, 1979; Larson, 1981, 1984, 1986; Essen and Sjödén, 1991). The difference in results may possibly be explained by the different methods used, and differences in expressing the meaning of nursing care.

IMPLICATIONS FOR NURSING PRACTICE AND EDUCATION
The results in this thesis may influence nursing practice, as well as nursing education, by focusing on the helping health strategies among some patients stricken by a life-threatening disease. In practice, nurses should search for the patient's own health strategies and in dialogue with the patient decide how to initiate and support the patient's health processes. Furthermore the excellent nurses' descriptions of what is to be done to provide supportive health strategies in nursing, and the educational and human prerequisites to obtain this level of nursing performance, should be able to guide nurses on there pathway to excellence.

FUTURE RESEARCH AREAS
In this licentiate thesis the patients suffering from a life-threatening disease were women suffering from breast cancer. It would be valuable, in future research, to investigate other groups of women suffering from other life-threatening diseases to see if the same patterns of health strategies are found. Likewise research conducted with men suffering from life-threatening diseases would be valuable to see if the patterns are the same. Furthermore learning more about patients' health strategies and nurses supportive health strategies for patients living with chronic diseases would make it possible to increase wellbeing/health for these groups in society. The concept concordance appeared to be of great importance to the
patients. As concordance is not previously dealt with in nursing literature, it would make sense to further study the meaning of the concept within professional nursing practice.

ACKNOWLEDGMENTS

For all the invaluable support during these studies I wish to express my sincere gratitude and appreciation to:

First and foremost, the knowledgeable and caring women and the excellent nurses who so generously offered their time to help me understand the meaning of their everyday experiences. The women revealed an understanding of supportive health strategies when living and coping with a life threatening disease and the excellent nurses illuminated the impact of professional caring/nursing on the health process.

Professor Kerstin Segesten, my tutor and co-author, for friendship, guidance, support and help.

Professor Calle Bengtsson, for valuable support, and for admitting me as doctoral student, at The Institution of Environmental Health, Department of Primary Health Care.

Siv Bäck-Pettersson, co-author and a close friend, for being there for discussions, for encouragement and support.

Evy Lidell my college for valuable comments during the preparation of this paper.

Evelyn Hermansson and Ann Nyström former colleagues, for valuable comments and a spirit of never giving in.

Helge Andreassen my friend, for support during the long and tedious hours of editing.

Gerda Lützen my good friend during the years, for improving my English grammar.

Susan Andersson a caring friend, for improving my language ability.

Karin Anna Pedersen, a dear friend, for encouragement and valuable comments all along the way.

And finally Dansk Sygeplejeråd for personal encouragement and economical support.
REFERENCES:


ORIGINAL PAPERS

